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DEVELOPMENT OF A SOCIAL SERVICE PROGRAM

FOR COLLEGE HEALTH SERVICES

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A Project

Presented to the

Faculty of

California State University,

San Bernardino

———————————————

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

———————————————

by

Joseph Harrison Greene

June 2001

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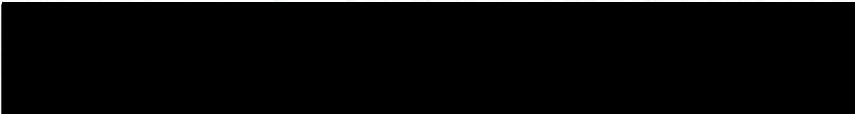
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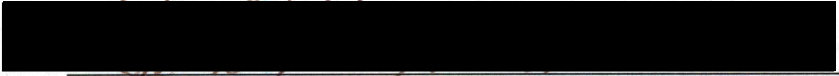Joseph Harrison Greene

June 2001

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ABSTRACT

The initial development of a social services program in a
college health setting is presented, with discussion
regarding causes, methods, and outcomes. Both empirical and
anecdotal data which were influential in the initial
formation of the program are reviewed, in the context of an
examination of the research literature relating to this
area. The actual development and implementation of the
program is followed through its first year of existence.
Outcomes are presented in the form of qualitative data
analysis and case studies. Discussion of the results and
recommendations for both future research and improvements to
the program are presented.

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CHAPTER ONE

INTRODUCTION

Purpose of the Project

As of 1995, 23.3 percent of all students at California

State University, San Bernardino were without medical

insurance (Lovett & Clark, 1994). In today's terms, that

would mean that approximately 3,000 students are attending

the University without medical insurance (CSU, San

Bernardino, 2001). That number can be expected to grow in

accordance with the increase in overall enrollment, and by

2010 the number of uninsured students could be around 6,000.

The University provides limited medical services

through the Student Health Center (SHC), which offers acute,

non-trauma services to enrolled students, but not their

dependents. The SHC is not accredited to provide services

for chronic medical conditions (AAAHC, 2001). Despite this

limitation, many students attempt to utilize the SHC to meet

their long-term health care needs.

According to anecdotal information from SHC health care

providers, students who are referred to community social

service programs to meet their health care needs tend to not

have those needs met. Given the difficulty often faced in

accessing public services, it is quite likely that student

faced with significant time constraints simply prioritize

the completion of their studies over the maintenance of
their health.

The eventual result, according to SHC physicians
(Jordan, 1999), is that the students eventually return to
the SHC for further services, sometimes due to the worsening
of the condition through neglect. Thus, the SHC is being
asked to provide quasi-chronic care without having the
benefit of the long-term, regular monitoring normally
utilized by chronic-care settings.

The problem, as it is perceived by the SHC, to link
students with community resources to meet their medical
needs. From a social work perspective, the problem is
somewhat more complex. In addition to simply meeting the
medical needs of the clients, it is important to be aware of
psychological and socioeconomic factors that may directly
affect the student client's ability and/or willingness to
seek those services. The application of the social work
model- that is to say, the biopsychosocial model- to meeting
the needs of the client is expected to address the multiple
needs of the clients in a way that the physicians and
nursing staff simply cannot.

There are three main areas of concern to be addressed
in this problem. First is the identification of the
biopsychosocial problems faced by the student population,

and how the interaction of these problems may be addressed by the social worker. The resources, both internal and external to the SHC, which can best address these problems must be identified. The process by which the students will be connected to the resources needed can then be developed. At this point, the social worker can begin to engage in the collaborative effort with the student to identify those resources which, in the student's opinion, would best meet those needs, and to actually connect the client with the resources. Finally, the services need to be evaluated for effectiveness by both the social worker and the client.

It was expected that the majority of the presenting problems would be biological, given the nature of the setting. Providers tended to refer patients for care of their medical problems, with social problems being of secondary concern and viewed primarily as obstacles to treatment of the medical condition. However, their social problems- poverty, lack of resources, lack of family support, etc- are also expected to manifest overtly. Additionally, it was important to observe the effect of the above areas on the psychological well-being of the individual. A thorough understanding of the biopsychosocial problems faced by clients was as important to understanding outcomes as it was in the treatment phase.

Resources are many and varied, but not necessarily simple to access. It is the role of the social worker to determine first what resources are available. Resources which will not place any further financial burden on the client include public health agencies and some private non-profit agencies. These will be the primary focus in terms of referral, as it is not unreasonable to expect that increased financial burden would decrease the likelihood of the client accessing the services. Understanding what resources were immediately available and which were more difficult to access will be an important component.

Networking is a critical part of any case management (O'Hare and Collins, 1997), in terms of developing resources for clients to access. It is equally important to understand the process by which resources were developed as it is to understand what the resources were. This is where the collaborative effort truly begins (Kisthardt, 1992).

The collaboration between client and case worker is an essential part of an effective working relationship (Kisthardt, 1992). It is the role of the case manager to identify appropriate resources for the client, present options, and assist the client in making well-reasoned decisions (Rapp, 1992, & Moxley, 1989).

There are three primary questions that can be clearly identified as central to this study. What are the basic characteristics and problems, speaking biopsychosocially, of the clients seen through the Social Services program at the SHC? What resources were identified and utilized for these clients? What was the experience of the clients in going through the process of the assessment, planning, and carrying out of treatment?

This project had its origins in the field instruction portion of the Master of Social Work program. The SHC had been aware of the need for case management and follow-up for some time, and a request was made by one physician that a first-year M.S.W. student intern be allowed to develop and implement a social services program to meet the needs in this area. A student with experience in program development was found, and the internship was approved. The program was begun in September of 1999 as a collaborative effort between the SHC and the Department of Social Work.

The effectiveness of practice in social work is based upon evaluation, using research methodology to continually improve services. Therefore it was determined, after the first year of the program, that the evaluative process would be carried out as comprehensively as possible through the use of this project. It was the purpose of this project to

critically analyze the effectiveness of the implementation of a social work program in a student health care setting based upon those ideas shown to be important in research literature. It was hoped that this project will point the way to further research in this area. As the provision of services to students without insurance would continue thereby to be improved, it was also hoped that these students will be able to continue and complete their educations.

Description of the Project

This was an exploratory project, whose purpose was to determine whether the social services program has met some identifiable goals as set by the interdisciplinary team at the SHC. Its qualitative model was used to examine whether the program performs in accordance with social work values and ethics, and whether the program was implemented in accordance with practice models as identified in the research literature.

The ultimate goal of the program is to connect the client with the most appropriate resources and ensure that the client has access to those resources. The role of the social worker in this arena at this stage is to assist the client in obtaining those resources with minimal difficulty.

Particular attention was paid to examining how the client was assisted in completing these tasks and receiving services.

The evaluation of the program focused on two major areas, focusing on the perspective of both the social worker and the client. To a large extent, a "Successful outcome" from the perspective of the social worker involves the successful connection of the client to a resource that the client reports as being useful and comfortable for their needs. These data were obtained primarily through the patient information files. It is additionally important, however, to recognize that there are several components involved in the ability of the client to feel comfortable with their solution. Perhaps most important to the client is the feeling that they have made a decision rather than having the decision made for them (Moxley, 1989). Case studies were used to examine how the subject's involvement in treatment planning was solicited and integrated into the plan.

The primary goal of the social services program, as defined by the SHC, is to provide case management services to students without access to medical care. Whether this goal has been met was determined by statistical analysis

which will be used to examine how many students were successfully connected to resources.

Application of the research suggestions as found in previous literature was measured primarily via the use of case study reports. These case studies were used to identify how approaches used are reflective of those suggested by existing research.

A discussion of the results will examine what areas need to be improved will be critical for purposes of program quality improvement. Any findings which appear to be contradictory to those in existing research will be addressed, with suggestions for clarifying and examining those disparities. Finally, some suggestions that may direct future research for quality improvement in this particular program.

The information gathered during the course of this study will be most beneficial to persons involved in developing social service programs that are intended to function as a part of an interdisciplinary team. It is also hoped that the data will be helpful to those working with uninsured populations in general. This study may additionally be of some benefit to university administrators concerned about the effect of health problems on student retention.

Significance of the Project

Case management is no longer universally presumed to be the exclusive province of social work. Nonetheless, it remains an important part of social casework. It is hoped that the information obtained through this research will further our understanding of what constitutes effective case management practice.

The impact of health on student retention will be discussed in the review of the literature. It is important to recognize, however, that as resources at the disposal of the student are directed towards resolution of health problems, they are drawn away from the process of education. It is for this reason in particular that the program was undertaken, and it is for this reason that improvement of the program is so significant.

Recruitment and retention are at the core of the existence of a university. In addition to the micro-practice issues involving the students themselves, this study is concerned with the macro-practice issues regarding health-care policies both in the campus community and within the larger community.

Limitations of the Project

One of the chief drawbacks of this research is that the program which is studied was never intended to be part of a controlled study. Despite this limitation, it is believed that descriptive analysis of the data can suggest areas of further research that might better lend themselves to a true experimental methodology.

In addition, while the program was designed and implemented using the ideas found in the existing research literature, the implementation was not performed for the purpose of performing a quality improvement analysis. As a result, although knowledge of the relevant literature was a factor in the design of the program, its influence was implicit rather than explicit. To some extent, this is cause to question how relevant these issues truly are to this particular study.

Although the study was designed after the fact, it is still possible to draw important conclusions from the data. It has been previously stated that one of the goals of this study is to suggest directions for future research. Some of these suggestions may include ideas on how to improve the methodology of future studies in this area. By accepting these limitations and understanding their impact on the current study, a helpful critical analysis may provide more

useful information than would have been revealed in a more controlled exploratory study.

CHAPTER TWO

LITERATURE REVIEW

There are three primary areas of concern in terms of examining the research as regards social work in the college health setting. It is important to understand the trends and needs of college health in general in terms of understanding what interests researchers in the field, as well as what specific issues seem to be relevant to the particular setting at CSU, San Bernardino. The role of social work in the medical setting in general is important to recognize how the social worker is often utilized as a part of the interdisciplinary team. At the same time, the social work profession approaches case management in a way that is unique to social work, and the theories and principles of practice of case management as practiced by social workers strongly influence how services are delivered in the medical setting. Additionally, it is important to understand how issues of diversity affect the services needed and provided in order to more effectively reach those groups which are under served.

College Health

As has been previously mentioned, there are trends within the population of students at Cal State San

Bernardino that are of concern (Lovett & Clark, 1993),

particularly within the context of a college health center

(Jordan, 2000). It is therefore important to consider what

are the general areas of concern to the college health

setting in general and to CSU, San Bernardino in particular.

It is critical to recognize that the problem of student

under insurance is not limited to the CSU, San Bernardino

campus. For example, research conducted at San Francisco

State University found that as many as 26% of all students

were uninsured, with higher percentages as one included

nontraditional-age students (i.e., 25 years old and older

among undergraduates). (Cohen, Kipnis, Hertz, and Lappin,

1989; Lappin, 1994). This clearly would tend to support the

findings of Lovett and Clark (1994), and would additionally

suggest that the 25% uninsured rate is both reliable and

externally valid.

In addition, Patrick and Covin (1997) found that 23.5 %

of students in a California-based study were uninsured-

results virtually identical to those found by Lovett and

Clark (1994), Cohen, Kipnis, Hertz, and Lappin (1989), and

Lappin, (1994). This would tend to suggest that the problem

of access to medical resources among college students is at

least a statewide if not a nationwide issue. Perhaps most

important was the finding of Patrick and Covin that students

in later years of their education were less likely to have insurance than their first-year counterparts.

This trend would tend to be supported by the findings of McManus, Brauer, Weader, and Newachek (1994), who found that persons aged 19-21 accounted for nearly 25% of all uninsured. This percentage increases to 43% one accounts for persons aged 25 to 34. This would tend to suggest that the issue of lack of insurance will be of particular importance on campuses serving nontraditional-age students.

One of the greatest impediments to improving the health of college students is that the students themselves have chosen to engage in behaviors that are risky (Keeling, 2000a). Most students, Keeling asserts, are not ignorant of the risks that they are taking with their health, but rather are choosing to engage in these behaviors for their short-term rewards. While Keeling discusses risky behaviors such smoking, drug and alcohol abuse, and unsafe sex, it is important to recognize the pattern of behavior in a biopsychosocial sense rather than as discrete behaviors in these areas. Students have tended to focus on alleviation of immediate symptoms (Jordan, 2000; Ruokis, 2000; Doetsch, 2000) rather than responding to the need for long term care, and this may be reflective of the tendency of the student to focus on the short-term goal.

Additionally, a number of these behaviors have strong connections to other health issues, hence the concern of the college health professionals in these areas. Of additional concern is the fact that in many cases one behavior may be a risk factor for several other health concerns. For example, alcohol and/or drug abuse may place the person at risk for unsafe sex practices (Desiderato & Crawford, 1995), which additionally may put the patient at risk for pregnancy and sexually transmitted diseases, including HIV/AIDS. Any treatment of either condition beyond the most basic level of care is likely to be beyond the capabilities of most college health clinics (AAAHC, 2001; Jordan, 2000). Students will therefore need to be connected with community resources to address the problems in these areas.

One of the factors that is multidimensional in its effect, according to Keeling (2000b), is that of the Social Norms. Social norms affect students in several ways, both in terms of what might be called "positive" and "negative" symptoms of risky behaviors. For purposes of this discussion, these types of symptoms are considered in the context of the relationship to previous functioning. Positive symptoms refer to those behaviors now present that were not previously present (i.e., substance abuse) and negative that were engaged in that now are not (i.e., help

seeking). Much of the literature tends to focus on these "positive symptoms" to the exclusion of the negative. The result is that there is little information regarding failure to maintain health insurance as a "negative symptom" that may be part of the social norms of college students of low income. Unfortunately, little literature exists that examines this idea in the context of social norms.

Patrick and Covin (1997) primarily examined health risk behaviors among college students. The fact that they included lack of health insurance as a risk factor is significant. What is also significant, however, is the fact that Patrick and Covin gave very little attention to the issue in the discussion of their findings. Unfortunately, the reasons for this are unclear. It can be speculated that the perceived lack of interventions may contribute to the problem being seen as insurmountable by traditional means. For example, Brindis and Reyes (1997) proposed several possible means to address the issue of the uninsured student. All four proposals involved changes in the funding process of the SHC, and none addressed the issue of utilizing community resources to alleviate the problem. The social work perspective would see utilization of community resources as essential to the solution.

One of the reasons that utilization of community resources will be critical is that a number of students simply do not have these private resources. It has previously been mentioned that approximately 25% of students in California, if not nationwide, are without insurance (Lovett & Clark, 1994; Cohen, Kipnis, Hertz, and Lappin, 1989; Lappin, 1994), and thus will need access to community resources to meet their needs. Many students feel as though they cannot afford the premiums required for coverage beyond "major medical" programs (Cohen, Kipnis, Hertz, and Lappin, 1989; Lappin, 1994), and some do not feel as though they could even afford this level of services.

Even when insurance is presented through colleges and universities proactively, there tends to be a low involvement rate (Mills & Gold, 1996). This would tend to support the findings of Cohen, Kipnis, Hertz, and Lappin (1989) and Lappin (1994) that many college students tend to feel that insurance is an unneeded expense. It is noted by Mills and Gold that universities with prepaid financing (i.e., usually private universities not reimbursed by the state) tend to be more aggressive in terms of ensuring that students have access to health care through insurance.

One possible explanation for this trend is that the financial structure of a prepaid-financing university

demands a higher level of retention; thus, it is more important to be proactive in terms of ensuring access to health care (Mills and Gold, 1996). However, this is ultimately speculation, and does little to resolve the problem as experienced by the SHC at CSUSB. However, the issue of retention is as important to consider for the state university as it is for the private, and access to health care would seem to be an important part of both enrollment and retention (Brindis and Reyes, 1997; Crihfield, 1995).

It may appear from the literature presented here that the greatest problem facing students is lack of health insurance. This is far from the truth; the prevalence of studies involving risky behaviors demonstrates that college health researchers consider the effects of these risky behaviors to be a significant issue (Keeling, 2000a). It is also the case, however, that attempts are being made to address many of these issues through primary intervention techniques (Keeling, 2000b). However, the program involved in this study was designed as a program for intervention at the secondary and tertiary levels. As a result, it is expected that many of the issues will revolve around the ability of students to gain access to health care. As has been discussed previously, the primary barrier to this is lack of health insurance.

The conclusions that can be drawn from the existing literature are far from clear. However, some general suggestions with regards to hoped-for outcomes can be raised. First, it would be helpful to recognize students without insurance- i.e., those who could most clearly benefit from existing community resources. Second, a means of connecting the students to those resources needs to be found. Third, it would be important to determine how effective the connection process was in terms of the final outcome.

Medical Social Work

The interdisciplinary movement has become the cornerstone for modern social work practice (Allen-Meares, 1998). The professional collaboration that is at the heart the interdisciplinary team has long been a hallmark of the practice of medical social work (Germain, 1984). Changes in the health care system have in part necessitated this approach and facilitated its acceptance by the medical community (Berkman, 1996). Abramson and Mizrahi (1996) have quantitatively demonstrated that positive outcomes are strongly associated with the use of the interdisciplinary treatment model.

In this practice area, the collaborative effort is extended to include several disciplines. There are many

obstacles to the development of the collaboration. Despite
the use of the model in professional practice, many
educators do not stress the importance of team practice
(Beatty, 1987). Temkin-Greener (1983) felt that many
educators fear loss of their discipline's particular area of
authority and expertise.

This concern over loss of prestige and power can be
carried into professional practice. Hilton (1995) mentions
that while many professionals value teamwork, they too fear
loss of status. The truth is that past experiences have led
to this concern; changes in health care have indeed
resulted in some professional ambiguity (Hardy & Conway,
1988). When these alterations in roles have negatively
affected professional roles, there is a substantial
impediment to the collaborative process (Abramson & Mizrahi,
1996).

Despite these barriers to teambuilding, it is very
possible to build an effective and cohesive team. For
instance, Cowles & Lefcowitz (1992), and Walton, Jakobowski,
and Barnsteiner (1993) found teams that had significantly
reduced interdiscipline conflicts by improving networking
and communications. Abramson and Mizrahi (1996) noted that
social workers who were effective communicators, as well as

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being competent professionals, were much more able to be significant contributors to interdisciplinary teams.

Additionally, commitment to the team (as opposed to the organization as a whole) tends to be associated with team effectiveness (Morrow, 1993). With this idea in mind, Nandan (1997) examined the factors that tended to be related to commitment. Nandan found that a synergistic approach to teamwork, wherein leadership roles are flexible as the occasion demands, is related to effective team building. It was also found that clear understanding of one's role as a part of the team contributed to one's level of commitment to the team.

To some extent, the role of social workers in health care settings is ambiguous and subject to facility policy. However, it has been observed that much of the controversy revolves around activities that are psychotherapeutic in nature (Cowles & Lefkowitz, 1995, 1992). Research tends to indicate that the perspective of the health care system is that the role of the social worker should be confined to discharge planning and connecting with resources (Loomis, 1988; Nason, 1990). This, according to Bender (1987), Blumenfield & Rosenberg (1988), and Caroff (1988), results in the neglecting of the psychosocial aspects of discharge planning as components of the overall health care picture.

Some of the cost-containment issues that Loomis (1988) and Nason (1990) state as driving this perception of the role of the social worker are not relevant to the SHC. Nonetheless it is important to remember that the attitude appears to pervade the health care system, and that it is the responsibility of the social worker to demonstrate competence in the emotional health arenas.

There appear to be several significant areas to address in terms of working as part of the interdisciplinary team. Clarifying the professional role of the social worker will reduce ambiguity and, it can be hoped, concerns over professional "turf." Networking and communication will improve not only the ability of the social worker to perform case management tasks effectively, but also will facilitate demonstration of commitment to the team process. Finally, demonstration of competence, particularly in areas of controversy, will reinforce the idea of the social worker as a multidimensionally competent professional. With the professional considerations accounted for, the social worker may utilize time and resources more effectively to provide appropriate case management services, which lie at the core of medical social work.

Case Management

Moxley (1989) defines case management as "a client-level strategy for promoting the coordination of human services, opportunities, and benefits" (pg. 11). Essentially, the effective case manager's goal is to coordinate services that may be supplied by various agencies and thereby ensure integration and continuity of care.

Case management is, in its modern form, based on the strengths perspective of social work (Rapp, 1992). As such, though it is goal-oriented and directive, the practice of case management is expected to take its direction from the client or consumer. The client states the perceived needs or goals, and the case manager in theory will attempt to help the client meet those needs or goals. It is also very linear; the technique pattern is followed in a rather precise manner despite is often cyclical nature.

In general, the approach of the case manager is cognitive. While there are behavioral components to the model, the first goal is to find out what the client wants and needs to function day to day. This will involve a great deal of reframing and discussion as the therapist attempts to understand how the client experiences his or her world, and how inaccurate beliefs about services may prevent the client accessing those services. At the same time, the

method of practice tends to work not only towards making problems manageable, but towards helping the client understand that the problems are manageable. The congruency of approach and method will tend to reinforce the implicit educational component of the model.

<u>Theory</u>

Inherent in the case management model is the theory that clients have needs that can be met through the provision of services. However, many clients encounter difficulty utilizing these services, either for internal or external reasons. The client who does not utilize services that he or she needs despite being eligible for those services out of anxiety over the application process, fear of stigmatization, or fear of change, faces difficulty for internal reasons. The client who has difficulty accessing limited resources, or ones for which the client is not obviously eligible despite the benefit those services could provide the client, faces external problems. Most often there is a mix of problems; for instance, accessing limited resources is difficult when the client has difficulty expressing their needs and legitimacy to the providing agency.

The basis for the case management model, therefore, is that clients' functioning can be enhanced directly simply by

assisting them in accessing services and resources which help to meet their needs (Moxley, 1989). This can best be achieved by entering into a partnership with the client (Kisthardt, 1992), in which the client to a large extent controls the direction of the help to be provided. By focusing on the client's perceived needs, it is expected that the systemic relationship between the client and the service providers can be improved. This restores what is essentially an ecological balance.

Principles of Practice

Kisthardt (1992) identifies six principles which derive from the basic theory of the model. These principles drive not only the specific techniques of the model, but if assiduously followed should guide the social worker in providing the techniques in a spirit that is reflective of that basic theory. It is one thing to state that the model is client-driven, and quite another to apply it.

It is expected that the Helping Method will focus on the "Strengths, Interests, and Aspirations of the Consumer" (Kisthardt, 1992, pg 60). It is assumed that the client has strengths that can be brought to bear on the problem. In the interest of self-empowerment, those strengths should be directed towards the client's immediate and long-term goals.

The idea that clients have the power to change is inherent in the modern case management model and derives from the strengths perspective (Kisthardt, 1992; Moxley, 1989). This is, according to Kisthardt, the "promotion of the possible" (pg. 62). He further points out that people with mental illness make choices every day, and can continue to do so in all but the most severe of cases.

It has already been stated that it is the client who drives the helping relationship. Although this idea has been popular in the literature for several years (Kisthardt, 1992), it is not always applied appropriately. The client's ability to provide input into the decision-making process has been shown to be a key factor in their involvement and success or failure in the rehabilitation process (Itzhaky & York, 1994; Tower, 1994). In fact, it has been demonstrated that the client will voluntarily tend to move towards self-directed problem-solving (Rowland, Gilliland, & Moxley, 1993).

That the relationship between the consumer and the case manager would become an "essential part of the helping process" (Kisthardt, 1992, pg. 64) would seem to be self-evident. It should, therefore, be no surprise to any effective case manager that such a simple things as being treated with respect and dignity by the rehabilitation staff

(Anderson, Wang, & Houser, 1993) can greatly enhance the client's experience and contribute positively to outcomes. Having needs listened to, appointments scheduled promptly, and telephone calls returned (Schwab, Smith, & DiNitto, 1993) all can have profound effects on the client's willingness to engage in the process with the agency in general and the case manager in particular.

"Assertive Outreach" may sound like a rather crusading principle that hearkens back to the days of Settlement House and the temperance movement. It is, however, the preferred mode of helping according to Kisthardt (1992), and involves meeting the clients on their own ground. Going into the community to work with the clients rather than expecting the clients to come to the service may seem obvious, but as budgets decrease and services recentralize it may become difficult to provide.

The ecological basis of the case management model holds that the services and resources that are needed by the client often already exist within the community, they just have to be accessed. Kisthardt (1992) discusses the idea that within the community are large numbers of service and resource providers which can be engaged in a collaborative effort to assist the client. He states that most communities are an "oasis" of such collaborators, to which

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the client is guided through the "desert" by the case
manager. Before the reader dismisses this poetic notion,
one is encouraged to examine a community resource guide.
Though often frustrating to use, many resource guides do
offer large numbers of agencies which can be accessed by
clients.

<u>Techniques</u>

There are five primary areas under which the techniques
of the case management model are grouped. These are as
follows: assessment, planning, intervention, monitoring, and
evaluation (Moxley, 1989, pgs. 20-22). As has been
previously mentioned, these techniques are typically applied
in a linear fashion: assessment leads to evaluation (and
possibly back to assessment to begin anew) and the steps
followed in a logical and consistent manner.

The collaborative effort begins with the Assessment
phase. In this, the case manager begins to employ
techniques that identify the client's perceived needs and
abilities to access resources. Cognitive questioning
techniques intended to reveal the client's beliefs about the
systems they need to access are essential to ensuring the
later follow-through on the part of the client, as well as
cognitive distortions about their perception of their
situation. Information about the client's social network

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and support systems is also valuable here. All of the information gained from the client is joined with the case manager's knowledge of available resources to assist in the next stage.

Cognitive techniques are equally important in the Planning stage. Clients may hold irrational beliefs about themselves or the agencies they will access, and these may need to be disputed before the client can make an informed decision. The manager is cautioned lest personal beliefs interfere at this stage (Kisthardt, 1992). It will require great skill to help the client make understand the choices available without using one's influence in the relationship to come to a premature solution.

The Intervention phase involves the implementation of the chosen course of action. A variety of techniques may be employed here, including some that are not typically thought of as "psychotherapeutic" per se. While the process of reframing cognitive schemas may continue, and behavioral reinforcers may assist in client follow-through, the networking and advocacy skills of the case manager will be equally critical (O'Hare and Collins, 1997).

It is essential that the case manager adequately Monitor the progress of clients (O'Hare and Collins, 1997; Kisthardt, 1992; Moxley, 1989). Without monitoring,

obstacles to resources can create a sense of disempowerment and increase psychosocial stress (Rappaport, Reischi, & Zimmerman, 1992). By monitoring appropriately the case manager can continue the cognitive and behavioral processes that were begun in the planning stage.

Prior to termination of the case, the manager must perform a comprehensive Evaluation as to the objectives met (or not) and how these changes have affected the client. Once again, the client engages in this stage collaboratively; it is essential that the therapist solicit feedback from the client as to their perception of how successful the interventions have been (O'Hare & Collins, 1997; Moxley, 1989).

It is true that many of these are not "techniques" as they are thought of in the psychotherapeutic sense. It can be argued, however, that any technique which facilitates client change in a positive way is therapeutic. In fact, it is clear that case management skills are emphasized more than one might expect among professionals, such as psychiatrists and psychologists, who traditionally have not been greatly involved in this arena (Saleebey, 1992; Moxley, 1989).

Issues of Diversity

One area of concern is the issue of diversity among students requiring services. Diverse groups require diverse solutions (Longres, 1997), and there are certainly additional concerns regarding the provision of services to diverse populations. For example, given the fact that CSU, San Bernardino is a recognized Hispanic-Serving Institution, it is important to determine how effectively the Social Services program is serving Hispanic Students. Given the fact that different populations utilize services differentially, and understanding these differences is critical in terms of reaching underutilizing groups.

Perhaps more important than the actual patterns that differentiate one population from another is the understanding of how cultures in general differ from one another. The idea of multiculturalism is not a new one, and has been the subject of some significant criticism at times (Atherton and Bolland, 1997) . However, this is perhaps due in large part due to the extreme generalization of the term "multiculturalism" rather than to some inherent invalidity of the concept.

In terms of examining multiculturalism, a working definition appropriate to practice goals must be clarified. Fellin (2000) suggests that there are three main approaches

to multiculturalism. These can be examined to determine which is most appropriate to this particular study.

One approach might be to examine multiculturalism from the perspective of people of color only (Gambril, 1997). This perspective has been the source of much controversy (Green, 1999) and seems to be to narrow a definition for general use(Fellin, 2000).

A broader perspective from which to view multiculturalism might include all people subject to oppression, whatever their ethnic identity; for instance, gays and lesbians would be included as "multicultural" in this definition (Newman, 1994). It is not always clear whether such a definition includes groups such as women and people with disabilities, according to Fellin (2000).

Gould (1995) and Longres (1997) seem to view multiculturalism in the context of cultural pluralism, and suggest that the goal of multiculturalism should be to accept diversity no matter what form it takes. This viewpoint considers the possibility that the majority culture may itself be diverse across a number of categories.

The perspective of cultural pluralism, according to Fellin (2000), is the most modern of the approaches to multiculturalism, and is the most appropriate to the practice of social work. It is this approach that will be

used to examine issues of diversity in this study, as it
will allow for the examination of differential effects of
many cultural origins.

CHAPTER THREE

METHODS

Study Design

The study was conducted as a qualitative survey of clients served by the social services program. As such, the design was in large part dictated by the design of the program being studied. As the program was already in existence and the clients had all terminated services, the subjects in effect were pre- selected. As this was primarily a descriptive study, however, it was not considered critical to observe concerns regarding random assignment of subjects.

As this was primarily a qualitative study, it is important to remember that this study did not specifically examining cause-and-effect relationships. It was the purpose of this study to examine what patterns exist among the clients served by the program, and to hopefully determine where strengths and deficits lie in order to continue improving services. Additionally, it was viewed as important to understand how individual cases presented unique challenges to effective case management.

Primarily, the study examined basic information from client records with regards to reported problems, observed problems, and perceived barriers to obtaining resources.

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These variables were examined to determine how they relate to one another and to demographic variables such as gender, ethnicity, and age.

It was important to examine how the client feels regarding their experience, and to determine if there are any patterns in client satisfaction with services. While a validated measure of client satisfaction has not been introduced into use at the SHC, a client satisfaction was created and is in use at this time. It was recognized that there are significant limitations to the use of this measure, but given the exploratory nature of the study these limitations were not considered critical to the final analysis.

Sampling

Subject consisted of 53 students enrolled at CSUSB during the 1999-2000 and 2000-2001 academic years. Thirty-five females and 18 males, ranging in age from 19 to 63, had been referred to SHC Social Services for reasons of having chronic medical conditions or acute medical conditions beyond the scope of the SHC's mandated services. All subjects had terminated services in order to be included in this study.

Data Collection and Instruments

The data for the study were initially collected during the involvement of the subjects in the SHC Social Services program. Data were collected from existing client records at the SHC Social Services program during the Spring Academic Quarter of 2001. No subjects currently receiving services were included in this study.

Procedure

All of the subjects were drawn from the clients from the first year of the program. All clients had terminated services prior to the end of the academic year, and thus were not receiving services at the time of data collection. If students had receive services during the 2000-2001 academic year, a new file would have been started and their information would not have been included in this study.

The researcher examined the initial referral from the provider, the Patient Assessment Form that was completed by the Social Work Intern during the initial interview, and any case progress notes. The case outcome was included as a note in the Patient Assessment Form and in case notes. Case study information was primarily collected from case progress notes and the recollections of this researcher.

Subject data were entered into a series of demographic categories for analysis. Where ambiguity existed, the case

progress notes and outcomes were examined to interpret the data and a judgement as to which condition of the given variable was appropriate was made by the researcher.

Protection of Human Subjects

Subjects participating in this study were to be protected to the greatest extent possible from any harm. The risk to subjects was minimal by the very nature of the study design. The identity of the subjects was protected at all stages of the study, and with the use of historical data the subjects were not expected to be involved directly in any way and thus would not be subject to psychological harm.

The subjects were not be completely anonymous by virtue of having been Social Service clients. However, the subjects were identified by a number which was used to gather additional data should such by necessary. The identifying number was placed in their file until the study is complete, at which time the numbers were removed from the patient files and destroyed. At no time were any names reported; all case studies presented had all names falsified to protect the anonymity of the subject.

No information was reviewed from charts of subjects currently receiving services. Should a subject who had terminated services again have required assistance, their current information would be kept separately until the study

was completed. Patient records have been reviewed, and no subjects included in this study were receiving services at the time of data collection.

CHAPTER FOUR

RESULTS

Statistical Analysis

A total of 53 subject cases were examined for demographic factors such as age, gender, ethnicity, marital status, and income. Other factors that were examined included whether or not subjects had private insurance, dependent children, and what family support system they had. Additionally, issues around housing and transportation were addressed to assess the subject ability to physically access the resources once they were identified and the subject had been referred. The primary areas of interest revolved around what referrals were made for clients, and how income and sources of income were related to those referrals.

Thirty-five females and 18 males were participants in this study, making up 66% and 34% respectively (see Appendix A). None of the subjects identified themselves as being transgendered. Subjects were not asked whether or not they were transgendered, however. The ages of subjects ranged from 19 to 63, with an average age of 31.51 years. The standard deviation for age was 9.92 years.

Ethnicity was widely varied, with representatives from several ethnic groups (See Appendix A). African-Americans accounted for 17% of the subjects with 9 individuals.

Asians were represented with 2 subjects, or 3.8% of all

subjects. Caucasians made up the majority of the subjects;

28 subjects representing 52.8% of the sample. Hispanics

were represented by 10 subjects, making up 18.9 percent.

Two individuals identified themselves is Multiracial,

accounting for 3.8% of the sample. Native Americans and

North African/Middle Eastern each were represented by one

subject, at 1.9% of the sample each.

Most subjects (41) were single, and represented 77.4%

of the sample(see Appendix A). Four of the subjects (7.5%)

were married, and two 3.8%) stated that they were living

with a significant other in what they perceived as a

domestic partnership. Five, or 9.4%, were divorced. Only

one subject stated being widowed)1.9%).

Monthly income ranged from what was described as "no

income" monthly to $2800 monthly (see Appendix A). Forty of

the subjects (75.5%) fell below $800 monthly income, which

is the cutoff point for the most restrictive of the county

MIA programs. Only 5.7 percent of all subjects (3 total)

reported an income of $2000 monthly or greater. The mean

income for all subjects was $561.83, with a standard

deviation of $656.94.

On the variable of employment, the subjects were nearly

evenly divided (see Appendix A). Twenty-five subjects

(47.2) reported that they were not employed either full or part-time. Twenty-eight, or 52.8%, reported that they were employed either full or part-time. Whether or not those who were employed worked full time or part time was not examined.

Nineteen of the subjects stated that they had multiple sources of income, making up 35.8% of the sample (See Appendix A). This might include financial aid augmenting the income of a part-time job, or by some form of public assistance. In some cases, this might include assistance from family members. No attempt was made in this study to examine which sources were used by which subjects. Of those who reported a single source of income, 17 reported that financial aid was their only income. This was not reported as "income" in the previous section, as referral agencies do not regard financial aid as income. Twelve subjects (22.6%) stated that their primary income came from their employment. Three, or 5.7% stated that public assistance (other than financial aid) was their primary source of income. Two subjects, or 3.8%, were primarily supported by their family.

Forty-eight of the subjects (90.6%) reported that they had no insurance, either through private or public programs (see Appendix A). Five reported that they did have

insurance program, of whom 2 (3.8% of the total sample) had some form of public insurance such as MediCal.

Many of the subjects reported that they lived with their family; 20 in all (37.7%) stated that they lived at home (see Appendix A). An equal number reported that they lived in an apartment or dormitory, of which 2 were dormitory residents. Two of the subjects reported that they were homeless. Most reported that they did have their own transportation; only 5 subjects (9.4%) reported that they were reliant on public transportation. None reported that family or friends were their means of transportation.

Only 11.3% of subjects had dependent children. Two had one child, two had two children, and one each had three and four children (See Appendix A). A majority (58.5%) stated that their primary support system was their family. Relative few (9.4%) stated that siblings fulfilled that role. Three subjects, or 5.7%, stated that their primary support came from outside of their family. Another 4 stated that they had multiple support systems in place (see Appendix A). Only one subject reported that adult children provided the primary support system. Nine subjects (17% of the total) reported that they did not feel as though they had any support system.

Subjects were referred to a variety of resources in the community (see Appendix A). Thity subjects (56.6%) were referred to county MIA programs. Six were referred to private non-profit agencies such as the SAC clinic. Two each were referred to state and federal programs; for instance, one was referred to the Healthy Families program as she had dependent children. Five were referred to multiple programs; in three of these cases, this included a Patient Assistance Program for low-cost medication. Three chose to seek follow-up at a private for-profit practice. 5 did not receive an outside referral, for various reasons. In one case, the subject had private insurance and simply wanted assistance in contacting the company to determine whether her condition was covered.

Case Studies

Several areas of concern have been identified with regards to providing services to under insured students coming to the SHC. For example, effective case management is at the core of the provision of services. Use of case management principles and techniques should ideally be demonstrated throughout the practice. Additionally, attending to the psychosocial factors that relate to health in general need to be addressed. Finally, the integration of the social worker into the interdisciplinary team of the

SHC needs to be demonstrated. This may be accomplished by showing how demonstrated competence in the above areas results in commitment to use of the social worker's skills by team members.

Each of the following case studies is intended to demonstrate how the above goals were reached during the development of the social services program at the SHC. In each case, an assessment of the client is presented, followed by treatment goals and outcomes. Finally, a summary will explain how each case study demonstrates achievement of goals in one or more areas.

It has been stated that it is expected that all clients have been treated with case management principles and techniques in mind.

Case Study 1-Assessment

Ms. MF was a 63 year old, African American female referred to Social Services for follow-up on a breast mass that was considered significant following a mammogram. She was widowed, and had two non-dependent children. Ms. MF was referred because she stated that she had no insurance, nor did she have the means to pay for a medical procedure out-of-pocket. The referring physician requested that she be evaluated for services to identify the nature of the breast mass for possible malignancy.

At the initial interview, Ms. MF presented with a mildly depressed affect. She was on time for the interview, and her hygiene and grooming were excellent. Ms. MF was oriented to date and time, location, and situation, and was able to answer questions clearly and easily. Her affect was typically congruent; when addressing issues that were uncomfortable or painful she presented a sad affect but at times was able to respond appropriately to humorous incidents which she related.

As previously stated, Ms. MF's presenting problem was the lack of access to medical services. Her income was insufficient for her to be able to afford private insurance, nor could she afford to pay be examined. Her income did, however, make her ineligible for the Medically Indigent Adult program for the county in which she resided. At 63, she was not yet eligible to receive MediCaid health services, and it was clear that waiting until she was eligible was not a viable option in the opinion of the referring physician.

During the initial interview, several issues emerged that clarified Ms. MF's perception of the problem. Breast cancer is not prevalent in her family, but there was some history, and this heightened Ms. MF's anxiety considerably. She stated that she felt as there were no way to find a

workable solution. If she were to pay for a biopsy of the mass, she would not have the money to continue with her schooling. Ms. MF also stated that the anxiety surrounding her situation was making it very difficult to concentrate on her classes and homework.

Ms. MF had a strong family support system, consisting of her two daughters, and a brother and sister-in-law. Both of her parents were deceased, as were her husband's parents. All had made the effort to provide emotional and, to a limited extent, financial support during this crisis. Ms. MF was concerned about asking for financial help, stating that she was very aware of the fact that they too have limited resources. She was not reluctant to ask for emotional support, however, and stated that part of the family's value system had always included the idea of supporting other members in time of need. Ms. MF did mention that her children and brother did not live in the area, and so their ability to be present was limited.

As a returning student, Ms. MF faces a number of difficulties involved in attending school. First, as a returning student she faces the proposition of having to relearn academic skills after a significant hiatus. Her financial situation is such that her attendance from term to term is uncertain at best. When one considers the

additional complications of her medical situation, it is clear that Ms. MF will have to access significant resources in order to continue the educational process.

Treatment Goals

Assessment of Ms. MF suggested that the following problem areas needed to be addressed. The first task was to provide supportive therapy or counseling to assist her in dealing with the fear, anxiety, and depression that are a normal part of this experience. Ms. MF then needed to be connected to resources that will allow her to undergo the further evaluation of the breast mass that was needed. Finally, it was important to connect her to resources that will ensure ongoing medical care and monitoring.

The psychological issues of fear, anxiety, and depression were addressed in two particular ways. During the initial visit, her feelings were normalized and validated, and the idea that they were not only normal but indeed appropriate was discussed at length. She was also given the opportunity to either continue in long-term therapy with the social work intern, or to seek another form of therapy or counseling. Alternatives to traditional therapy that were suggested consisted of involvement in breast cancer support groups and other women's support groups. Ms. MF also discussed the idea of talking about her

feelings to a close friend who lived near to her, and this alternative seemed to be the one she preferred. She felt that if she could know that she could have the breast mass examined without incurring serious debt she could manage any resulting anxiety, whatever the outcome, at that time.

With this in mind, the Breast Cancer Early Detection Program (BCEDP) was suggested to Ms. MF. The BCEDP is a program that provides thorough examination, including biopsy if necessary, for low-income women who are identified as having a potentially dangerous breast mass but who do not otherwise qualify for public assistance medical programs. After being informed about the process of application, Ms. MF stated that she felt this to be an acceptable option, and the process was begun. Ms. MF was told that as much assistance as she wished would be available in terms of assistance with the application. She stated that it was her preference that Social Services complete and send the application form with information that she provided.

The final goal of treatment was to provide Ms. MF with a local resource for continuing medical care. She stated that she could afford a small fee on an occasional basis, and that she would need to feel as though she were not being treated differently because of her low-income status. The Social Action Community (SAC) clinic provides basic medical

care at a cost that Ms. MF found acceptable. Additionally,
as their stated mission is to provide low-cost medical care
to the community, the majority of their clientele have
lower-income status. When this was explained to Ms. MF, she
responded positively, stating that she would feel
comfortable seeking services at such a clinic.

Outcome

On her follow-up visit, Ms. MF stated that she had been
discussing her anxiety and depression with the friend she
had initially identified to assist her in this area. She
said that her conversation with this friend had greatly
alleviated her symptoms in the area, so much so that she had
not felt the need to seek additional counseling from support
groups or therapists. She also indicated that the
validation of the social work intern had greatly assisted
her in being able to discuss the feelings in the first
place.

At that time, Ms. MF had obtained an appointment at the
surgery clinic at her local community hospital to have the
breast mass examined. She had been accepted by the BCEDP
program, and thus was not required to pay out-of-pocket for
any services related to the examination or biopsy of the
mass. She was later contacted for follow-up regarding the
outcome of the examination, what she reported as having been

identified as a benign cystic mass which did not need to be removed.

Ms. MF stated at her follow-up visit that she intended to obtain an appointment at the SAC clinic. She also stated this during the later telephone-contact follow-up. It is not known whether or not she eventually made the appointment.

Summary

The case of Ms. MF addresses two important areas. First is the effective use of case management skills in order to connect Ms. MF to vital resources. Of equal importance was the need to address psychosocial factors. While Ms. MF's provider was updated as to her progress regarding follow-up, her case was not addressed in depth by the interdisciplinary team as a whole; thus, the issue of integration of social work practice is peripheral but nonetheless important.

Although all areas of the case management model were involved in this case, perhaps the most important stages in working with Ms. MF were planning and intervention. Planning required the use of the collaborative alliance, while intervention required the use of networking by connecting Ms. MF with the person at the BCEDP program who facilitated the process for her.

Appropriate assessment and treatment of related psychosocial factors was likewise significant in reaching a successful outcome. Although it would have been possible to assume that resolution of the medical crisis- i.e., how to obtain an examination with limited financial resources- it was also important to recognize the stress Ms. MF was experiencing. By engaging with her in planning a solution to provide a supportive relationship, if not actual therapy, she was able to acknowledge her need and to address it.

Ms. MF was the first patient of the program to be referred to BCEDP. While by this time the social services program was well established, it was still important to continue to demonstrate to the providers that connection to resources was an area of expertise on the part of the social work intern. By successfully and expeditiously learning and using the referral process, competency with new areas of need was demonstrated.

Case Study 2-Assessment

Mr. LN is a 25-year-old, Asian male originally from Cambodia. He is single, with no children. He does have a significant other with whom he does not reside, but with whom he plans to live in the future. Mr. LN stated that he believed this would occur in approximately six months. Mr. LN's significant other was not interviewed at any time

during his treatment, but she was consulted by him on one occasion. Mr. LN's parents are living, but he does not reside with them.

Mr. LN appeared for the interview on time and was pleasant and cooperative throughout. His hygiene appeared to be good, and while his grooming was somewhat unkempt it was not remarkably so for a University student. He appeared to be oriented to his surroundings, and to understand English well. Mr. LN did indicate that English is not his first language, but that he has been a resident of the United States for several years (since he was a teenager).

During the initial interview, Mr. LN stated that he had referred for treatment of a recurring bladder infection which appeared to be chronic but treatable. The physician's referral indicated that with treatment most of the symptoms of the condition will be greatly reduced, but that long-term monitoring will be necessary. Mr. LN stated that he did not know that he was eligible for free medical care.

At the time of the interview, Mr. LN had an income of less than $650 per month. His primary income was his financial aid and a part time job. He had his own vehicle and stated that he was renting a room in the area.

Treatment Goals

The primary goal of treatment appeared to be to connect Mr. LN to the medical services that he needed to monitor and treat his bladder condition. Mr. LN had come into the SHC before needing treatment for the same condition, and the physician had eventually convinced him that the level of care available at the facility was not sufficient to adequately treat him. Mr. LN agreed that obtaining adequate medical treatment was his primary goal as well.

Given his age and his lack of dependent children, Mr. LN was clearly eligible for at least two programs. One option would have included the SAC clinic, as mentioned in the previous case study. Another would have been the Medically Indigent Adult (MIA) program, which would provide no cost care. Mr. LN indicated that he would be interested in the MIA program.

Mr. LN was asked about other areas of concern or distress, which he denied. Mr. LN appeared to be very goal-directed in the area of obtaining services, as appropriate for his culture. Despite the fact that his English appeared to be good, it was important to insure that he clearly understood the process of obtaining his medical care. This was discussed at some length, and Mr. LN stated that he felt confident about getting the help he needed.

Outcomes

Approximately two months later, the physician who had originally referred Mr. LN sent him in again, as he had returned for assistance with the same physical problem. When asked why he had not obtained MIA, Mr. LN did not respond. He was asked if he would be willing to talk to the social worker, and he stated that he would. Mr. LN was seen immediately.

Instead of asking why he had not obtained MIA coverage, I asked Mr. LN if he had encountered any difficulties with the process. He explained that he had not begun the process. I then asked if he still wanted to obtain MIA coverage. He said he did, and I suggested that we talk through the process, and he would identify any areas with which he wasn't totally comfortable.

When we discussed the fact that he would need proof of residence, Mr. LN exhibited some concern. When questioned, he stated that he was renting a room from another Cambodian family, and that his permanent address (which was on his driver's license) was in fact in Orange County. He seemed to be concerned that his landlord could have gotten in trouble for renting to him informally. Rather than disputing his belief, alternative options were explored.

It was suggested to Mr. LN that it was likely that he would also be eligible for the MIA program for his home county, and that it would be possible to find out the process and facilitate his enrollment. Mr. LN stated that this would be difficult, since he never went to his home county anymore even though it was only an hour away. Mr. LN stated that he did have bills that came to his current residence, and asked if these would be sufficient to establish his residence. The MIA program was contacted, and confirmed that this would be adequate as long as they showed a street address.

Mr. LN expressed great relief at this news, and stated that he would begin the process immediately. He was asked to contact Social Services when he was approved for the MIA program or if he encountered any difficulties. He did not contact Social Services, and a follow-up call produced no response.

Summary

Mr. LN's case demonstrates the importance of cultural awareness in social work practice, and the need for the social worker to be sensitive to the beliefs of persons who have immigrated to this country, specifically as they relate to governmental agencies. These agencies may be perceived as symbols of government authority, regardless of their

actual role. This is often the role of agencies with whom individuals interact in other nations, and these beliefs are rather strongly rooted.

It was important to find a solution that would satisfy Mr. LN's concerns about possible problems with his residence rather than to challenge his belief. While this belief may not be rational in current society, it is nonetheless a "reality" for Mr. LN. Seeking alternative solutions addressed his issues of resistance indirectly and allowed him to be less concerned about consequences to himself and his landlord. This also avoided placing Mr. LN in a situation that might have actually been worse for him, in which his landlord might decide that having him as a tenant was too risky. Mr. LN would then be facing housing issues in addition to his medical ones.

In this case, addressing psychosocial factors was the greatest area of importance. The resource management tasks were negligible, as Mr. LN was clearly eligible for services. It was Mr. LN's culture of origin which contributed most greatly to his resistance, and addressing the diversity issues in a way that empowered Mr. LN and allowed him to achieve his goals on his own terms the factor that contributed most to the successful outcome of this case.

Case Study 3- Assessment

Ms. BJ was a 23-year-old, single Caucasian female with no children who was referred to social services for assistance in finding long-term care for her severe allergy and asthma problems. The referring physician stated that her allergic reactions frequently caused her to develop asthma attacks. This had resulted in numerous SHC visits and some emergency room visits throughout the year.

Arriving on time for the interview, Ms. BJ was oriented to time and date, location, and situation. Her affect was congruent but slightly blunted. Ms. BJ expressed that she was having some difficulty breathing at that time and stated that she was very nervous about the interview. I asked if she was nervous about anything in particular. She stated that she felt that she had to be at this interview to stay in school.

I expressed my confusion, and she stated that she was afraid that if she didn't use social services she would be kicked out of her current department as she had been her previous one. I asked how she had been kicked out. Ms. BJ said that her previous department chair had told her that she could no longer take classes in the department as her attacks were so frequent and severe as to disrupt classes.

She had changed her major, and feared that she would be told to leave her current department.

At this time, I stated to Ms. BJ that I was not aware of any intention to remove her from her department, and that the referring physician had asked if I could help her obtain medication and long-term monitoring for her condition. I also stated that, to the best of my knowledge, she could not be mandated to see me for any reason and that she was free to leave if she felt uncomfortable. She said that she would prefer to see if I could help her get her medication, which I agreed to do.

At the time of the interview, Ms. BJ's total income was from financial aid. She made some money from a summer job, but by this time in the academic year it was gone. Her effective income according to the regulations of the MIA program was zero. She was therefore qualified for the MIA program, and normally could have gotten her medication via the county formulary. However, the medications she needed to control her allergies and asthma were both fairly new, and as a result were difficult to obtain. Given her income, she was also able to utilize the SAC clinic if she so chose. The problem with obtaining the prescribed medication remained the same, however.

<u>Treatment Goals</u>

The case management treatment goals were to get Ms. BJ connected to a physician to monitor her conditions and to prescribe medication as needed, and to get access to the medication she needed. Ms. BJ stated that she really did not feel as though she could pay to visit a doctor. When she was informed about the county MIA program, she appeared greatly relieved and asked to begin the process of application. She received an appointment that day. We examined the process to apply to a Patient Assistance Program (PAP) for her medications. One was a fairly straightforward application which was available in the social services office. The other required a letter from her referring physician. Both processes were begun immediately.

The psychosocial treatment goals were rather more complex. Ms. BJ had experienced what she perceived as outright persecution by her previous department. Her concern that such an incident might occur again verged on the paranoid. She was experiencing so much anxiety over the issue that she was having asthma attacks and symptoms similar to a panic attack. I considered it to be critical to the successful outcome that she not be in fear of being restricted from her studies. Permission was obtained to

discuss her case with the director of the SHC, who would be able to determine what her standing was.

The interdisciplinary team was aware of her medical conditions, but was not fully aware of the circumstances around her anxiety. It was important that they be aware that there were significant psychological issues in her case, and that it was important that a plan for de-escalating her anxiety be developed. It was agreed that if I were available when she came to the SHC following an attack, I would be informed and proceed to assist with crisis intervention. If I were not available, an attempt would be made to have her speak to one of the psychological counselors on campus.

Outcome

Ms. BJ's application for the MIA program was approved, as were those for the PAPs. Medically speaking, the case management appeared to be effective in that Ms. BJ was connected to the resources which she felt she needed. Her condition continued to be a problem, however, and she still came into the SHC frequently.

Ms. BJ and I discussed at length her concerns regarding being kicked out of her department. The director of the SHC had determined that there was no plan to do so, and that the department fully supported her attempts to achieve her

academic goals. I did some reality testing with Ms. BJ's perceptions, and discovered that her apprehension was based primarily in her previous experience. It was never determined whether she had in fact been told to leave the previous department or if this were an interpretation on her part.

The interdisciplinary team was highly supportive of the team effort in Ms. BJ's case. When she did come to the SHC after an attack, I was informed while she was being stabilized. I was invited to talk with her in the treatment room until she was physically and emotionally ready to go to the social services office. I later found out that it had been one of the nurses who had asked her if she wanted to talk to her social worker.

Summary

Most of the treatment goals were met, at least to the extent possible in the limited time period. Also important was the fact that all of the identified areas received attention in this case. However, from a treatment standpoint this case does have some areas where the social services program could have served the client more successfully.

Particularly in the area of psychosocial issues, there were areas that needed to be further addressed. Ms. BJ

continued to discuss experiences in her past and present life that strongly indicated some psychological trauma. She was encouraged to seek counseling for these problems, and given an opportunity to continue with myself and discuss these issues. It was not the primary role of the social work intern to provide mental health services, however, and it was expected that she be referred to a counselor if at all possible.

In this case, to refer her to an outside counselor was to ignore the effect of the therapeutic relationship that was already established. Ms. BJ was disclosing significant issues that had not been discussed with other SHC staff. She attributed her willingness to the fact that she felt comfortable doing so with me, and she stated that she would prefer to do so. I indicated that this would be fine, but that she would need to consider looking for a longer-term counselor eventually. She did not make any further appointments.

It is not certain that Ms. BJ's abrupt termination of services was directly related to my statement, but the possibility is presented so as to give scope to the needs of the program. While dependence upon one therapist is certainly not in the long term beneficial to the client, it is important to remember that Ms. BJ had experienced what

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she perceived as significant rejection in her past. As this was an area of sensitivity, she might well have voluntarily ended treatment rather than risk the possibility of further rejection.

The ability to continue in therapeutic treatment would have been very helpful in this case. However, the last incident occurred fairly close to the end of the academic year, and I was scheduled to leave at its end. A longer-term therapeutic relationship was simply not possible. Nonetheless, Ms. BJ might have been better served had the option to continue been available.

Overall, Ms. BJ was served successfully and appropriately. Her case is included because it does demonstrate the ways in which areas that could be changed or improved may be identified. Despite Ms. BJ's medical needs having been met, the temporary nature of the social work internship made it difficult to meet her psychological needs in the manner that was most comfortable for her, within the context of the existing therapeutic relationship.

CHAPTER FIVE

SUMMARY, CONCLUSION, AND

RECOMMENDATIONS

This study was primarily conducted as an evaluation of the social services program at the Student Health Center, CSUSB. It was the purpose of this study to determine how well the program's goals were met across a continuum of criteria. In Chapter Three, it was observed that one of the issues involved in the study design was the fact that most of the design for the study was developed after the first year of the program.

It was hoped that this study would demonstrate that the program had successfully achieved its initially established goal of addressing the need to connect students to medical resources. Based upon existing research, it was also hoped that the study would demonstrate that the areas of case management, psychosocial factors, and integration of social work with the interdisciplinary team were addressed.

The effectiveness of the case management component was measured by examining patterns of referral to outside agencies. It was hoped that students could be connected successfully to medical care resources within the community, and that this would increase retention of students.

How well psychosocial factors were addressed was evaluated via use of the case studies. These case studies were intended to address several areas of practice, but much valuable information regarding this area was found.

Addressing the area of integrating the social services program with the interdisciplinary team was more complex. Evaluation of this process was primarily conducted via use of the case studies. Anecdotal information regarding the staff's response to the program was collected but not analyzed per se; though the opinions were typically favorable, this was not measured in a systematic way.

It was evident that the original goal of the program, connecting students to medical resources, was met. Most of the students who were seen by social services were able to be successfully referred. Of the 53 students who were seen for an initial interview and assessment, only 9.4% did not receive a successful referral. In most of these cases, the student was found to have resources available already. In the other cases, the student voluntarily terminated services before a referral was made.

Addressing the psychosocial needs of the students was for the most part effective, as was demonstrated by the case studies. In each of these cases, the process by which such issues were handled by the social work intern was shown.

Issues such as resistance and depression were clearly evident, as were issues of diversity. These issues were able to be addressed appropriately and a successful outcome was reached. One of the drawbacks of the case study method of evaluation is that it presents an opportunity for the evaluator to select cases that best demonstrate success. In this study, cases were selected which demonstrate challenges that were presented in the identified problem areas. This allowed for the process by which these barriers were addressed to be examined, rather than focusing exclusively on success or failure.

The integration of the social work intern into the interdisciplinary team appears to have been effective, based on several sources of information. The case studies were used primarily for purposes of this study, and these demonstrate that attention was paid to acting as a part of the team at every step. Anecdotal statements from the other members of the team were uniformly positive when team members were asked to assess the usefulness of the program. Finally, the program was continued for a second year, at the specific request of the providers and the director (Hatton, 2000). To a large extent, it is this last point that demonstrates the effectiveness of the integration, as it

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shows that the staff consider it a vital part of the overall health care program.

There are several areas where further research is indicated for this program. Probably most important is to determine how successfully students are able to connect with the agencies to which they are referred. Many students did not contact the social services office to report their success or lack thereof, or reply when contacted for information. It is not known, therefore, whether they were successful or not. To determine a process for evaluating this aspect of the program would be highly recommended.

Although the majority of referrals to the program came from SHC providers, there were some students who stated that they had heard about the program elsewhere. Attempts had been made early in the year to advertise the existence of the program so that students wanting assistance with social services would be aware that such help was available even if they did not have an immediate medical need. While this outreach appears to have been successful, it will be important in the future to examine what effect the outreach had on self-referral by clients.

There are many other possibilities for future evaluative research in this program. There are several areas that would be of interest clinically speaking. For

example, it would be important to understand how use of specific therapeutic modalities affect successful outcome. Given the brief nature of the contact, it would be interesting to study how the client responds to specific interventions. Although the college student population in this study typically presented in a state of crisis, there were often underlying issues that are affecting the client globally. Understanding how to best address these factors would be useful, and much of the existing work on addressing psychosocial factors in medical settings would be useful. Of particular interest would be any differences between the general population and the student population across several dimensions.

While the role of social work in medical settings is well established, the role of the social worker in this college health setting is still ambiguous. For instance, students were not specifically referred to the social services program for psychotherapy, but it was understood that given the nature of the conditions some students might be seen on a continuing basis. To what extent should therapy play a role in college social work? Typically, "case management" is viewed as mutually exclusive to "true" psychotherapy. While it is certainly the case that caseloads often interfere with the time available to perform

therapeutic intervention, it should be remembered that the case management model contains within it principles and techniques that are clearly intended to be therapeutic in nature. Additionally, brief therapy may prove effective even given the time-limited setting.

The social services program is still continuing, and it is hoped that the program will continue to grow. Long-term goals for the program include the development of a full-time social work/health education program to address the varied needs of the population and do primary interventions at the same time. With the benefits of integrating the social work profession into this interdisciplinary team having been clearly established, the shareholding members now have a vested interest in continuing to see that the program continues to develop and provide services to students in need.

APPENDIX

TABLES OF SUBJECT DATA

Table 1

Frequencies and Percentages of Subjects

by the Condition of Gender

Gender	Frequency	Percent
Female	35	66.0
Male	18	34.0
Transgendered	0	0.0
Total	53	100.0

Table 2

Frequencies and Percentages of Subjects by the Condition of

Age Group

Age Group	Frequency	Percent
19-25	20	37.7
26-35	17	32.1
36-45	10	18.9
46-55	5	9.4
56-65	1	1.9
Total	53	100.0

Table 3

Range, Mean and Standard Deviation of Subject Ages

	Age
Min	19
Max	63
Mean	31.51
SD	9.92

Table 4

Frequencies and Percentages of Subjects by the Condition of Ethnic Group

Ethnicity	Frequency	Percent
African-American	9	17.0
Asian	2	3.8
Caucasian	28	52.8
Hispanic	10	18.9
Multiracial	2	3.8
Native American	1	1.9
Middle Eastern	1	1.9
Total	53	100.0

Table 5

Frequencies and Percentages of Subjects by the Condition of

Marital Status

Marital Status	Frequency	Percent
Single	41	77.4
Married	4	7.5
Domestic Partner	2	3.8
Divorced	5	9.4
Widowed	1	1.9
Total	53	100.0

Table 6

Frequencies and Percentages of Subjects by the Condition of

Income Level

Monthly income	Frequency	Percent
$ 0-399	23	43.4
$ 400-799	17	32.1
$ 800-1199	5	9.4
$1200-1599	3	5.7
$1600-1999	2	3.8
$2000-2399	1	1.9
&2400-2799	1	1.9
$ 2800+	1	1.9
Total	53	100.0

Table 7

Range, Mean, and Standard Deviation of Subject Income

	Income
Min	$ 0.00
Max	$2800.00
MN	$ 561.83
SD	$ 656.94

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Table 8

Frequencies and Percentages of Subjects by the Condition

ofEmployment Status

Emp. Status	Frequency	Percent
Not Employed	25	47.2
Employed	28	52.8
Total	53	100.0

Table 9

Frequencies and Percentages of Subjects by the Condition of

Sources of Income

Sources of Income	Frequency	Percent
Family Support	2	3.8
Financial Aid	17	32.1
Public Assistance	3	5.7
Employment	12	22.6
Multiple Sources	19	35.8
Total	53	100.0

Table 10

Frequencies and Percentages of Subjects by the Condition of

Insurance

Insurance	Frequency	Percent
No	48	90.6
Yes	5	9.4
Total	53	100.0

Table 11

Frequencies and Percentages of Subjects by the Condition of

Housing Status

Housing	Frequency	Percent
Homeless	2	3.8
Apartment	18	34.0
Dormitory	2	3.8
House	11	20.8
Live with Family	20	37.7
Total	53	100.0

Table 12

Frequencies and Percentages of Subjects by the Condition of

Primary Transportation Method

Transportation	Frequency	Percent
none or public	5	9.4
Self	48	90.6
Total	53	100.0

Table 13

Frequencies and Percentages of Subjects by the Condition of

Number of Dependent Children

Number of Children	Frequency	Percent
0	47	88.7
1	2	3.8
2	2	3.8
3	1	1.9
4	1	1.9
Total	53	100.0

Table 14

Frequencies and Percentages of Subjects by the Condition of

Support System

Support System	Frequency	Percent
none	9	17.0
Parents	31	58.5
Siblings	5	9.4
Multiple Supports	4	7.5
Extrafamilial Support	3	5.7
Adult Children	1	1.9
Total	53	100.0

Table 15

Frequencies and Percentages of Subjects by the Condition of

Type of referral agency

Referral Type	Frequency	Percent
No referral	5	9.4
City/County Agency	30	56.6
State Agency	2	3.8
Federal Agency	2	3.8
Private non-Profit	6	11.3
Private for-Profit	3	5.7
Multiple Referrals	5	9.4
Total	53	100.0

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