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Professional Portfolio

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Table of Contents

<i>Introduction</i>	3
<i>Critical self-reflection</i>	4
Identify as a professional social worker and conduct myself accordingly.....	4
Apply social work ethical principles to guide professional practice	6
Apply critical thinking to inform and communicate professional judgments	8
<i>Historical, Cultural, and Political Perspectives</i>	11
Engage diversity and difference in practice	11
Advance human rights and social and economic justice	13
Apply knowledge of human behavior and the social environment	17
<i>Integrate skills, bridge levels of intervention</i>	21
Respond to contexts that shape practice.....	21
Engage, assess, intervene, and evaluate.....	22
Apply knowledge and skills of integrated practice to work.....	24
Engage in research-informed practice and practice-informed research.....	26
Engage in policy practice to advance social and economic well-being.....	29
<i>Assume a leadership role in the profession and community</i>	34
Support collaborative relationships and community participation	34
Demonstrate understanding of key challenges locally and globally.....	36
<i>APPENDIX A: Advance Practice Final</i>	39

APPENDIX C: Analyzing a Family Event 53

APPENDIX D: Exploring Positionality.....66

APPENDIX E: Jane Doe CSR..... 76

APPENDIX F: HBSE Interview #2 83

APPENDIX G: Model for Social Work Practice.....94

APPENDIX H: Role of MSW Volunteers at PCC101

APPENDIX I: CTR Presentation105

APPENDIX J: EMDR Overview and Application for Special Populations.....109

APPENDIX K: Clifford W. Beers and the Mental Health Hygiene Movement119

APPENDIX L: Advanced Practice Final139

APPENDIX M: 100 years Documentary157

Introduction

All of my life, I have always enjoyed seeing people at their best. There is nothing more heartwarming than witnessing someone prevail in the face of struggle and truly feel proud of their accomplishments. I have always wanted to be a part of something that helped people see the best in themselves and live a life where they felt connected to those around them. Though I was unsure for years of what route I would go to make a career out of empowerment, I knew from my time working in mental health that nothing made me happier than seeing a client with so many odds against them work toward a better life. I did not quite know it at that time, but I was destined to be a social worker.

Though I had previously graduated with a BA in psychology and had planned on pursuing a doctorate in clinical psychology, I had never deeply considered what I actually wanted to do. I knew I wanted to eventually be a therapist of sorts making a difference for people with mental illness but hadn't fully conceptualized what that would take. Regardless, I haphazardly applied for psychology PhD programs hoping to get into a lab, do some research, and figure out along the way how to work with people directly. Fortunately, I had role models that I worked with at Winds of Change Mental Health that were doing exactly what I wanted to do with master's degrees in social work.

Recognizing that social work was the optimal path to working with people directly, I began to look into programs. Around the same point in time, the state of Montana was hit with several budget cuts. Infuriated that the State seemed to be cutting programs that were already so underfunded, I realized my passion for social justice. I did not want to work in a system where my clients were subjected to blatant discrimination that completely undermined their worthiness of recovery. Though I still very much wanted to work with clients on a micro level, I knew that I

could not ideally stand by and watch elected officials so disconnected from my clients create and support legislation that oppresses them. There was no question that the UM's MSW program rooted in social justice, empowerment, and seeing people from a person-in-the-environment orientation would be perfectly in alignment with my experience and values.

Critical self-reflection

Starting out working in social work as a 23-year-old bachelor with a BA in psychology, my understanding of a person in the environment was myopic. Through my three years at Winds of Change (WOC) prior to pursuing my MSW yielded a significant amount of self-reflection and examination of my values, this program and my practicum have pushed me out of my comfort zones to help me discover my desire to pursue social justice for others. By utilizing papers to reflect upon and critically analyze both practicum experiences and personal past experiences, I truly feel that I fully identify as a social worker conducting myself accordingly, understand how to abide by the NASW code of ethics and feel that the code aligns with my values, and am continuously working toward an ability to make professional judgments in practice by utilizing knowledge from classes and practicum. The process has also laid a road map for my future social work path, helped me to recognize the importance of utilizing the NASW code of ethics for future ethical dilemmas as an MSW, as well as a reminder to consider potential biases of "best practice."

Identify as a professional social worker and conduct myself accordingly

In 2018, the Addiction and Mental Disorders Division (AMDD) of the Montana Department of Health and Human Services (DPHHS) proposed several revisions to the provider manual (which is adopted by the State of Montana and governs policy). One of the proposed restrictions was to restrict group home stay to an initial 120-days with 90-day extension.

Agencies would need to write initial prior authorizations (PAs) as well as continued stay reviews (CSRs) that would be reviewed by a third-party insurance agency (Magellan) who is in charge of approving or denying request based off of “medical necessity” (AMDD, 2018, p. 59). Accepting the position as a clinical case manager in charge of compiling information and writing the group home CSRs significantly enhanced the quality of my practicum experience. Concepts of power, meaning, context, possibility, positionality, and intersectionality were brought to light on a side of social work that I had not previously encountered (Finn, 2016). I learned the true meaning of social justice and advocacy and just how difficult it can be to articulate information to people of power who do not share the same meaning and context as I do for my client’s needs. Above all else, my experiences with doing CSR’s for winds of change lead me to realize the social worker I am and how these values will guide my future practice as a master’s level social worker.

In my advanced practice course, I was prompted to explain an impactful experience at my practicum that will help guide my future practice as a master’s level social worker (appendix A). Drawing on a CSR I wrote for a client who was perceived by both Magellan as well as others in the company as “able to live independently,” I realized how important conveying the context and meaning that I had of this client to both Magellan and my supervisors would be for the client’s continuation of care. I needed to draw attention to the client’s recent decompensation that had resulted in her being too vulnerable for successful recovery on her own. Succeeding in advocating for this client to both WOC and Magellan, I realized how useful my perception of populations who are heavily stigmatized by society would be if I worked for a third-party insurance auditor like Magellan. In my ten-year plan I discussed how I could pursue my goal of obtaining my LCSW and LAC doing forms of micro level social work to eventually work in private practice while simultaneously working for managed health care company like Magellan. I

would have the advantage of having a uniquely shaped understanding of the vulnerable populations that would be beneficial to ensuring clients get access to the care that they need. With my understanding of clients with SDMI diagnosis from a micro level, macro level, and a realistic understanding of how insurance is delegated through managed care, I would continue a private practice while working as a legislator advocating for policies that facilitate the recovery of clients with mental health issues.

The paper was one of the first times that I have ever genuinely considered doing macro level social work. It was an opportunity for me to realize how many people in positions of power may not been exposed to the same meaning and context of clients due to a lack of experience of actually working with the population. I realized, as someone who has worked with clients with SDMI diagnosis from virtually every level of social work, I would have the foresight to challenge harmful stigma and genuinely consider a client's unique struggle for recovery (regardless of their diagnosis) to help make a better informed and more ethical decision on covering care. I can then take all of my direct work with clients, mezzo level advocacy work, and understanding of how insurance is realistically delegated to help form and support ethical and pragmatic policies that realistically facilitate the recovery of client's with SDMIs. In my Advance research class, My project discussed how clients would have the best insight of how the CSR process could be modified to appropriately facilitate recovery (appendix E).

Apply social work ethical principles to guide professional practice

I have always considered myself an ethical person. Working in social work for three years before starting the MSW program at the University of Montana, I had encounter numerous ethical dilemmas involving both myself as well as other staff. Though I feel that I consistently maintained good judgment and decision making through some tough calls, I was not at all

familiar with the social work code of ethics. Before reading the code, I would have assumed that it was strict and though ideally how social work should be carried out, not realistic in a real-world setting. The second assignment in the foundation class (appendix B) was not only an opportunity to become familiar with the code but prompted me to apply the code to a hypothetical situation that could possibly happen at an outpatient mental health agency. In the assignment, I discussed a hypothetical agency and their issues with providing psychoeducation groups with designated material and competent facilitators. I discussed how the code of ethics would realistically consider the impact of budget cuts on quality of services while challenging all social workers involved to ensure group facilitators are working from existing competence or have the intention of acquiring the knowledge necessary to be competent.

The paper also helped me to realize the essential role of the observing social worker. As a social worker observing unethical behavior, it is our responsibility to do everything necessary to correct the behavior. However, unlike the Radical Code of Ethics that asserts that unethical behavior is unquestionably the responsibility of anyone involved, The NASW code of ethics leads for a more relativist point of view by having on looking social workers “consult with that colleague when feasible,” and to “take adequate measures” (Galpher, 1975; National Association of Social Workers, 2017, p.20). Writing this paper helped me to conceptualize how to realistically use and refer to the code in real situations I will encounter in the future. The paper also helped me to realize that having social workers held to the NASW standard would be very beneficial to the quality of service provided to clients. When a hearing was held for multi-tier licensing for bachelors and master’s level social workers, I spoke on behalf of Montana adopting the licensing procedure by expressing my support for all social workers being held to the NASW standard. I also recently acquired a membership to NASW.

Apply critical thinking to inform and communicate professional judgments

I feel that a great deal of my drive to be a social worker has come from watching people I love struggle with mental health as well as substance use. Before starting my career in social work, I was unable to understand why people I love fell through the cracks of society especially when it seemed as though they had so many protective factors to safeguard their wellbeing. The final for Human Behavior in the Social Environment one (HBSE one; appendix C) was the most elegant way of helping me to process a tragic family event while applying critical thinking and an understanding from a professional lens as to what ultimately went wrong in the situation.

Analyzing the completed suicide of my seventeen-year-old cousin, I was able to identify risk factors that unfortunately outweighed the protective factors for his safety. Bringing in Social Behavioral Perspective (Hutchinson, 2013; Ciccarelli, 2015), research on the prevalence of deviant behavior and inconsistent parenting (Stice, 1995), research of the impacts of social influence on youth already at risk (Hutchinson, 2013), research about the addictive nature of oxytocin and prevalence in suburban area (Cicero, 2005), as well as Dan Siegel's research about emotional dysregulation (Segal, 2012), I was able to professionally analyze what factors led to my cousin taking his own life.

Though this was one of the most difficult papers I have ever written, the paper led to some important realizations. The paper broadened my understanding of a person in the environment as well as prompted me to consider the various reasons why someone may use substance. Though the paper did not discuss this, there was speculation that my cousin was slightly on the autism spectrum and suffered from major depression. After writing the paper, I wondered if my cousin was possibly self-medicating by using substance. I truly believe that the experience with my cousin, thinking from a critical lens with professional judgments, as well as

other substance use related hardships I have witnessed throughout my life, have led me to realize how useful perusing my LAC would be useful for my social work career. Already as I have been working with people with mental illness, I have realized the prevalence of co-occurring substance use disorders and mental illness. With this realization, I decided to take the social work Addictions course and plan to take the Motivational Interviewing and Use and Abuse of Drugs course over the summer to obtain my LAC. In order to truly apply critical thinking and professional judgments for people struggling with both substance use and mental illness, I will need to fully understand the process of addiction.

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Historical, Cultural, and Political Perspectives

Through my BA in psychology and just under five years at WOC, I have been exposed to different historical, cultural, and political perspectives. For my psychology degree, I took courses such as multi-cultural psychology and health psychology to acquire a comprehensive understanding of different clients as well as understand different approaches to therapeutic interventions. Though I felt I was prepared for a world where I would eventually be treating people's mental health issues across cultures, I did not expect to work in such a flawed system that was entrenched with so much stigma. Though I knew that racism and stigma existed, I had previously believed that we lived in a world that facilitated the resources to even the playing field for everyone. I began to realize how difficult the mental health care system was to navigate especially with the addition of oppression many people with intersecting marginalized identities face. These issues were both infuriating as well as motivating to want to change the system. However, I wouldn't have had the slightest clue of where to start without a deep understanding of myself, personal experience with social justice action, as well as an ability to challenge the validity of well-respected theories. My positionality paper for HSBE two (appendix D), my time spent doing CSRs (appendix E), and my HSBE one assessment paper (appendix E), brought about a critical understanding of difference and oppression from a person-in-the-environment approach.

Engage diversity and difference in practice

I say with no reservation that the positionality paper for HSBE 2 was the most difficult and vulnerable paper that I have ever written. Though I have had ample opportunities in both the program as well as my five years at WOC to engage with diversity and difference in practice, nothing has made me more blatantly aware of the concept of privilege, positionality,

intersectionality, as well as my own biases with diversity/difference than exploring my I place in the world of diversity and difference. Being cisgender, heterosexual, able-bodied, male, and white, it can be pretty difficult to talk about any diversity I have experienced without feeling like I have no right to claim any issues. Due to feeling out of place and immensely uncomfortable with my own relation to these concepts, I usually avoided the conversations altogether and would refrain from putting forth my input due to feeling that my input honestly does not matter. Though it was uncomfortable and, in all honesty, cringy to dig deep within myself and be so vulnerable, I truly explored the reasons why I am where I am and what lens I bring when engaging with diversity and difference.

In the paper (appendix E), I discussed how I was able to transcend parental modeling of racism, experienced both low and high socioeconomic status (SES), but grew up mostly feeling like I had to prove that I was an “alpha male” and in doing so, condemned anyone who was homosexual. Though the patriarchal influence was not enforced from my parents and mainly just enforced by peers, I greatly struggled with navigating how to express myself in a way that aligned with my values and would be accepted by my peers. I discussed how high school brought about more opportunities to express who I truly felt I was but still was met with challenges and ultimately resulted in taking up alcohol abuse as a coping mechanism.

Though I had a family who modeled ideas of overt racism growing up, I always perceived people of color as being “cool” and conversely from ideas of racism, was always jealous of who they were and resented that was white. However, I am ashamed to say that homophobia persisted through most of high school due to social learning and as a defense mechanism for my own feelings of being an inferior man. Fortunately, I was able to really start to challenge homophobia when interacting with gay friends in high school as well as supporting

the LGBT community throughout college. I also grappled with understanding why experiences that question my “manliness” continue to be so triggering for me while simultaneously understanding the underlying reasons why others may feel the need to put down my masculinity. Specifically, with work situations, I discuss understanding that a client putting me down regarding my manliness may have their own reasons that lead them to feel that they need to prove their masculinity.

I have often wondered why someone with my upbringing and my set of intersectionalities would be driven to be a social worker. Though I have a strong passion to advocate for people with mental illnesses due to work and family experiences, this paper has led me to believe that my own personal discontentment of feeling like a slave to the patriarchy has helped facilitate empathy for others who are even more oppressed by its influence. I couldn't imagine how it would be having to go to my same Catholic school if I were homosexual. Similarly, I couldn't imagine having a family member with overt racial biases if I were someone of color. Fortunately, I am someone with many privileged intersectionalities who is very passionate about advocating for and empowering others who are oppressed. I recognize that our rugged individualist “pull yourself up by your bootstraps” culture can leave us blind to the struggles and oppression of others. I possess the “power with” by being both a positive male role model for my clients as well an advocate that can give my “microphone” to others who would otherwise not be heard (finn, 2016).

Advance human rights and social and economic justice

The last year of doing CSRs for the group home has brought about a very deep understanding of virtually all aspects of social work. My job required that I create the most comprehensive picture of a client from every staff they have worked with at WOC, assessments,

progress notes, recovery data, and any information available from other agencies they have worked with. I was responsible for consolidating this information into one big document to convince a third-party auditor (Magellan) that a client was in need of continued service. What has been more eye opening for me in this process than anything else is how quick Magellan was to deny someone for such minute reasons. No matter what information was presented, if a CSR was unlucky enough to be deferred to a doctor, there would be a denial based on faulty, unjust, and misinformed reasoning.

Quiet often, my CSRs would pass with no requests for additional information. Taking over the job from their inundated case managers in March of 2018, I was able to devote a substantial amount of time gathering information and compiling that information into the CSR document. With some feedback from the State as well as suggestions from my supervisor, I was churning out ideal CSRs that would comprehensibly address all relevant information to satisfy the level of impairment (LOI) criteria proposed by the Addiction and Mental Health Division of the Department of Human Health and Services (AMDD of DPHHS). Each LOI section would begin with an assigned severity justified by a plethora of supporting information. I would even give a sum up paragraph at the end of each of the five sectors that would summarize the supporting data in language taken directly from the LOI criteria. Though my information was enough justification for the vast majority of CSRs we submitted, reviews that were deferred too doctors were met with strong but almost contrived criticism. This was the case for the CSR I wrote for my client Jane Doe and her Denial letter from Magellan (appendix F).

Though Magellan had previously complained that CSRs did not show enough demonstrable progress over the past 120 or 90 day period, progress was often used as their justification for a denial no matter how minute or to what extent the progress was outweighed by

persisting issues. What seemed to be the case often was that a doctor didn't like a client's medication regimen which was much harder to appeal due to the prescriber not being a part of the appeal process. However, with my client Jane Doe, the doctor attempted to make the case that she was ready to discharge into independence right as she was finally putting in real effort with treatment compliance. I was perplexed with the task of having to tell a doctor who was using my own written information against me that he was missing the bigger picture. As a practicum student, I can safely say that this was my biggest call to advance human rights and social justice.

Whether or not a client has somewhere to go after being discharged is irrelevant to Magellan. If they do not qualify for medical necessity to be in the group home, they will no longer reimburse the care. Jane is a client with no family support, no friends, and had no leads for an apartment. She was someone who did the bare minimum to not get kicked out of services, crossed numerous boundaries with staff and peers, she rarely talked and was difficult to understand when she did, and would not open up about issues with her psychosis or other symptoms. She was a client that our team worked desperately to get to engage with services but with little successes for over a year of services in the group home. However, with a medication adjustment and therapy accommodations, Jane miraculously started advocating more for her issues, engaged more with staff and peers with less inappropriate behavior, and was starting to show great efforts of treatment compliance. However, Jane still qualified as a severe level of impairment for four out of the five sectors due to an inability to attend appointments, an inability hold down a job, continued difficulty articulating needs, lack of outside support (including friends or acquaintances), continued poor boundaries, severe psychosis (hallucinations/disorganized speech), severe anxiety, sleep issues, depressive symptoms (mainly

isolation), as well as a past of multiple hospitalizations for suicidal ideation with a plan. However, the doctor cited that due to her ability to be her own payee, insight for denying a job, recent ability to cooperate with medication management appointments, progress with boundaries, as well as the impact of positive psychotic appearing to be more relative to Jane's "negative symptoms of schizophrenia," Jane was denied continued care. At one point, the letter claimed that "No severe symptoms of SDMI are cited." Strongly disagreeing with the Magellan doctor's decision, a peer to peer appeal was set up by WOC to challenge the denial.

Though I had prepared material, the clinician and I were never given a conformation of when the appeal would be. Around 8:30am of the morning of one of the requested times, Magellan called and left a message saying that the appeal was set for 10am. This message not being received until after the appointment, our clinician was blinded sided with the call without me there with the information. She called me and had me come into her office. The doctor seemed to aggressively and in a frustrated manner argue that Jane does not need our services. Incredibly nervous while also realizing that Jane's recovery depended upon me in that very moment, I pulled myself together and discussed how a client who I had known for years rarely engaging at all due to the severity of her illnesses was finally willing to engage in treatment and is just starting to make strides in her recovery. I further explained that letting Jane go now would throw away such a great opportunity for her furthering recovery and would result in a major setback that would diminish all the progress she had made so far. Miraculously, the doctor asked for a couple bits of clarifying information for Jane's symptoms and then decided that she would be approved for three more months.

It was so foreign for me to be put in a position where I had to verbally go beyond the information in the CSR, leave behind my fear of authority, and put it all on the line in the name

of social justice. Never once before did I think I had the power to tell a doctor that he was wrong and that I was able to see a bigger picture of a client than he could. Learning in our policy and leadership classes this year about the importance of vulnerability and stepping out of my comfort zones has really resonated with me looking back on situations like the appeal for Jane Doe. With a frustrated doctor armed with words I had written and a blindsided supervisor who did not have my prepared information yet, I had to step way outside my comfort zone and attempt to use what power I had if to advocate for Jane's right. Though the experience was horrifying in some regards, it was incredibly rewarding and eye opening. Though I am the type of person that easily second guesses themselves (especially when an authority figure tells me I am wrong), the experience gave me the confidence to continue on using the voice I have as a microphone for people whose voices are often silenced.

Apply knowledge of human behavior and the social environment

In HSBE one, the class was challenged to analyze the behavior of someone who we did not know very well by using different theories of human behavior. With two different interviews and two different papers, we designed two sets of questions that explored where the interviewee placed in relation to theories of human development. In the first interview, we were prompted to use older theories (such as Erickson's Eight Stages of Psychological Development). In the second assessment, we were prompted to use new theories of human development. I feel that I benefited the most from both my application and critiques of the theories in the second assessment (Appendix G).

Using Gilligan's Ethics of Care theory and Goleman's Theory of Intelligence, I discussed how my Interviewee (who I call Cyndie), meets the majority of the requirements to be considered completely morally developed and "fairly" emotionally intelligent. However, I

brought up how both theories are biased by not taking into account Cyndie's potential diagnoses of borderline personality disorder (a diagnosis that her and her therapist believe she has). I brought up how issues arising from romantic relationships are given no leeway in either theory but are a common symptom with BPD. I argued that it is unfair that Cyndie is technically disqualified for meeting several stages when she meets the majority of criteria in all stages of both theories. I end the paper with a critique of my own thoroughness.

This paper was an excellent opportunity to uncover how even newer and well-respected assessments of human behavior contain biases for certain intersectionalities. As will be stated throughout this portfolio, my greatest passion is advocating for people with mental illness that are discriminated against. This paper was a way to apply didactic knowledge of human behavior to the social environment while still recognizing that respected theories are going to contain flaws that don't account for everyone in the population. Though I understand that crafting these theories to account for every intersectionality would be an arduous and possibly unrealistic task, this assignment is a reminder that using any method of assessing human behavior is going to come with a plethora of potential biases that have the potential to oppress others. Therefore, as social workers, we need to constantly question the validity of any and all assessments that attempt to define a human being. We understand that the complexity of a single person's intersectionality as well as the influence of external factors likely will be missed in assessment measures.

I truly believe Cyndie is an emotionally intelligent girl with a fully developed sense of moral. Unfortunately, if I were using Gilligan and Goleman's theories strictly, she would be qualified as lacking morality and only being fairly emotionally intelligent. Thanks to this paper as well as other experiences in seeing the biases of standardized testing, I feel that I have the

foresight to constantly challenge evaluation methods for potentially biases toward different intersectionalities.

Referneces

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Integrate skills, bridge levels of intervention

Before this program, I had my mind completely set on micro level social work. However, my experience with seeing the direct effects of budget cuts made me realize I would need a deeper understanding of how the system affects clients to truly understand how to intervene in client issues. Though I went out of my way to take classes and engaged in trainings to facilitate micro level classes (such as my psychopathology course and my EMDR training), required core classes helped me to see how necessary mezzo and macro level social work are to work toward a world that truly facilitates just practice. I was encouraged to design a model of social work that addresses oppressing contextual factors in the current system as well as engage in bettering a community outreach project that provides resources and fights stigma of people who are homeless. Lastly, I was able to learn, utilize, and teach others in my cohort about a strength-based therapy that empowers an incredibly vulnerable population.

Respond to contexts that shape practice

Receiving my BA in psychology, I feel that my practice in the field and current study of social work seem to align much more with my values than the studies from my undergraduate degree. I attribute this mostly to my ongoing ability to be mindful of how a person in the environment approach accounts for far more other important factors that may be glossed over in other fields of study. However, the Build your Social Work Model paper from the Foundation class (appendix H) greatly challenged me to take contextual influence to a deeper level and really explore external factors that may exacerbate addiction and mental health.

In the paper, I discussed the over representation of people with mental health and addiction issues in prison, how prison exacerbates addiction and mental health recovery, as well as the prevalence of co-occurrence of mental health and substance use. Basing off the study

called “Rat Park” where rats were seen choosing to use substance less when put in highly stimulating environments, I proposed a study that would function as a prison alternative where inmates with mental health and substance use problems would be put in an ideal environment. This environment would both facilitate all of their recovery needs in a strength based non-judgmental way. I then proposed that this study could act as a model for prison reform.

In all honesty, this paper was not my best work. As professor Finn pointed out in her comments of the paper, my idea was very close to the Finish prison system and their prison reform efforts. However, this assignment was the first time I truly began to conceptualize just how influential context can be on behavior. Though I was previously familiar with Rat Park and implications for addiction, writing this paper made me more aware of our broken mental health system and how attempting to navigate the system may be more harmful to recovery than helpful. For example, having a panic attack or a psychotic break at the wrong place at the wrong time might result in “resisting arrest” or “assault of an officer.” Having a criminal record makes housing next to impossible leading to homelessness. Homelessness may lead to substance use as well as other illegal activity to inhibit recovery even further. Contextual factors play a key role in both recovery as well as oppression. This paper helped me to consolidate my belief that a big piece of facilitating client recovery is advocating for reform of the systems that they are apart of.

Engage, assess, intervene, and evaluate

Last spring, I participated in Project Community Connect (PCC). The experience was very transformative for me. Many clients who I knew well and had mostly seen in crisis or sullen due to the debilitating nature of being hopeless were smiling and genuinely seemed to enjoy themselves at the event. For some, it may have been the most invited and welcomed they had ever felt in their lives. Though the event was successful and did an excellent job of facilitating

client's needs, my community class was asked to work in groups to generate ideas of how future MSW volunteers could help make the event even better. Collectively coming up with ideas and writing the paper for the project (appendix I) not only broadened my understanding of engaging in mezzo level social work, the project taught me valuable lessons about working cooperatively with others who may not share similar ideas or style of work.

Our group focused on having MSW students supports clients in crisis if crisis came up, acting as client guides, and aiding in childcare. After surveying MSW students, analyzing existing volunteer data, interviewing a participating staff from an agency, as well interviewing one of the PCC event planners, we were able to conclude that all three positions were needed and MSW students would be willing to do them. Though the project ended well and I am proud of the work we did, our group encountered many obstacles.

One group member was set on an idea that was very similar to client guides. They were adamant that we could have both as an option. Other members had health issues come up that stunted their ability to contribute. I had a tough time reconciling wanting to not take control of the majority of the project but still wanting the project to yield a good grade. It was a time where I had to be a leader and pick up slack where others were physically unable to do so but not to dominate a project that other colleagues equally wished to contribute to. What ended up saving the project was good communication.

Though working in a group may have been foreign to most of us, we realized that nothing would get done equally distributed and yield a good end result if we didn't communicate what we all wanted to see in this project and how we could all equally contribute. Though the process was a challenge, it helped me to realize that real mezzo level social work is only possible when

people can effectively collaborate and communicate with our colleges in a productive way.

Though I will not miss group projects, I am thankful for the lessons I have learned from them.

Apply knowledge and skills of integrated practice to work

At WOC, I have often worked with clients with psychotic disorders. Many of my clients with these disorders experience negative psychotic symptoms that inhibit their ability to connect with others and ultimately lead to little engagement in treatment. Fortunately, the State of Montana State was given a grant to train mental health agencies in Recovery Oriented Cognitive Therapy (CT-R) which is the first therapy to show “statistically significant and clinically meaningful improvement in psychosocial functioning” for clients on the extreme low end of neurocognitive functioning from psychosis (Grant et. al., 2012, p.125). My agency took advantage of this training and trained all of our staff in CT-R. Since we have been trained and CT-R has been implemented, I have been citing in my CSRs for clients who struggle with low-neurocognitive functioning schizophrenia that this evidence-based therapy is being implemented for them (as I did with Jane doe see appendix F). I have also referred several client’s to CT-R when recognizing from my reports that the clients may be struggling to engage in treatment due to their negative symptoms of schizophrenia. I have even personally used CT-R techniques (such as accessing a client’s adaptive mode) to help build rapport and make it easier for a client to provide information for there CSR. However, what really helped me to recognize CT-R’s importance was exploring the research behind the therapy as well as familiarizing myself with CT-R well enough to present the therapy to my Advanced Practice class. The presentation was also a chance to disseminate useful information to my cohort who will likely go on to work with clients who experience low-neurocognitive functioning from a psychotic disorder.

Co-facilitated by a fellow MSW student, we discussed how CT-R was founded, the difference between positive and negative symptoms of schizophrenia, defeatist beliefs and their correlation with negative symptoms of psychosis, and the research backing CT-R through a power point presentation (appendix J). The presentation also went through every step of CT-R, discussed where CT-R has been successfully implemented, and how it aligns with social work values. We also did an exercise that helped simulate the frustration clients feel when a delusion is challenged. This led to a discussion of the counterproductive nature challenging delusions. Instead, CT-R challenges the therapist to explore the unmet needs behind delusions and alternative ways to satisfy those needs.

Though I believe I have already met this competency with my EMDR training last fall, I chose to talk about CT-R because it addresses a population that is often written off as “unable to recover.” One of the reasons why I am such an advocate for the adult SDMI population is because this population seems to be a group of people that others feel are a burden to work with. Though I believe a lot of this notion comes from misinformed stigma around clients with SDMIs (especially using Medicaid) and their ability and worthiness of recovery, it is a pervasive idea that I believe detracts mental health professionals from working with the population (Al-Alam and Omar, 2008; Parcepe and Cabassa, 2012; Martinez-Hume et al., 2016). I am lucky to have not only learned and applied knowledge of effective therapeutic approaches like CT-R but also to be in a setting to educate my future colleagues about an often forgotten and neglected population that has both the ability and the worthiness of mental health recovery.

Continually bring research, policy analysis, and advocacy to bear in practice

As an undergraduate, I was taught that research is an essential piece of client intervention. Most importantly, I was taught how to be a good consumer of research by both

questioning research methods and making an informed decision on best practice based on what good research says. Though ideas of what constitutes “good research” was challenged in my Advanced Research class, I still recognize the importance of utilizing practices that are supported by traditional research conducted in the lab as well as in the real world. However, what I did not learn as an undergraduate was how imperative fighting for social justice is in advancing policy and challenging oppressing practices is to provide clients with the best practices. This degree has been the perfect balance of appreciating what I have been formally taught as important (good research) while bringing to light that our ability to utilize best practices is due to a history of fighting for social justice. Through my study of EMDR and project on Clifford Beers, I feel that I have been able to engage in practice supported by good research as well as analyze how the development of outpatient mental health came about from advocacy. Specifically, how the work of a man once oppressed by the system found the power within himself to transform the mental health system.

Engage in research-informed practice and practice-informed research

Though my experience with CT-R fulfills this competency, my experience with learning Eye Movement Desensitization and Reprocessing (EMDR) therapy expanded my knowledge of research informed practice and practice informed research even further. In the fall of 2019, I went to a five-day intensive training for EMDR. Before the training, I had heard many good things about EMDR but did not really know much about it. When it was first demonstrated at the training, I was very skeptical that waiving your fingers in someone’s face for 30 seconds was going to help them reconcile their trauma. The demonstrations made me feel that the participants were experiencing some time of placebo effect or merely wanted to please the therapist.

However, when I saw that the therapy had been heavily researched since the late 1980s and has been considered an evidence-based practice for quite some time, my skepticism began to diminish.

When EMDR was performed on me during the training, I had a positive experience as well as a negative one. Though the positive experience left me with a newfound outlook on a formally strained relationship with a family member, the negative experience left me feeling like I was slightly disconnected from myself for over two weeks. Though the session was not conclusive and we were warned before not to attempt to try to process an issue that would put us out of our window of tolerance, the experience made me realize how important having a deep understanding of EMDR would be before using it in practice (Walker, 2019). A comprehensive understanding of EMDR would be even more important given that I work with an incredibly vulnerable population of people with SDMIs. Though we went over what needs to be done when using EMDR with certain populations in the training, we did not discuss what must be done for people who are highly dissociative or who have psychosis. To feel more confident in my ability to provide EMDR for these special populations, I decided to take an independent study in EMDR supervised by a professor trained in EMDR (Jim Caringi), in order to feel confident in my ability to provide the therapy for these special populations, cultivate a deeper understanding of the research behind EMDR, as well as engage in EMDR practice that is analyzed with critical incidents. For my first paper for the independent study, I analyzed the research and discussed what actions must be taken when working with people with psychosis or who are highly dissociative (appendix K).

Though EMDR is considered an evidence-based practice by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2011 and has been deemed by the World

Health Organization (WHO) as one of the only two therapies recommended for children, adolescence, and adults for PTSD, It did not dawn on me until writing this narrative that I had not looked into research that validates EMDR's use across cultures (Kiessling, 2019). Though one would assume that EMDR would be effective for any human being due to its ability to consolidate memories as people do while in REM sleep, it is always important to explore the research for different cultures (Stickgold, 2002). Though there is definitely more cross cultural research out there for EMDR to hold its title with WHO, the research that I found indicates that EMDR was effective with Syrian refugees experiencing PTSD and depression (Acarturk et al., 2016), was effective for Italian people with multiple sclerosis suffering from PTSD, anxiety, and/or depression (Carletto et al., 2016), and reduced PTSD and psychotic symptoms for inpatient clients in the Netherlands with psychosis and PTSD (De Bont et al., 2016). My paper also discussed how EMDR is empirically shown to be effective with multiple mental and physical health conditions ranging from body dysmorphic disorder to phantom limb pain (Kiessling, 2019). My paper explored how the EMDR procedure is very accommodating to people at different levels of ability to process certain traumas. Depending on if a person is only ready to process recent and future events, some past events while restricting others, or is able to process all past events, the three EMDR procedures (EMD⁺, EMDr, and EMDR respectively) can facilitate these needs (Kiessling, 2019). Though the numerous amounts of research and titrated versions of EMDR shed light into the therapy being informed by practice, I took my training a step further and let my own practice inform what other research and information to seek out to better enhance my ability to perform EMDR.

After diving into the research I could find for the effectiveness and procedures of EMDR, I wanted to explore how to use EMDR with clients who are highly dissociative and/or experience

psychosis. I decided to undertake this task because I knew from previous work in my field that people experiencing these issues are people I have come into contact with and will continue to serve as a clinician. With clients with psychosis, I was able to get a simple answer from my EMDR consultation instructor, Robert Manrique. He discussed that the only thing to be mindful of is whether or not the experience or false belief cited is not rooted in a delusion nor is cause by a hallucination. As long as you can guarantee the event and false belief have occurred from an actual experience, EMDR is appropriate to use with someone who experiences psychosis. As for a client who is highly dissociative, the paper gave me a chance to explore how a plethora of grounding techniques are first used to help someone expand their window of tolerance (a metaphorical window that allows a person to process void of an overwhelming emotional experience or a complete disconnection from emotions and reality) before even starting the EMDR session (Walker, 2019). Since writing this paper, I have yet to work with clients who are highly dissociative but have done some EMDR with a client who experiences psychosis. I am thankful that I took my training a step further to prepare me for working with this client as well as work with other clients in the future.

EMDR is a great example of both research informed practice and practice informed research given my training, literature review, and using my own practice to expand my training. Though EMDR is useful for many populations, I found a way to make it consistent with my theme of facilitating the various needs of clients with SDMIs. EMDR will be a great research informed tool for my practice as a future clinician.

Engage in policy practice to advance social and economic well-being

Before this program, I had some valuable experience with engaging in policy practice. When the 2018 budget cuts were proposed, I joined a number of clients and fellow staff to

protest the cuts at the State Capitol though I did not speak myself, I helped make protest signs and made up several protest chants (unfortunately, we did not get to use either). I also encouraged clients to get up and tell their story during the hearing. Along with this experience, I made a trip to the Capitol to last spring to speak on behalf of MSW students in favor of multitier licensing as well as accompany my supervisor in giving the representative of her district a de-identified version of a Magellan denial letter in hopes to bring awareness to the unjust nature of Magellan's denials. Though both of these experiences were valuable examples of engaging in policy behavior to advance social and economic wellbeing, my research project for my history and policy class allowed me to analyze policies for social wellbeing of the SDMI population in a way that has informed my ability to formulate and advocate for future policies. The project also helped me to understand how powerful and essential client's perspective is in policy change.

In my project, I discussed Clifford Beers a man who was institutionalized in the late 1800s due to symptoms of psychosis, mania, and extreme suicidal ideation (Dain,1980; Parry 2010; Beer, 1980). Clifford, who witnessed and was subjected to severe maltreatment in institutions used his experiences as motivating to write a book, *A Mind That Found Itself*. When he was released from the institution, his book helped him to gain support from donors to start a mental health reform movement with philosopher William James and psychiatrist Adolf Myers (Dain,1980). His movement (which underwent many names but is now called Mental Health America) helped to promote concepts of prevention and after care (such as outpatient mental services) and had influence in passing the Community Mental Health Center's act which led to the deinstitutionalization over 50% of clients in asylums (Parry,2010; Bassuk & Gerson, 1978; Mental Health America, 2018).

Not only did I cultivate a good understanding of how agencies like WOC came to be, this project is a great reflection of how someone who was once so vulnerable can rise up and change the system. Granted, Clifford Beer was a white middle class male with good outside connections with powerful people, he is still a great example of how someone who is told that their voice does not matter can be empowered by others who believe in them. This project was a great base for both client empowerment as well as clients taking the lead role in fighting for their own rights. Eventually, I would look into client led research and policy work.

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[powerpoint slides]

Assume a leadership role in the profession and community

In my psychology undergrad degree, I truly felt my role was to serve clients. However, I was under the impression that this would happen from learning and implementing the best interventions developed by other mental health professionals in the existing system. As I have gone through this program, I have realized clients are not only a key component to their recovery but also have the power to advocate for change. Though we sometimes may need to hand them the microphone to be heard by those in power, they have the most important voice in their own recovery. My project for advanced research (appendix L) helped to develop this concept in the mental health context I was familiar with. Though I would assume a leadership role in bringing the idea to fight the current CSR system, I would advocate for a client-led study that ultimately let them take the lead in challenging the system. Through this program, I have also developed a deeper understanding of the existing oppression of Native Americans. My paper on the 100 years (appendix M) documentary helped to understand how oppression still plays out as well as admire the tenacious advocacy for the tribe and the money they were entitled to.

Support collaborative relationships and community participation

My history project with Clifford Beers helped me to recognize the power of client knowledge and the potential of a client-led movement. Learning about Critical Participatory Action Research (C-PAR) in my Advanced Research class expanded this idea even further. C-PAR is an epistemology that acquires research data by incorporating the dialectical critical participation of the general public (especially those who have been the most marginalized; Sandwick, Fine, Greene, Stoudt, Torre, & Patel, 2018; Torre, Fine, Stoudt, & Fox, 2012). Passionate about the 2018 budget cuts affecting length of group home stay, I decided to do a research project that explored how Magellan was getting away with unethical denials and how a

C-PAR team could challenge the current continued stay process. My research explored managed care, issues of parity between the reimbursement of mental and physical health, high cost of mental health care exacerbated by emergent services, as well as the stigma bestowed upon the Medicaid and SDMI population. Due to stigma being one of the main roots of the problem aiding in the idea that the population is perceived as lazy, intentionally unemployed, undeserving of help, and dependent of help, I reasoned that a client led study would both challenge the stigma and lead to pragmatic ideas for reform coming from clients, people who understand its effects better than anyone (Martinez-Hume et al., 2016).

With the design of the study, I did not develop any hypothesis, nor did I propose analyzing any quantitative recovery or monetary data. This was a study where I truly wanted clients to take the lead and decide what was important and relevant for formatively evaluating the process. Though I decided not to pursue this project due to limited resources and time, I am in the process of working on a bill in my policy class that would incorporate client testimony and possible participation in creating a bill that advocates for initial group home stays to be a year and extensions to be six months.

Though I greatly respect formal research and was glad that the research one class discussed the importance of concepts such as impact factors, internal validity, and external validity from a social workers lens, I equally appreciated the authentication of using client led research practices in social work. Though I may not go onto engage in research in my career, I will almost definitely engage in some form of policy work. Both my history of social policy final and my advanced research final have provided me with a good foundation to understanding just how imperative client involvement is in advocating for their rights.

Narrative explanation. Full skill: Apply forms of leadership to support collaborative, interdisciplinary relationships and active participation of community members in addressing needs and concerns of individuals, families, and groups and communities.

Demonstrate understanding of key challenges locally and globally

From both being in this program and living in Montana for the last nine years, I have learned a lot about the social, political, and economic changes facing natives' tribes in the surrounding area. Interestingly, I took a class for my psychology undergraduate degree called Native Peoples of Montana. As a history class elective that I took for fun, the class discussed how a lot of the taking of native land was done by supplying enemy tribes with guns and making trade deals if they took over desired land. Though this still painted a picture of manipulation from white settlers, it seemed to act as a narrative to make native tribes almost appear as if they "did it too themselves." However, reading the book *A People's History of the United States*, taking the ICWA class, and learning about the subjugation and sly manipulation that white people inflicted on native people painted a much different story. One assignment in particular that really brought home how native people are still subjugated in this day in age was watching the 100 Years documentary and writing a paper on my reaction.

In the documentary, Native people were told over the last century that they would be reimbursed for oil drilled on their land. The US government owed the landowners billions of dollars but the documents were either lost stored poorly where they would be weathered away. The drilling also led to the land being unable to be farmed on often leading the landowners to wallow in poverty. A brave woman, Elouise Cobell sued the federal government from what went from a 27.5-billion-dollar settlement to 3.4 billion. Though this was the largest successful lawsuit against the government, the pay outs still took years to be given out.

The lawsuit was filed in 1996 and even with a Tenacious fight from Cobell and others, the 3.4 billion settlement did not go through until 2011. It's Jarring to realize that as recent as when I first started college, that the US government had such archaic resistance to doing the right to a group of people they had blatantly wronged. I think it's common for white Americans to qualify or even completely disregard the subjugation of native people due to guilt that cannot be easily reconciled. I am lucky that live in an area and am in a program that has exposed me to the truth of what native people have to deal with even in 2020. My experience with the documentary as well as others in this program has helped me to be mindful of the specific issues facing people in the rocky mountain west that are seen on national levels as well. As a social worker, I hope to aid in advocating for their equality.

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APPENDIX A: Advance Practice Final

Abstract

This paper explores how the program has helped me to realize that I can use my privilege to advocate for those in society who have often been “given up on.” I discuss how my current job of writing continued stay request (CSRs) is difficult when the documents are denied for reasons other than medical necessity. I give the example of a client named Linda who had previously been doing well but recently regressed with symptoms. I discussed how both Magellan and my supervisors felt that the denial was fair due to past progress with the client. I also discussed how Magellan is more prone to bias against this client given the stigma of BPD as well as having a different context and meaning for the client. I then explain both the power over that Magellan has as well as the power within from myself to advocate for the client's continued stay to both my supervisor and Magellan. I then discuss how my experiences with CSRs have made me want to go above and beyond micro level work by first perusing my LAC and LCSW, working for a company like Magellan from a different meaning and context, as well as eventually lobbying for policies that advocate for people with mental health issues.

Advanced Practice Final

Through this program, it is difficult to put into words just how much I have learned. Not only have I learned a great deal about my identity as a social worker, I have had my perception of American history completely altered, my understanding of mental illness, low SES, and other diversities is far more accounting of external influences. I have also learned to accept my privilege and use it as a tool to advocate for oppressed groups of people. I have realized that in order to help people, we must recognize and challenge the common notion of “what is wrong with them.” Instead, we must recognize that what we consider “maladaptive” as being a normal adaptation to a maladaptive environment. Thus, we can recognize our clients are not broken but are resilient beings who could rewire neural pathways in the right environment. As social workers, we need to recognize our client’s ability to obtain a better life and be there to advocate for them and help guide them on their journey to recovery. What I have really learned this year is that I want to advocate for the client’s that society and possibly even other social workers have given up on. A recent case at the agency I work for is a good example of how I would like to continue on as a social worker

As I have discussed before, I write the Continued Stay Requests (CSR) for the Winds of Change (WOC) group homes. We have had several cases where the third-party agency that approves and denies requests (Magellan) has gone against their own guidelines and denied people based of reasons other than “Medical necessity” (Addictive and Mental Disorder Division, 2018, p. 44). For example, we had one woman denied based on a disagreement in using a certain medication for treatment and another woman denied based on her safely managing suicidal thoughts independently in the community was an “unrealistic goal for a borderline.” Though sitting in on an appeal call with a doctor referring to a client as a “borderline” was both

infuriating and a great example of me advocating for the maltreatment of a client (the denial was over turned), a recent case is a good example of advocating for a client not only to Magellan, but also to my superiors at WOC.

There is a client at WOC who has been in the group home system for at least two years. She is in her late 50s with a primary diagnosis of borderline personality disorder and a secondary diagnosis of major depression. For the purposes of this paper, I will refer to this client as Linda. I have written at least three CSRs for Linda as of now. Every time, I have discussed her desire to live independently, her skills she has obtained over the period, as well as her severely disabled ability to have healthy relationships and avoid triggers of past sexual abuse. For some of the past CSR periods, Linda had made a substantial amount of progress and was months away from having the skills to live on her own. Unfortunately, the last three months before her most recent CSR, Linda was aggressively sexually harassed by a client (who was moved out of the house) and she was castigated by house mates for “bossing around another client.” Her impeccable dietary habits to manage health conditions, group attendance, and progress with her ability to focus on herself and respect other boundaries was greatly jeopardized. She was now isolating often, skipping meals to avoid others, had become completely fixating on her issues with peers, and was unable to be redirected in therapy to focus on herself. There was even indication that she was struggling with suicidal ideation (as she has been hospitalized for in the past) but would deny it was an issue when asked.

As of October, CSRs are approved or denied based off five dimensions for Levels of Impairment (LOI). Using my information gathered, I was able to determine that Linda LOIs for the five dimensions were as follows:

- 1) Selfcare/basic needs (mild LOI)

- 2) Employment/education/housing/financial (Severe LOI)
- 3) Family/interpersonal relationships (Severe LOI)
- 4) Mood/thought functioning (Severe LOI)
- 5) Self harm behaviors/suicidal/homicidal ideation (high LOI)

Though she had mostly maintained compliance with ADLs (with the exception of eating regularly) and had plans of pursue a GED, Linda was severely and highly impaired for every other dimension. When we received her denial letter, the rationale was that Linda “can obviously take care of her basic needs and is pursuing a GED so she appears stable. There was not one mention to anything that qualified her as a severe or high level of impairment. Due to her length of cumulative group home stay and impression from my direct supervisor and clinical advisor that Linda could live on her own, my superiors questioned if Linda’s continued stay denial was worth appealing. I realized that this was a big moment for me to advocate for Linda when both Magellan and my superiors questioned her need to continue home stay.

Our clients are people with SDMIs on Medicaid. The Medicaid population has been historically thought of as lazy, intentionally unemployed, undeserving of help, and dependent of help (Martinez-Hume et al., 2016). People with primary diagnoses of BPD seem to face added stigma as Magellan has often singled out these clients as not needing group home level of care. I have noticed that that out of the five denials I have had, four have been women with BPD. Though all of these clients exhibited symptoms that were more than enough to classify their cases as having a medical necessity need, the denial letters would focus on their recovery efforts aspirations and efforts as being “unrealistic” or “inappropriate” for their diagnoses. Looking at the history of BPD, the diagnosis was first added in the DSM in 1980 (Friedel, 2018). Over the last 40 years, BPD has routinely been used to label people who are

considered hopeless, make therapist upset, and is considered one of the most controversial diagnoses (Al-Alam and Omar, 2008). Avirm, Brodsky, and Stanley (2006) assert that the stigma associated with BPD affects perception of how mental health professionals tolerate and interpret people with BPD's behaviors and can therefore lead to minimizing symptoms and overlooking their strengths. There is also evidence that many mental health professionals believe that people with BPD have "self control" over their behaviors (p.250). Though Magellan doctors have admitted via phone call appeals that "BPD is an advanced form of PTSD," they seem to feel that these clients are not in need of group home level of care.

For staff at WOC, our meaning and context is quite different. As stated by Finn (2016), "our social location and experiences shape how we make sense of the world" (p. 33). Finn also states that context is "the background and set of circumstances and conditions that surround and influence particular events and situations." Staff at WOC see our clients beyond their diagnoses and medication. We see their strengths, weaknesses, and everything else that makes them human doing their best to work for a better life. Though we may ourselves become partially jaded by stigma, jaded by systemic trauma, or fail to recognize a client's progress, our ultimate goal is to advocate for and empower our clients to facilitate their recovery. On the other hand, Magellan does not see these things in our clients. Though My CSR's are written in the hopes to convey the same meaning that I have for my clients, the Magellan team tends to focus more on diagnoses, medication regimens to treat the diagnoses, and the cumulative length of time that the client has been in group home. Any information regarding a client's progress indicated in the CSR will usually be cherry picked out to justify their decisions. Magellan's context is jaded by both stigma of clients with SDMIs using Medicaid as well as being hired to

save the state money. The stark difference in contexts between Magellan and WOC greatly shapes the meaning of a client's need for continued outpatient care.

As for power, Magellan ultimately has the power to approve or deny clients even if their claims are not based off of medical necessity. The only way WOC has been able to circumvent this power is by reaching out to Magellan's overseer, the Department of Public Human Health and Services Addition and Mental health Disorders Division (AMDD), to be part of the appeal process. However, with the case of Linda, I not only had to advocate to the Magellan doctors for her medical necessity need for continued group home stay, I had to advocate for her to my supervisors. Fortunately, my supervisors were receptive to my claims of her multiple severe impairments based off the LOI form. I was also able to call on her case manager and the group home manager to corroborate that Linda is currently in a vulnerable state that requires continued group home care. Though I originally intended on just doing micro work, the experience and other CSR experiences have made me realize that I am also passionate about Mezzo work.

In a year, I hope to be working at an agency as a therapist while also having a hand in advocacy work. First, I plan on staying at WOC at least until August. WOC has guaranteed that I will be hired as a therapist. I plan to work part time taking on therapy appointments and accumulating supervision hours, continue facilitating the CSR process, apply for my ACLS, and working toward certification for specific therapeutic orientations (such as DBT). Simultaneously, I will be applying for other agency jobs in towns in Washington, Oregon, as well as Las Vegas looking for therapist positions at agencies. I am hoping that my time as a therapist and accrued therapy certifications will help me find a job at another agency. Depending

on what I find, I will either move to another job in August or stay with WOC through the first year continuing to accumulate LCSW and LAC hours.

By year five, I plan to be fully committed to staying in either Washington, Oregon, or Nevada with all of my hours completed for my LCSW and LAC and therefore, licensed in that state. Wherever I find that job, I will have worked as a therapist for three years with clinical supervision in order to accumulate the hours for licensure. When I have my licenses, I would hope to be doing part time private practice as well as part time working at a third party agency that deals with prior authorization and continued group home stay for the SDMI population (as well as other populations). I believe that meaning and context will remain shaped for social justice from my past experiences with WOC. I will have a deep understanding of what realistic recovery looks like and will be able to be of a place of greater power to withhold that value to a greater degree. In 10 years, I hope to have gained the experience and credibility to lobby for policy that dispel stigma and empower SDMI clients. I also hope to stay connected to the people whose lives are governed by the power of elected officials by continuing micro level therapy on the side.

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APPENDIX B: Using the NASW Code of Ethics to Resolve an Ethical Dilemma

Abstract

After a brief intro on the important of ethical social work, the paper discusses how Montana state budgets have jeopardized the ability of social workers always to practice ethically to some degree. The paper then discusses how a hypothetical agency host psycho educational classes that are not using empirically based material for the classes and are taught by unprepared/inexperienced staff who often resorting to the internet and personal insight. The paper then discuss how the NASW code of ethics requires social workers to work from existing competence or the intention of acquiring the knowledge necessary to be competent. The paper then discusses how the NASW code prompts an observing co-worker to first help the unethical staff acquire the ability to teach competently first and report them if the staff continually fails to practice competently. The paper compares the radical code of ethics that asserts that unethical behavior is unquestionably the responsibility of anyone involved and how the more relativist view of the NASW code is more pragmatic and appropriate for the situation at hand especially given the factor of budget cuts.

Using the NASW Code of Ethics to Resolve an Ethical Dilemma

Social work carries a plethora of situations that may qualify as ethical dilemmas. Social workers deal with themes such as suicidal ideation, homicidal ideation, HIPPA violations, employee misconduct, and quality of care. Ethical dilemmas may be inevitable but are more prevalent when social work is conducted poorly. Fortunately, the *NASW code of ethics* has been put in place to handle specific dilemmas when they arise. This paper will explore a hypothetical ethical dilemma involving poor quality of care witnessed by a co-worker and how that co-worker should respond to the event in accordance with the *NASW code of ethics*. The paper will then compare and contrast resolving the situation by the *NASW code of ethics* and the *Radical code of ethics*.

Before giving the example, it is important to mention how Medicaid budget cuts have contributed to ethical dilemmas and have skewed the ability of social workers to be able to respond to and correct unethical practice. Agencies are having to lay off workers and reduce wages. This results in higher turnover rates thus inundating remaining workers with extra work. A decrease in the quality of care is inevitable in the era of extreme budget cuts. One result is likely to be subsequent ethical dilemmas that agencies will not be able to respond to as they would like. What must be considered, however, is if there are dilemmas that are avoidable yet persist due to incompetence or unethical behavior on the part of the social worker.

A hypothetical agency provides educational and therapeutic based classes to their adult mental health population. These classes are required to be taken by clients living in the agency's group homes to ensure active participation in the client's recovery. Recent budget cuts lowered wages and resulted in many employees quitting their jobs. The agency finds new class facilitators to replace the previous facilitators but many of the new facilitators have little to no

understanding of how to teach the classes. Though some classes have designated books for the facilitator to use, other classes have no assigned materials to be found. Class facilitators in these bookless classes may do their best to provide educational based information using the internet or personal insight, but the classes are not being taught with empirical based curriculums. An observing co-worker must use the *NASW code of ethics* to decide if the practice of the class facilitator is unethical.

The *NASW code of ethics* (2017), section 4.01, states that social workers should only carry out duties “on the basis of existing competence or the intention to acquire the necessary competence,” and that social workers should “base practice on recognized knowledge, including empirically based knowledge, relevant to social work and social work ethics,” (p.25). Staff members who are inadequately trained to facilitate specific classes and are asked to facilitate the classes without empirically based material are, therefore, not operating under the code of ethics. This fault lies on both the agency and the class facilitator specifically. Class facilitators may have sat in on classes during training and were trained to facilitate some classes by the previous facilitator, but they should not be facilitating classes that they do not have existing competence, intention of acquiring competence, nor designated empirically based material to guide the lessons (NASW, 2017, p.25).

In Section 2.09 (A), *Incompetence of colleagues*, the *NASW code of ethics* (2017) states that the observing co-worker “should consult with that colleague when feasible and assist the colleague in taking remedial action,” (p.20). In this example, the observing co-worker could assist the class facilitator by helping find empirically based material for the existing classes or encouraging them to change the class to something equally beneficial to clients’ recovery but for which there are existing empirically based materials.

For example, if a facilitator is teaching a *Mind over mood* class but does not have any empirically based material, the observing co-worker could help the facilitator find designated *Mind over mood* books to be ordered or suggest that the facilitator teaches a class with books that the facility has, such as *Worry control*. If this suggestion does not fix the problem, *NASW code of ethics* (2017), section 2.09 (B), prompts the observing co-worker to “take action through appropriate channels established by employers,” (p.20). This may be as simple as going to the shared supervisor or clinical director to inform them of the situation.

The class facilitator in the above example may also be considered not just unqualified but also unethical for claiming to teach recovery-based classes correctly, despite the lack of empirical material. The observing co-worker is instructed by the *NASW code of ethics* (2017), section 2.10 (A), *Unethical conduct of colleagues*, to “take adequate measures to discourage, prevent, expose, and correct the unethical conduct of colleagues,” (p.20). In this case, the co-worker should speak up and inform the class facilitator that their actions are impeding the client’s recovery. Exposing the facilitator to their own biases may be important as well. The facilitator may claim that the groups are inadequate at the moment due to issues with staff changes and class facilitators taking on more work. The facilitator might also say that they are experiencing apathy due to burn out/poor self-care. Though these may be understandable circumstances, neither excuses the lack of quality care provided to clients.

Looking at the dilemma from *Radical code of ethics*, the message stays fairly consistent with the *NASW code of ethics* in regard to the stated ethical dilemma. The *Radical code of ethics* states that the observing co-worker should consider themselves “accountable to all who join in the struggle for social change and will consider them accountable to me for the quality and extent of work we perform and the society we create,” (Galpher, 1975, p.1). The code also states that

the co-worker must “help protect the community against unethical practice by any individuals or organizations in the society,” (Galpher, 1975, p.1). A difference between the *NASW code of ethics* and the *Radical code of ethics* is that the *Radical code of ethics* appears to be adamant, taking the absolutist approach that unethical behavior is unquestionably the responsibility of anyone involved in the unethical situation (observers included).

The *NASW code of ethics* (2017), leaves room for a relativist view point. The code asks us to “consult with that colleague when feasible,” and to “take adequate measures” (p.20), but not that a observing co-worker is directly “accountable to all who join in the struggle for social change,” as put in the *Radial code of ethics* (Galpher, 1975, p.1). In the situation where one must consider the impact of both budget cuts and incompetence/unethical behavior, the *NASW code of ethics* delineates the most appropriate and pragmatic course of action. Any social worker following this code can be both mindful of unavoidable ethical dilemmas while simultaneously correcting the ethical practice that can be avoided.

It is important to consider how social workers, inundated with other tasks, may be compromised in their ability to provide quality of care. It is more important, however, to make sure that they are aware of their own potential biases and that they are following the code as much as humanly possible. Social workers may not want to admit that they are not putting in the effort that they should be. Nevertheless, it is the responsibility of the fellow social workers to remind their co-workers of the code of ethics and work collaboratively with them to keep practice as ethical as possible.

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APPENDIX C: Analyzing a Family Event

Abstract

The paper starts out by describing the incident where I found out about my cousin Charlie's death by suicide. The paper then explores protective factors in the situation such as strong family support towards the immediate family, religion as a protective factor (while avoiding judgment of suicide) and other cousins and the strength-based perspective the family had toward Charlie's immediate family. The paper discusses how strength-based perspective and Fowler's stages of development perspective validate family support and religion as protective factors. The paper then discusses how Charlie's parents' inconsistent parenting, Charlie hanging out with the wrong crowd, and prevalence and perceived safety of OxyContin all were risk factors that culminated in Charlie's drug addiction and subsequent suicide. The paper validates these as risk factors by citing Social Behavioral Perspective (specifically operant conditioning), research about the prevalence of drug addiction with inconsistent parenting, research of the impacts of social influence on youth already at risk, as well as the addictive nature of oxytocin and prevalence in suburban areas. Lastly, the paper discusses how the event of the suicide was exacerbated by law enforcement trusting that Uncle Rodger could handle the situation with Charley threatening suicide given his occupation as a school psychologist and crisis counselor as well as citing how Rodger's emotional state would bias his ability to think clearly according to Dan Siegel.

Analyzing a Family Event

It was November 20, 2010. My family was at my little brother's 6th grade basketball tournament. A coach came up to my step-mom and emotionally told her how sorry he was. My sister and I knew something were wrong but were unsure as to what had happened. After picking up Subway sandwiches, we went to the house and were asked to eat as a family around the table. My step-mom then told us that she had some difficult news. "Your cousin Charlie is dead." "Which cousin Charlie?" I asked in a terrified and emotional voice. We had two cousins named Charlie that were on my step-mom's side of the family. One was my little brother's age and the other was a year younger than me. The one who was a year younger than me was my closest cousin, someone I considered a close friend. I had not heard from him over the last year and he hadn't made it up for his yearly week-long lake cabin trip the last summer. My step-mom clarified that it was the cousin I was very close to. Everyone around the table immediately broke into tears. My little brother, lachrymose and barley able to speak, asked "how did he die?" My step mom, also teary eyed and trying not to burst into tears, stated "He shot himself." With a look of disbelief and terror my little brother exclaimed "He shot himself?!"

To this day, my cousin's death was one of the most challenging and emotional events that I have ever dealt with. He was only 17 and lost his life to addiction resulting in suicide. Though this is a very hard story to write about, there are many positives qualities that it brought out in my family. After talking about the positive aspects, I will mention the protective and risk factors for both my cousin and the family that occurred. I will analyze the systems that played a role in the event. I will also focus on what aspects may have exacerbated the situation as well as the factors that could have played a bigger role in the prevention of this tragedy.

My step-mom's side of the family is big and very inclusive. There were always large gatherings with an emphasis on making sure everyone, including step children, knew that they were just as much a part of the family as everyone else. Immediately after the tragedy, the family put forth their support. The whole family attended Charlie's service on the west side of the state. Charlie's grandma, uncle, and aunt stayed up with his immediate family in their house for the three weeks following his death. They wanted to make sure that the family was not alone.

The family has always made a point to celebrate each other's strengths rather than mourning weaknesses. Charlie had been battling drug addiction that had started in his early teenage years and culminated with him taking his life while his father in the next room. Such a traumatic event, preceded by years of misfortune, may have made it difficult for his immediate family to embrace his good qualities. His service was comprised of family sharing stories of his playful and positive attitude as well as his altruistic actions towards those that he loved. Stories, to this day, are still shared with my aunt and uncle by family and friends to remind them how much of a positive impact he had on those around him.

There was a great effort to make sure that everyone felt connected in processing what had happened. As I said, I was very close to Charlie. Several other cousins were also very close to him. There was an emphasis by many family members to help us process losing someone so important. I have never felt more cared for and validated. The death of someone so close who I hadn't heard from in so long made me feel empty and alone. I was only 18 and had never processed something so tragic and quite honestly, had mixed emotions of both sadness and anger. My family helped me remember how important I was in Charlie's life and how important it is to remember all the positive that his time on earth had on our lives.

My uncle and aunt experienced quite a bit of pain and perceived themselves as bad parents. The family was very quick to validate all of the good qualities that they had as parents and reminded them of all the family bonding trips and unconditional love that they had always shown Charlie. His dad, Uncle Rodger experienced severe depression after Charlie's death. One of the ways that my uncle processed Charlie's death was by writing songs about him. Members of the family reminded Uncle Rodger of how strong he was and validated him for using creative song writing to cope with Charlie's death. Similarly, Finn (2016) discuss the Strength Perspective in a social work context and how focusing away from problems and redirecting to "praise of resiliency, creativity, and the capacity for survival in the face of adversity" (p.156). The families focus on strength's was a way of taking a negative situation and capitalizing on the positive aspects.

The family has strong Christian culture that has been emphasized through processing positive and negative life events. Grace was always said at dinner and there were always prayers for each other's good fortune, well-being, as well as praying for their hardships. Fowler's stages of development indicate that faith yields coherence and direction in people's lives, shared trust and loyalties with others, understanding themselves in a greater context and enables them to deal with the limited conditions of life (Hutchinson, 2013, n.p.). Though Charlie's death was not something anyone may ever truly be able to understand, the resilience and comradery that comes from faith had a significant impact on the family's ability to cope with his death.

What I have also found very important was the ability for the family to understand Charlie's death as a tragedy instead of a sin. Many Christians believe that suicide is a sin that sentences those who "commit" it to hell. The family made sure to convey to all of the children

that Charlie was suffering and is now with god who will help him heal. I believe that this strong sense of a personal relationship with religion was brought about by my grandma. She always stressed the important of a personal relationship with god and how love should be the center of beliefs instead of shame and blame. The strong supportive nature of the family was the strongest protective factor for the wellbeing of Charlie's immediate family as well as to each other while dealing with the tragedy. Their unconditional support and love may have been more of a protective factor for intervening in the situation if they had known the extent of his situation.

Charlie's dad was not forthcoming to the family in regard to the severity of Charlie's drug addiction. The family was aware of Charlie's addiction and how it had advanced from marijuana, cigarettes and alcohol to illicit use of prescription opioids. The family also knew that Charlie was not around a good group of people and that uncle Rodger had tentative plans of removing him from his peers by taking him to a secluded farm. What the family outside of his immediate family didn't know, however, was that he had owed a drug dealer a substantial amount of money. This, in fact, was the precipitating factor that lead to his death.

Growing up, I was always amazed at how poorly Charlie treated his parents. He was selfless to other family members. For example, he would spend all day giving personal watercraft rides to the little ones who were not old enough to drive themselves. It never really appeared, however, that he fully respected his parents. Discipline was very limited and often inconsistent. His dad and mom would threaten to take his Xbox away for disobedience, for example, but with enough protest from Charlie, they would rescind their threat. I vividly remember Charlie trying to coach me about how I could get away with more from my parents if I only "argued harder for it." There was also significant splitting between his parents in terms of expectations. For example, his mom wanted him to be a part of family dinners, but his dad would

let him eat in his room. He would play off the inconsistencies between his parents to manipulate a desired result.

During the last couple of months before the end of his life, he had been begging his parents for money stating things such as “this guy will kill me if I don’t pay him.” Money was given to Charlie by his parents to pay off the dealers several times. In the last instance when Charlie asked for money, he was denied the money and told by his dad that they would be going up to a farm to get away from the situation. Charlie made a last attempt to get more money from his dad by threatening suicide. His dad called the police and was assisted in a negotiation to get Charlie to take the bullets out of the gun. Charlie was able to grab more bullets and ended his own life.

Social Behavioral perspective sheds light as to why the lack of discipline and inconsistent parenting is problematic. The theory suggests that “human behavior is learned as individuals interact with their environments” (Hutchinson, 2013, n.p.). Specifically, operant conditioning may have been a factor into reinforcing negative and manipulative behaviors. Operant conditioning is a form of behavioral learning where behaviors are reinforced by the learner’s environment making the behaviors more (or less) likely to continue through reward and punishment. This is done through both positive and negative reinforcement. Positive reinforcement is adding a variable to either reinforce the continuation of a behavior or extinction of a behavior (Ciccarelli, 2015). For example, positive reinforcement would be treating a child to ice cream if they did their homework, so they keep doing homework in the future or adding extra chores for not doing their homework, so they quit the behavior of procrastinating. Similarly, negative reinforcement either rewards or punishes a behavior but by taking something away

(Ciccarelli, 2015). For example, a child could be given less chores for the week for doing their homework or have their video game taken away for procrastinating on their homework.

As mentioned, Charlie's behavior was reinforced when he would argue for his way. The reinforcement was inconsistent both by his parents saying one thing then doing another as well as and inconsistency between the reinforcement of one parent over the other. His addiction, as well as his aggressive behaviors to get his way, were reinforced by his parents by the great sum of money they gave him to pay off the drug dealer. Aside from the basic concept of operant conditioning and behavioral reinforcement, research has shown that inconsistent parenting is positively correlated with drug addiction. Stice (1995), a longitudinal study with adolescence, discusses finding that "parents promote problem behavior because of inconsistent disciplinary measures and deficits in monitoring." In addition, inconsistent parents "disrupt the internalization of parental norms and increase the risk of affiliation with deviant peers" which ultimately results in a high correlation between inconsistent parenting and adolescent substance use (p.330). Inconsistent parenting may have therefore been a risk factor for both the learned disobedience as well as the substance use itself.

Charlie did appear to associate with deviant peers. He constantly would tell me stories of drinking and smoking marijuana as early as 13 years old. He would also try to peer pressure me to take part in using the substances. I vividly remember a story he told me of him and his friends, all of which were around 13, dealing with one of the friends having alcohol poisoning in a public setting. He one time made a comment to my step-mom, who had told him he was more than willing to bring a friend up to the lake cabin, that he "could never have my friends around my little cousins (my little brothers). [The friends] wouldn't know how to act appropriately."

Hutchinson (2017), in reference to the social aspects of adolescence, discusses how peer influence “may not be strong enough to undo protective factors, but if the youth is already at risk, the influence of peers becomes that much stronger” (n.p). Charlie grew up in a middle-class suburban home with parents both employed and together. The family went to a bonding “family camp” every summer and went on multiple outdoor and fishing trips. Charlie’s inconsistent parenting, however, may have been the risk that made the delinquent peers more of an influence.

Charlie’s drug of choice was prescription opioids. He once told me that he was smoking OxyContin 80mg and that I would “die if [I] tried smoking one because my tolerance was not built up.” Cicero (2005) found that unlike the abuse of illicit drugs that are prevalent in urban areas (such as heroin), OxyContin abuse is most prevalent in rural and suburban areas. This prevalence is because it is easy to obtain, prescription drugs are not as closely monitored by law enforcements like illegal drugs, prescription drugs are more socially acceptable, and they are highly predictable in terms of dosage.

Cicero also found strong preferences to abuse of OxyContin and Hydrocodone that are the most prevalent and wide spread when compared to other prescription drugs (such as methadone, morphine, and fentanyl) in part due to the pernicious nature of it being an extended release drug which the drug company had at one time deemed “safer” than other prescription formulations. It is now the only prescription opioid drug with a “black box” warning due to its highly addictive nature (p.663). Hutchinson (2013) discusses that since 2002, illicit drug use between the ages of 12-17 is as high as 10%. Though Charlie had protective factors, inconsistent parenting, association with the wrong crowd, the high prevalence of addictive opioid medication in suburban areas, and the high rate of drug abuse among adolescence were all risk factors that added to his addiction.

Taking a look at what happened in the moments leading up to Charlie's death will be the hardest part of writing this paper but, nonetheless, an important analysis. Charlie was given a gun by his dad Rodger. Rodger's reasoning was that Charlie associated with dangerous people and wanted Charlie to be safe. As Charlie's drug addiction progressed, and the money he was begging his parents for was totaling to well over 100,000 dollars, Uncle Rodger was making plans to get Charlie out of the house to a safe and secluded location. Charlie's mom, aunt Linda, wanted Charlie to go to rehabilitation but there was disagreement between Rodger and Linda in what the proper way to handle the situation was. The difference in opinion resulted in nothing being done about the situation except paying the drug dealer more money. The police were involved before the tragic event, but it is unclear as to what extent. During the event, Charlie was on the phone with the drug dealer who was now threatening the life of both him and his family. After begging for money and being told by his dad that they were leaving for the farm that day, Charlie brought out the gun and was threatening to end his life if Rodger did not give him more money to pay off the dealer. Rodger called the police who sent the swat team to be positioned outside of the house.

Rodger was on the phone with the team in front of Charlie but told law enforcement not to come into the house. Rodger explained to them that he would handle the negotiation. In this crisis life threatening situation, the only threat of harm was to Charlie himself. It would seem there was no reason why the team should not have directly intervened. The justification, however, was that law enforcement were aware that Rodger was a school psychologist and crisis councilor and that he had insisted on being the one to negotiate with Charlie. Rodger was able to convince Charlie to give him the gun to merely take out the bullets and then handed Charlie back the gun. Rodger then informed the swat team that he was going to

use the bathroom to which the SWAT team, still outside, had okayed. While Rodger was using the bathroom, Charlie went to his room, grabbed more bullets, and took his life.

It is important to talk about what happens to the brain during a stressful and emotional event. As learned in class, when people are in an emotionally charged state, their cortical activity declines. Logic and reasoning are, therefore, significantly impaired and results in people making poor decisions. Segal (2012) explains a concept called integration where the brains regions are actively communicating with each other and reasoning is optimized. He explains that, biologically speaking, emotion impacts cortical brain function and it can be interpreted as a shift in integration (p.32-4). Uncle Rodger was in a very highly emotional state. Though he is a crisis councilor, he was dealing with his son. Doctors do not operate on their families because their emotional bias is likely to affect their quality of performance. Similarly, uncle Rodger was biased in feeling like he was able to handle the situation. The mistake of giving Charlie back the gun may be attributed to a disruption in brain function from intense emotion.

Letting uncle Rodger negotiate in the situation was a big mistake by the law enforcement. Uncle Rodger's persistence in handling the situation himself should have been overridden by law enforcement recognizing the inappropriateness of dealing with the crisis. It is hard to understand why law enforcement trusted Rodger's judgment on giving Charlie back the gun. One could understand how Rodger's emotionally biased reasoning neglected that Charlie had more bullets in his room, but to be given clearance from the law enforcement does not sense. Allowing Charlie to be alone was a grave mistake. With a situation deescalated enough to receive cooperation from Charlie (allowing Rodger to take the bullets out), one could speculate that law the swat team had a good opportunity to come into the house at this point. Instead,

however, they let Charlie be alone with the gun. Ultimately, one could speculate that if law enforcement would have been cognizant of the emotional bias of Rodger, there might have been a higher potential of successful intervention from a trained crisis negotiator who was not biased.

Social behavioral perspective, the reliance cultivated by faith as mentioned in Fowlers Stages of Development theory, as well as the research cited to validate substance use and delinquent peer research, appeared to accurately depict the protective factors and risk factors that lead to Charlie taking his life. While analyzing the strengths perspective, this paper focuses on the strengths of the family for facilitating healing after Charlie's suicide. As critiqued by Finn (2016), however, the strengths perspective may "underplay constraints and the often-overwhelming struggles" of people (p.157). The family's propensity to optimize each other's strengths and focus less on each other's weaknesses may have made it easier to downplay the severity of Charlie's drug addiction. A common theme between the short-term intervention from law enforcement and the long-term intervention from family members appears to be hesitation in action due to trusting that the situation would be handled properly by Charlie's parents. For law enforcement, this trust came from Rodger's credentials and for the family, this trust came from Rodger and Lisa's many other qualities as good parents. The ultimate lesson here is to celebrate strengths while also being able to check for and assist others with their deficits.

Though this was a tragedy that has for ever since changed my family, many positive aspects came out of it. It brought out the vast protective factors in the family which facilitated both coping and optimizing the remembrance of Charlies best qualities. Theories and research validated these protective factors as well as illuminated the risk factors. This paper has not only help me to apply theories we have studied in my own life, but it has helped me to make sense of

the reason why this happened as well as the factors that could have prevented my cousin's death.

I will apply the insight that I have learned from this paper in my own work as a social worker.

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APPENDIX D: Exploring Positionality

Abstract

The paper starts out by defining positionality. The paper then discusses being exposed to racism and homophobia at a young age from my mom and catholic school, both low and high SES from my living situation with divorced parents, but still having a good balance of my parents providing me a safe environment to appropriately express my masculinity as well as my artistic and sensitive side. The paper goes into issues with being berated for being small in stature as well as sensitive. I discuss a desire to be seen as masculine and spite against old friends I felt betrayed by led to me feeling the need to bully the old friends for their un-masculine attributes. The paper discussed being in high school and being able to express my creative and sensitive side safely by consistently dating girls. However, I still dealt with some bullying for not being “masculine” enough (not engaging others in fights). I discuss how from late high school all the way to years after graduating the use of alcohol as a coping mechanism for feeling inadequate due to being emotional and not masculine enough. I discuss how drunkenly trying to prove myself ended up hurting a friend and made me realize that the true way to gain respect was to start respecting myself for who I was and take care of myself. I discuss how people of other races never felt inferior and how even though I was homophobic through some of high school, I was able to transcend this issue before coming to college. I also discuss how questions of my manliness can still be triggering to this day. I end the paper by discussing how my experiences with positionality have made me the social worker I am today who can be a positive male role model by having unconditional positive regard and genuinely care and work to understand their situation.

Exploring Positionality

Positionality is our “location in the social world, is shaped in terms of these multiple identifications” (Finn, 2016, p.26). Before learning this definition last semester in the Foundations of Social Work course, I am embarrassed to say that I had never heard of this concept. I believe that I always have tried to have an empathetic understanding of those around me who society had laid out as “different,” but I feel like I was most certainly guilty of qualifying the suffering of those around me. I feel that I have a firm understanding of how race, sexual orientation, socioeconomic status, religion, sense of place, age, and disability status have shaped my positionality.

I often thought about how my race has affected my positionality. I vividly remember my mom telling me not to just eat fruit from the store because “what if some black man had touched it before I did.” My mom would treat black people with respect to their faces but would make these derogatory remarks in private. Moreover, she expressed overt condemnation of those who identified as LGBTQIA. I remember being admonished as a young child for making conversation with the “lesbian” neighbors. She would justify this partial treatment because they were “sinners” that needed not be associated with. I was all too familiar with the concept of sin from both Catholic school as well as the Protestant church I went to with my mom. Though I do feel my mom instilled an incredible amount of empathy and caring in me, it was definitely partial to heterosexual white people.

My socioeconomic status growing up was interesting. Resulting from divorced parents, I spent a year and a half between the ages of four and six going back and forth every week to either my cardiologist dad’s 500,000 dollar house in a private community or my mom’s run-down little house in the heart of Spokane’s worst area of town. I had rich kid friends who had

pools in their back yards, and I had poor friends with parents who had methamphetamine addictions. Though I did not live at that specific house with my mom for long, I believe the experience made me realize how important it is to be grateful for what one has. I have never suffered from any injuries that have classified me as disabled. I feel that I have a solid sense of place from good family and friend support and have never had any major questions of positionality from my age. I feel like I have explored all of the concepts mentioned in significant detail throughout my young adult life and have transcended the hateful biases of certain parental influences and teachings of Catholic school. I have dispelled stereotypes of people of different races, feel I have arrived at my sexual identity regardless of what I was taught, and I appreciate and understand that I am lucky to be in the financial situations I am in.

A dimension that I may have not explored in as much detail is my gender expression and how that has affected my positionality. Quite honestly, thinking about exploring this topic is making me feel anxious and guarded. This may be a good reason to use this subject so I can truly understand my positionality in whole. I will first talk about how ideas of masculinity have shaped my identity as a male throughout periods of my life. I will then talk about how other interlocking intersectionalities have shaped masculinity and have in turn shaped certain aspects of my positionality. I will then explore how this has shaped me as a social worker as well as other insights that writing this paper has given me.

When I was little, my parents never pushed any overt masculinity ideas on me. I was encouraged to participate in sports, play with trucks and other “boy toys,” but was always given the option to creatively express myself in any way that I wanted to. Though you could find me out playing with bugs or having fake gun battles with my friends, I also enjoyed playing with civil war dolls and was very involved participating in theater. My mom taught me from a young

age that it was alright to cry, and both parents always validated my emotions instead of telling me to “be strong.” Aside from certain prejudice from my mom, both parents, as well as my step-mom, stressed the importance of putting others before my own selfish needs. I do feel that I was modeled a healthy amount of masculinity that was coupled with freedom of expression and compassion for those around me. Where my sense of gender expression seemed to be challenged was when I went to middle school.

In preschool through grade school, I feel that I was fairly well adjusted and had good close friends who had similar interest as me. However, when my hormones kicked in, my priorities became a lot different. I was going to a Catholic middle school where derogatory terms for people who identified as homosexual were the insult of choice to be directed at kids who were more sensitive. I was called ugly by girls, gay by boys, and was told by teachers that I needed to “buck up” and start working to my potential. I hated how sensitive and helpless I felt. I just wanted to be like all of the cool kids. It would bother me how old friends would become “cooler” with the other kids and then would use things such as my small stature or my sensitive nature to tease me in front of everyone. I resented that kids would be more accepted if they bullied others for not being as masculine. It wasn’t until I became an eighth grader that I would adapt to the toxic nature of my middle school in hopes of being seen as cooler.

In eighth grade, I tried out for football. I ended up being decent at it and was, therefore, slightly more accepted by the cool kids. They would let me sit with them at lunch and bond with them over making fun of kids who they saw as feminine or sensitive. I mostly directed my acrimony to past friends who had previously put me down. I would put down their masculinity in front of the cool kids. I felt powerful making fun of one old friend for how high his voice was.

The feelings of revenge, the intoxicating feeling of being masculine, and resentment for who I really was, were enough to make me not think twice about participating in such an awful culture.

This toxic mentality carried on into my first year in high school. I joined the high school football team, wrestling team, and track team, in hopes to be accepted by my peers as a “macho cool kid.” However, I always seemed to feel like I was faking everything I was doing. The feeling of putting others down felt powerful but always left me empty (especially, when someone would put me down). I had dropped all of my creative expression and had no safe way of expressing any sort of emotional side. It wasn’t until my sophomore year of high school that I realized that nobody would question someone’s masculinity as long as the person dated a lot of girls.

Suddenly, I could embrace being emotional and caring for it was now met with approval from girls. They liked my silly sense of humor, musical expression, and my less masculine clothing and hair style. I was a goofy “scene kid” who wore skinny jeans, metal band T-shirts, and had straightened hair. Male peers would try to insult my masculinity but all I needed to do was cite the number of girls I had dated and the lack of girls that they hadn’t dated, and my masculinity would be restored. Though, at first, this seemed to be my golden ticket to being accepted by my peers, dating came with a pretty significant backlash. The cool kids dated girls with the intent of validating their “manhood.” It was cool to “get” with a girl and then leave her after the guy got what he was looking for. I found this repulsive and yearned for genuine human connection from my relationships. This led to accusation of being called a plethora of derogatory feminine names not only from male peers, but also from girls I was dating. I remember being chastised for refusing to engage in certain activities early in a relationship.

There was also the pressure of having to fight other guys who would “call you out” when you were with the girl you were dating. I always thought fighting was puerile and arbitrary. Fighting seemed to be this magic masculinity thing for guys that would prove any point they were making as right no matter how wrong they were. I can think of several instances where I would be walking with a girl and another guy would impertinently say that I was too “weak” to be dating the girl I was with. I remember a specific instance where I was called out by a guy while I was with a girlfriend. I was infuriated and felt vulnerable but had the sense to walk away. The girl was upset that I didn’t engage this guy in a fight for both of our “dignities.” It was hard and shameful to have everything in my environment telling me to “be a man” and fight for my dignity. For years, this made me feel inferior and embarrassed of the “weak man” that I felt I was. My feelings of inferiority made me search out for something that not only functioned as a coping mechanism but also a way to be cool with my peers. By my junior year of high school, I started drinking.

Drinking carried itself through my undergraduate degree and a couple of years after. I used alcohol to cope with feelings of inferiority that were most likely cultivated from years of trying to be accepted as a man. I can think of several instances where a girlfriend would put me down or even openly flirt with other men in front of me. Drinking seemed like the perfect escape until its inevitable culmination to an outpour of emotions. A pivotal moment was in 2016 when I became intoxicated and betrayed a friend. He had strong feelings for someone he had known for years and I disregarded his feelings for my own selfish gain. I flexed years of ingrained toxic masculinity to prove to myself that I was not the powerless and sensitive person that I had been made to be so ashamed of. I ended up hurting a friend who had only been kind and supportive to me. It became clear that I needed to be the sensitive caring person that I truly was and let go of

the shame of not being the man that society told me to be. I directed this motivation to be the best version of myself by going to the gym on a regular basis, eating well, and taking a two-year abstinence from drinking.

Accepting that the best version of myself is one who embraces my sensitive and caring nature has been the most important part of developing my positionality. I accept that I am a heterosexual straight white male from a well-off family, but I reject the toxic masculinity that I tried to fake for years. I am ashamed that I ever hurt anyone in the process, but I recognize now that the most important thing I can do is use the self-growth I have achieved to become an even better person each day. Though I feel I have mostly transcended toxic biases, I believe it is important to see how ideas of masculinity may have interlocked with other intersectionality's.

Interestingly, race never seemed to play the role of superiority in my social life. At least for non-white males, this was directly related to me seeing them as more masculine. Even in catholic school, I often associated people who were nonwhite as cool, funny, athletic, and someone who deserved respect. I often found myself wishing that I "wished I was black" so I would be seen as cool kid. I realize now that this perception is jaded but it had seemed to contribute to a different experience with racial superiority for me growing up than other white men may have.

However, for kids who identified as LGBTQIA, they seemed as a direct threat to any guys' sexuality. "Only closet gay kids hang out with other gay kids" was a common phrase that was thrown around my high school. Guys were so preoccupied with proving that they weren't homosexual that they couldn't afford to be seen associated with kids who weren't straight. Though it took me time, I became significantly more comfortable with my sexuality and started to realize that people who identified as LGBTQIA were people just like everyone else. As I

became acquainted with more non-heterosexual people, I began to realize that their friendship was more important than the bigoted views of those willing to question my sexuality. This was a big predecessor into my understanding of how people come first before labels that may be put on them.

The most direct interlock of these dimensions and my drive to be in social work is my ability to now comfortably embrace my caring and sensitive nature while also being empathetic and understanding of other people's differences. I had been jaded by stigma of certain social groups in the past, but I now recognize this was merely a means of guarding what I felt was shameful in myself. I now use this concept to understand why there is a world of people that can be so unkind towards other people who challenge what they were brought up to believe to be right or wrong. It is much easier and often safer to reject what peers have deemed as unacceptable than to stand up for what you truly believe is right or wrong. Advocating for people with severe mental illness has been a way for me to direct my caring and empathetic nature towards people who have often dealt with an enormous amount of invalidation of their strengths as people. As a male social worker, my strengths are especially useful for clients who have not been exposed to unconditional positive regard, genuine caring and understanding from males in their lives.

Though I consider myself well-adjusted and comfortable with my sexuality now, I have been in situations where clients have challenged my masculinity. I once had a client who challenged me to fight them when I told them they had to leave for their verbal threats toward another client. Initially, this triggered toxic feelings inside myself of being inadequate from his implication that I would not be "big enough" to fight him. I mindfully had to be aware of the heated reaction in myself while simultaneously realizing that the client's reaction came from a

place of pain and what he may have known as means of survival. Transcending my own hateful biases has made me realize that people with hate in their hearts are not only in pain, but also wish to be accepted for who they are by those around them. Accepting people and meeting them where they are at has been one of the most effective ways for me to do my part in social work. Something that I do tend to struggle with is applying that logic to those whose hate infringes on people of vulnerable groups. Even when thinking of my past self, taking part in a homophobic culture to fit in with my peers, it is hard for me to be empathic to why I did this. I feel like I “should have known better.” However, I may have embraced my true self earlier if I would have been around people who made me feel safe to be who I was. An accepting culture where people are free to be who they really are is one void of resentment and hate. Being a part of social work gives me hope to one day change the oppressive structure into a system that celebrates and supports everyone’s individual strengths and differences.

Writing this paper was harder than writing any other paper that I have had yet. I am ashamed and repulsed to say that I was a bully because I was told that putting down other boys masculinity gave me self-worth. Writing this paper has made me realize not only how intertwined inferior feelings of sexuality has contributed to major issues I have had in life but also how reveling against ideas of traditional masculinity has not only made me a better person, it sent me on a career path. Though I do feel that my parents did a great job at raising me to be who I truly was, I will definitely be hypervigilant of my future kids’ conflictions to be themselves or try to fit in. I do realize that everyone has things in their past that they are ashamed of but working through these things to become a better person is all what matters at the end of the day. I am thankful that I am now able to embrace who I am and that I do everything I possibly can to care for people and bring out their strengths regardless of their positionality.

References

Finn, J. L. (2016). *Just practice: A social justice approach to social work*. New York, NY: Oxford University Press.

APPENDIX E: Jane Doe CSR**Abstract**

This is a deidentified Continued Stay Review (CSR) that I submitted to Magellan health for a client who was living in the group home. I was able to articulate that Jane had made significant progress with treatment compliance, more of an ability to articulate herself, and progress with boundaries over the previous three months but still qualified for at-least a severe level of impairment for four of the five areas of the Addition Mental Health Disorders Division's (AMDD's) Level of Impairment criteria. This was due to an inability to attend appointments, hold down a job, difficulty articulating needs, lack of outside support (including friends or acquaintances), continued poor boundaries, severe psychosis (hallucinations/disorganized speech), severe anxiety, sleep issues, depressive symptoms (mainly isolation), as well as a past of multiple hospitalizations for suicidal ideation with a plan. Magellan's denial letter (which could not be included due to confidentiality) justified a denial by citing that progress as well Jane's stable strengths indicated prove that she does not meet medical necessity requirements. The brought up her ability to be her own payee, insight for denying a job, recent ability to cooperate with medication management appointments, progress with boundaries, as well as impact of positive psychotic appearing to be more relative to Jane's "negative symptoms of schizophrenia. At one point, the letter cites that "No severe symptoms of SDMI are cited" regardless of the in-depth points made for severity in four categories laid out by AMDD. Though this cannot be physically included in the form of a document, a peer to peer appeal was to be held with the Magellan doctor. Though I had prepared material, we were never given a conformation of when the appeal would be. Around 8:30am of the morning of one of the requested times, Magellan called and left a message saying that the appeal was set for 10am. This message not being received until after the appointment, our

clinician was blindsided with the call without me there with the information. She called me and had me come into her office. The doctor seemed to aggressively and in a frustrated manner argue that Jane does not need our services. Incredibly nervous while also realizing that Jane's recovery depended upon me in that very moment, I pulled myself together and discussed how a client who I had known for years rarely engaging at all due to the severity of her illnesses was finally willing to engage in treatment and is just starting to make strides in her recovery. Now was the time that we could actually intervene and begin to prepare her for independent living. The doctor overturned the denial and Jane was approved.

Addictive and Mental Disorders Division
Form C – Adult Group Home

IMPORTANT - In determining eligibility, all criteria that is checked must include supporting individualized information. Requests missing individualized information will be considered incomplete and will be denied.

Section D The member continues to exhibit behaviors related to the SDMI diagnosis that result in significant risk for placement in the MSH, MMHNCC, or acute hospital inpatient care if services are not provided to be successfully treated in a less restrictive setting and the following:

Active treatment is occurring, which is focused on stabilizing or alleviating the psychiatric symptoms and precipitating psychosocial stressors that are interfering with the ability of the member to receive services in and less intensive outpatient setting. (Enter individualized information below)

At the group home Jane is working on improving their independent living skills with staff by working on appointment attendance, disorganized behavior and subsequent compromised ability to articulate needs, depressive apathy and subsequent interpersonal issues and isolation, and other possible symptoms of psychosis (poor insight).

Self care/ basic needs (moderate LOI)

Jane is not having issues with taking care of ADLs or medication needs. Staff claim that she gets her medications, showers, cleans her clothes, and cleans her room, without prompts. In the last CSR period, Jane was having issues where she was falling asleep too early or not waking up on time to take medications and was missing doses here and there because of the issue. Both Jane and Group home staff claim that this is no longer an issue. Though Jane still claims that she has significant issues with sleep (will be discussed later), her sleeping has gotten “better” with medication adjustments and seems to aid her consistency with medication compliance. Both staff and Jane discussed Jane’s love of watching sports as well as other tv programs. Jane goes to church every week and seems to get a lot of support through spirituality. Jane is attending anywhere from four to eight groups a week (though she is only required to attend four). she attends Dialectic Behavior therapy, Illness management and recovery, AA/NA, as well as double trouble in recovery on a regular basis. Staff claim that she will “participate unprompted and insightful content if she is in a good mood.” All of this aside, Jane still has significant issues with committing to and attending appointments. Though she has gotten better, she has tended to be obstinate to her tx team scheduling her to see a therapist and has missed several scheduled therapy appointments. her therapist claims that she has no showed several tx plan appointments as well as psych assessments. Group home staff claim that Jane can be told multiple times about attending an appointment with her CM or to go to the day center for an appointment, will claim that she will go, and then never show up. Though Jane seems adamant about making it a point to see her therapist regularly, her tx team is concerned about her poor ability to show to appointments. Along with medication adjustments by her provider, her therapist is planning on continuing to engage Jane with Recovery oriented Cognitive therapy (CT-R) at the group home to keep Jane in an “adaptive mode” to help Jane comply better with appointments. Though therapy and medication adjustments are helping Jane be open about symptoms, articulate her self more clearly, and engaging with treatment (will be discussed in more detail later), Jane is still greatly struggling with appointment attendance. With this information, Jane is at a moderate level of impairment. Though Jane has maintained good ADL compliance and has even improved with medication compliance and group attendance, Jane is missing appointments more than 75% of the time.

Employment/education/housing/financial (severe LOI)

Jane would really like to work. Not only has she sought out utilizing VOC rehab in the past (which she is trying to get back in), she also has taken the initiative to put out job applications. she claimed that she got a job at Walmart “stocking items in the back” but the job required late night hours that she felt would “mess with (his) sleep even more” so she had to turn it down. Jane also would like to go to “trade school at the Missoula college. Though

she claims she met with an advisor last August, she felt that she was too late to make it work and claims that she wants to “wait till next year to reapply.” Though Jane has worked in the past, is receiving SSDI, is ambitious about working, and plans to apply to trade school for next fall, her therapist feels that Jane may not be quite ready to start working or go to school just yet. The therapist expanded upon this notion by citing that even with Jane’s progress with engaging in treatment, “he is not anywhere ready for school or work given her symptoms and current inability to attend to appointments.” As for independent living, Jane would like to live on her own. she is on the waiting list for section eight and is working with her case manager for getting on other housing list and apply to housing agencies. With finances, Jane is her own payee. Though she claims that she sometimes has issues budgeting, especially when “trying to save money shopping at Walmart,” she is working on staying on a “tighter budget.” Both group home staff and Jane herself claims that she has no issues with paying rent. With this information, Jane is at a severe level of impairment. Though Jane only seems to have minimal issues with finances, she lacks insight onto taking care of symptom and appointment compliance ability that are imperative for her ability to hold down a job or go to school. Symptom management and appointment compliance are also a concern for Jane for living independently. This is also further convoluted by the fact that both Jane and Staff admit that Jane still has tendencies to isolate and not seek help from others unless prompted (will be discussed in greater detail below).

Interpersonal (on the border of severe and gravely disabled LOI)

Several staff have discussed improvement in Jane’s communication skills. In the last CSR, Jane’s old therapist discussed how “it is hard to follow Jane’s logic and her sentences are jumbled and she mumbles” especially when you asked Jane about her mental health. When speaking to Jane directly to gather information for the last CSR, it was hard to get her to expand upon topics or to understand what she was saying at all. Now, Jane is mostly speaking in complete, well-articulated, and at ideal volumes. Though intermittently it was hard to follow her logic, she was able to discuss information about symptoms and strives for further engaging in recovery that was in accordance with information given by other staff. When speaking to a day center staff, she discussed that though Jane has been better at articulating herself within the past couple of week, her ability is still “somewhat dependent on her mood.” As for inappropriate social boundaries, Jane has only had one incident in the last three months. In the last couple of CSR periods, Jane was making sexually charged comments to staff and peers on a regular basis. Now, Jane has only had one incident where she was “staring at a client as they were coming out of the bathroom” according to group home staff. However, her therapist claims that it appeared to be a mis understanding, and Jane merely was looking over because she heard a noise. Though Jane has made progress with sexual boundaries, she still struggles with understanding social boundaries in general. Group home staff claim that she is often asking clients personal questions. For example, she will be asking clients things like “why aren’t you at work right now?” or “what things are you working on in therapy?” Group home staff claim that it doesn’t appear that Jane has any malicious intent behind asking questions but does not appear to be responding well to staff redirection (as she does not feel she has done anything wrong and continues the behavior according to group home staff). Jane is still greatly impaired when it comes to social relationships. Though day center staff claim that she is checking in with them for group information and is initiating conversations with staff, staff in all realms of Jane’s treatment team discussed Jane’s reluctance to appropriately socialize with others. Jane discussed that the only time she really socialized well with others was while she was smoking. However, now that she has quit smoking, she does not socialize with “other people nearly at all.” Jane also discussed that she “kind of keeps to (herself) and would rather just isolate in (his) room.” Along with issues of understanding how to respect peer’s boundaries, some continued issues with mumbling and disorganized speech also appear to impede social relationships. Though group home staff engage Jane to socialize with others in the common rooms, Jane’s therapist will begin working more on appropriate social skills (especially now that her therapist has been able to get Jane in a more “adaptive mode”). With this information, Jane is right on the border of gravely disabled and severely disabled. However, due to some improvement in her ability to articulate herself and less severe issues with boundaries, she is closer to a severe level of impairment. she does not have any friends and has poor relationship formation and maintenance due to poor boundaries and difficulty articulating herself.

Mood (severe LOI)

As stated, Jane has been significantly more engaged in addressing mental health concerns. As discussed in the last CSR, Jane had incredibly low insight about hallucinations claiming that she wore sunglasses because of issues with “floaters” and how she was not hearing voices just “hearing the radio” (though her therapist asserted that she was having issues with hallucinations). Within the last couple of weeks, Jane has admitted to hearing voices and is open and cooperative with working on medication adjustments with her medication provider. her medications were recently adjusted, and she feels that the adjustment is making her “feel much better.” she plans on continuing to meet with the medication provider to ensure that medications are addressing all of her symptoms. Along with working with her medication provider, We have seen improvements for Jane’s willingness to engage in therapy on a regular basis as well as an ability to be forthcoming and articulate about her symptoms. her therapist claims that Jane is “tending to isolate a great deal and continues to not socialize with peers.” Though the therapist is working on combating these behaviors with CT-R. Jane is just now beginning to really engage and progress should continue as time goes on. The therapist will also work on addressing visual hallucinations with Jane. Jane claims that she is still having significant issues with anxiety and voices. Though she claims to “watch tv” to cope with these issues, medication management and therapy are working to address these symptoms. Jane is also having significant with sleeping as well as “nightmares.” Though she is going to bed after night meds and waking up on time for morning medications, she still is having sleeping issues. With medication adjustments and a CPAP adjustment in the last couple of weeks, sleeping has gotten a bit better, but this is still an issue that Jane would like to further address. Jane claims that she is utilizing group home staff more and that she keeps them “up to date with how the medication adjustments are helping with symptoms. With this information, Jane is at a severe LOI. Though she has taken a significantly more active role in addressing mental health symptoms in the past couple of weeks, she is greatly struggling with psychosis (hallucinations/disorganized speech), anxiety, sleep, and depressive symptoms (mainly isolation) more than 75% of the time.

Self-harm/suicidal ideation (Severe LOI)

Though Jane claims that she is not currently struggling with suicidal ideation, she has “called 911 in the past for issues.” she has been sent to the state hospital as well as crisis houses several times for suicidal ideation with a plan (was unclear if there are attempts due to issues articulating information). Fortunately, she claims she now just has “thoughts of getting healthy” and has not struggled with thoughts of suicide for the past eight or nine months. With this information, Jane is between at a severe level of impairment in this area. Though she has no current thoughts of suicide, she has been hospitalized multiple times for suicidal ideation with a plan and has possibly had suicidal attempts in the past.

Current Symptoms	Frequency of Symptoms	Severity of Symptoms	Resulting impairments	Recovery activities and discharge goal addressing this symptom
Auditory Hallucinations	consistent	severe	Causes her to isolate	Improving medication compliance by increasing motivation to take medications through behavioral skills training, motivational interviewing, and psychoeducation. To Discharge, Jane should be able to demonstrate the ability to continue seeking help from her therapist and working with her medication provider to address the symptom.
Visual Hallucinations	Unknown (poor reporting)	Unknown (poor insight)	Causes her to isolate and not become forgetful of	Jane will start meeting with her therapist regularly and the therapist will work with Mare to address these symptoms. To discharge, Jane should be able to continue

			taking medication	seeking help from her therapist and working with her medication provider to address the symptom.
Lack of motivation	of daily	moderate	Causes isolation, social withdrawal, and forgetful of attending appointments	Jane is working with group home staff and support staff to increase motivation. Jane will additionally attend various independent livings skills groups. To discharge Jane should be able to demonstrate attending appointments without staff prompts for at least two weeks.
Flat affect	daily	severe	Makes it difficult to understand client by manifesting in mumbling	To Discharge Jane will need to demonstrate her ability to socialize with peers and community members with minimal staff support.
Depressive apathy	Severe	severe	Makes it difficult to attend to relationships and engage in appointments	Jane is working on this issue in therapy, but progress is inhibited by poor insight. she will continue to see therapist, psycho education and therapeutic groups as well as receive redirection from staff. Once Jane is able to redirect apathy and attend to appointments without staff prompts, she will be closer to being discharged
Disorganized speech and thought	Severe	severe	Makes it difficult to convey meaning and self advocate.	Though Jane has improved dramatically with speaking in an articulate and organized manner, she still tends to mumble and can be difficult to understand. Therapy and further medication compliance will help prompt good communication. When Jane develops the skill to consistently speak coherently, she will be closer to being discharged.

Demonstrated and documented progress is being made towards the treatment goals and there is a reasonable likelihood of continued progress. (Enter individualized information below)

Jane has been participating in services and has made apparent progress in some areas. It is likely we will continue seeing progress in various areas, but Jane is still far from being able to live independently.

AGH is the least restrictive service to meet the clinical needs of the member. (Enter individualized information below)

Jane is currently unable to live outside of a “Supervised Living” situation such as the group home without immediately decompensating. This has been evident numerous times in the past with Jane’s history of decompensating and relapse in medication compliance, psychosis, and result in hospitalization. As we continue to see symptoms consistent with those present in past instances of Jane’s decompensation, I am confident that a similar outcome would be the result of Jane leaving the group home at this time without first resolving impairments and stabilizing symptoms. Given Jane’s current trajectory of rehabilitation it is ill-advised for them to live independently and unnecessary for them to move to a higher, more costly level of treatment such as Assisted Living or Nursing Home Care since Jane is currently able to maintain within the group home which is the least restrictive level of care available to client at this time.

APPENDIX F: HBSE Interview #2**Abstract**

The paper starts out with the questions asked of “Cyndie”. The paper then summaries Cyndie’s life stages indicating that she Puts Others before herself, does the right thing with moral dilemma, considers herself responsible, is a good support from social relationships, has issues with romantic relationships, exercises tough love with others, does not agree with violence, and claims to be Intune to others emotions as well as her own. The paper then analyzes Cyndie in relation to Gilligan’s Ethics of Care theory to conclude that Cyndie fully morally developed when assessed by the theory. The paper then analyzes Cyndie in relation to Goleman’s Theory of Intelligence to conclude that Cyndie shows success in all five concepts of emotional intelligence but the deficits in self-regulating, empathy, and social skills draw the conclusion that her emotional intelligence is fair. The paper then critiques both theories for not accounting for the potential of borderline personality disorder. I then critique myself for not asking questions to elicit Cyndie’s tendencies to isolate, her desire for social acceptance, and if she has self respect.

HBSE Interview #2**Questions asked**

- Tell me about your ability to do things that you need to get done (I.e school, cleaning, chores) over things that you would rather be doing.
 - Rationale: to asses her ability to distinguish between necessity and desire
- What is your opinion on doing things for yourself regardless of how it might affect others?
 - Rationale: to asses her ability to be considerate of or to be selfish.
- Take a hypothetical example of a group project where people were depending on you to get your portion done but you really didn't feel like doing the work. What would you do?
 - Rationale: specifying whether a selfish desire would inhibit the well-being of others.
- Tell me about your ability to connect and derive fulfillment from intimate relationships.
 - Rationale: to assess the fulfillment that she derives from relationships.
- Tell me about your ability to do the "right thing" when faced with a moral dilemma
 - Rationale: to asses from selfishness to responsibility
- Explain what your actions would be if you saw someone being physically harassed in public and you were the only who could do anything about it. Would you intervene even if this put you in a dangerous situation?
 - Rationale: to asses her ability to do the right thing even if the outcome does not align with the desire of avoiding a possible precarious situation
- What is your stance on putting others before yourself?
 - Rationale: asses her level of self-sacrifice
- In a hypothetical situation where a friend had an opinion that you didn't agree with but you knew confronting her would hurt her feelings, how would you handle the situation?
 - Rational: asses propensity to align judgments and avoiding hurt of others
- In a hypothetical situation where you were in school for EMT training but were asked to drop out to help a sick family member, what would you do?
 - Rationale: asses ability to consider own needs as well as responsibility
- What is your opinion on being cruel to be kind or tough love?
 - Rational: assessing ability to recognize difference between hurt and care
- When is it ok to putt your needs ahead of others?
 - Assessing if she values her own needs, responsibility, and the needs of others
- What are your opinions on using violence to resolve conflicts
 - Rational: assessing for the third level of non-violence
- Explain how someone could be both selfish and responsible at the same time.
 - Rationale: assessing whether the dichotomization of selfish and responsible has disappeared
- Explain your ability to be aware of your mood, emotions, and drives to do things and the effects these have on others
 - Rational: assessing self-awareness
- Explain your ability to put emotional reactions aside before reacting.
 - Rationale: assessing self-regulation

- Are you driven to succeed by money or fulfillment from doing a good job? Why?
 - Rationale: assessing internal motivation
- Do you feel sorry for others in bad situation or do you “feel their pain?”
 - Rationale: assessing her levels of empathy
- Explain your ability to relate, build rapport, and maintain in relationships.
 - Rationale: assessing her social skills

Summary of life stages

- **Other before herself:** She claims that she usually put’s other before her even if doing so is “not in [her] best interest.” She claims to do most things for others rather than herself because “she cares about their feeling and opinions a lot” but that she is working on not caring about other people’s opinions or how her actions would affect them if it is “in the greater good for [her].” When asked about intervening in a situation where someone was being physically harassed and the possibility of intervention might affect her wellbeing, she claimed that she would “absolutely intervene by either calling the cops, or if there was a more immediate need, [she] would jump in and speak [her] truth.” She further elaborates she could “never be a witness even if it puts me in a bad situation.” When asked about a hypothetical situation for dropping out of school if a family member was sick, she claims that she would only do this if she absolutely had to but would do everything to try to figure out another way because “school is really important.” She elaborates that putting her needs before others will only happen in the context of or advancing her life (such as going to school) or when taking care of her mental health.
- **Moral judgment:** She talks about her inclination to do the right thing when faced with moral dilemmas because “doing bad things makes [her] feel bad.”
- **Responsibility:** Cyndi considers herself pretty responsible. She claims to be “pretty good at being responsible when I know I needs to get stuff done for something important like school,” but that she is not as good at being responsible with things that aren’t as important to her “such as house work.” When looking at responsibility in the context of working as a team with others, she makes it a point to follow through on her end regardless of if she didn’t feel like doing the work stating that “I take a lot of pride in following through in a team setting and not letting down others.” When asked if someone was able to be both selfish and responsible at the same time, she claimed that she not only feels that this is possible, but that “is how [she] lives most of her life.” She then draws attention on how this might contradict putting others before herself.
- **Relationships:** She claims to “get a lot of fulfillment from friendships,” and in particular, her long standing friends “really keep [her] going and they are there when [she] needs them. With romantic relationships, however, she feels like they “take more from [her] than they gives [her].” She claims that in romantic relationships, she “puts in too much” and that they keep her in constant worry about what her significant other leaving her because she never “knows what they want.”
- **Tough love:** She claims that though she cares about others opinion, she will absolutely call someone out on for an opinion she morally doesn’t agree with. She cites an example of a friend who had “a lot of terrible opinions” and how she knew calling them out would make them cry. She claims that she lost the friendship from this but it was justified because if a moral dilemma is something she really needs to “speak on,” then she will “speak on it.” She talks about how when it comes to her friends, she is 100% honest, and

that saying something that may come off as cruel is for the better, than she will definitely say something.

- **Violence:** She feels violence is always “childish and inappropriate.” She claims that she feels that “nothing gets solved when people use violence, it just creates more trauma and anger.”
- **Emotional intelligence:** She claims to be hyper aware of her moods emotions and drives to do “struggling with mental health” her whole life. She explains that it has been “[her] job to watch emotions and moods” to keep her mental health in check. She feels like she is very aware of how other perceive her moods emotions and drives stating that she can tell that “sometimes it makes other people uncomfortable how open and honest I am but [she] can also tell that it’s easier for people to read me and know where [she] is at because [she] is so open with my moods.” She claims to be good at putting aside emotional when reacting in situations but that “this is easier with people I know and care about verses those I don’t know or care about.” She talks about deriving internal happiness from doing task well but also valuing the rewarding benefits of money. She talks about how being an EMT is perfect for “you make good money and get to help people.” She talks about merely feeling sorry for people she doesn’t know but experiencing empathy “too much” for people that she knows and cares about. She gives an example of a friend telling her about being sexually assaulted and how this resulted in Cyndi “crying for three days straight.” She articulates that she has good social skills for she easily connects, build reports, and maintain friendships because she is “open minded, a good problem solver, and is very understanding.”

Gilligan’s ethics of care theory

Cyndi’s moral development will be analyzed by assessing which level she is at on Carol Gilligan’s Ethics of Care theory. Carol Gilligan did work with both Eric Erikson as well as Lawrence Kohlberg (Caringi, 2018). She specifically challenged Kohlberg’s theory of development for conclusions drawn from an underrepresented female population as well as a diversion from rules and a stronger emphasis on caring and justice (Evans, 2010, p.111). Like Kohlberg, her theory included set stages (or levels) of development but focused on relationships with others and how they must eventually carry “equal weight with self-care when making moral decisions” (Evans, 2010, p.112).

The three levels include two transitions. The first level, Orientation to Individual Survival, the individual is unable to distinguish between necessity and what they desire. These

needs are about the self regardless of the needs/wants of others. This stage is typically marked with an inability to form relationships that meet expectations as well as a propensity to isolate (Evans, 2010; Caringi, 2018). This level is followed by the first transition, From Selfishness to Responsibility. This Transitions is marked by a shift from selfishness to acting out of connection with others as well as responsibility to do the right thing (Evans, 2010; Caringi, 2018).

The next level, Goodness as Self-Sacrifice, is marked by care for others, reliance from others, and survival becomes social acceptance. Disequilibrium arises from conflicts that may negatively impact others and the individual is therefore more likely to align their judgments with the judgments of others. (Evans, 2010; Caringi, 2018). The level is followed by the transition titled From Goodness to Truth, where there is a continuation of putting others first but with an examination of their own needs that align with responsibility. Issues arise from attempts to reconcile the difference between hurt and care, but the individual is beginning to put value on their own needs as truth while still considering both responsibility and other's needs. The last level, Morality of Nonviolence, the focus is on none violence being paramount. Self-respect becomes very important and they gain the ability to discern between selfishness and responsibility. This allows them to have more flexibility in moral dilemmas while staying true to their own needs (Evans, 2010; Caringi, 2018).

Cyndi appears to be well past the first level of orientation to Individual survival. She claims she is very inclined to putting others first with the exception of responsibilities that she has held high (such as school and mental health). She further demonstrates her values of selflessness with the example of doing her portion of a group project regardless of not wanting to do the assignment. Though she talks about some issues with romantic relationships, she makes it clear that friendships are an important part of her life that she considers fulfilling. She claims to

have a consideration for other people as well as strong urge for doing the right thing when faced with a moral dilemma which qualifies her for the first transition, from selfishness to responsibility.

For the next level of goodness as sacrifice, she indicates a reliance on others by speaking on how important long-term friendships have meant to her and how their thoughts and opinions really matter to her. One could speculate that this would also imply the importance of social acceptance in her life. However, she later articulates how her need for social acceptance may be deviated if she has strong moral objections to opinions of someone else in her social sphere. When considering the next transition, From Goodness to Truth, Cyndi has made it clear that she cares about the opinions of others but her strong urge to be responsible takes precedence. This is well articulated in her answer to quit school to take care of a family member per she would only do quit school to help “if she absolutely had to.” Her ability to discern between hurt and care is seen with the example of the immoral friend who she felt calling out for having bad opinions was justified by her care for the moral issue. She drives this point in that when it comes to friends, honesty is paramount and if saying something cruel is for the ultimate better, she will do it which shows that she not only puts values on truth, responsibility, other’s needs, and she is able to justify “hurting” someone if it “ultimately for the better.”

For the last level, Morality of Nonviolence, she has a very decisive answer of violence never being acceptable and that it always causes more problems than solutions. In terms of responsibility, the dichotomization of responsibility and selfishness is none evident. She claims that she often feels that anything she may do that others could deem as selfish, she knows very well are being done for the right reasons and exude responsibility. Interestingly, this has her draw attention to what she feels is a contradiction for she puts others first but also recognize that

moral obligations and responsibilities still must take precedence. I believe this merely brings attention to her ability to value both caring and justice as well as caring an “equal weight with self-care when making moral decisions” (Evans, 2010, p.112). Aside from minor issues with romantic relationships, Cyndi has shown that she has fully morally developed when assessed by the Ethics of Care theory.

Goleman’s theory of emotional intelligence

Cyndi’s emotional intelligence will also be analyzed by assessing her alignment with the five components of emotional intelligence as presented by Daniel Goleman. The term emotional intelligence, coined by John Mayer and Peter Salovey in 1990, was expanded into five concepts by Goleman who felt that this form of intelligence was ignored in traditional IQ testing (Room 241, 2013). The five concepts include self-awareness, self-regulation, Internal motivation, empathy, and social skills.

Self-awareness is the ability to be observant as well as understanding of your own moods, emotions, and drives and how these may affect other people (Sonoma, 2009). Self-Regulation is the ability to subvert emotional influences as well as stopping to think through a situation before acting. Internal motivation is motivation absent of incentive for material goods. It is being galvanized by internal motivations such as the satisfaction in doing a task and receiving joy from learning. Empathy is the ability to appropriately recognize and even experience the emotions of others. It promotes “selfless compassion and action on behalf of another person” (psychology today, n.d.). Empathy is also different from sympathy, which is merely feeling sorry for someone (Sonoma, 2009). Social skills are the ability to manage and maintain relationships. It is also the ability to inspire, find common ground, and build rapport with other people.

Cyndi, over all appears to be fairly emotionally intelligent. She assesses herself as self-aware due to a “need” for self-awareness resulting from mental health self-care. She feels that her tendency to be vocal about what she is feeling has made it to where others are aware of how she is feeling and that she is very in tune to how they respond to her drives, emotions, and moods. She feels that she is good at self-regulating when she is subverting emotional reactions, but this is only with people she knows and cares about. She admits, however, that she is more likely to act emotionally when dealing with issues from strangers that she is not connected to. She talks about examples of internal motivation such as the satisfaction she gets from doing well in school and work but how she does still see the value in monetary incentives for work. She claims that she merely feels sorry for strangers but feels “too much” empathy for those she cares about. She also feels that she has good social skills in the context of platonic friends, but seeing from the Gilligan section on relationships, this does not translate to romantic connections. She articulated how she has trouble communicating with romantic partners for she doesn’t understand “what they want.”

Though Cyndi is self-aware and has a good sense of internal motivation, her ability to self-regulate, empathize, and have good social skills are context dependent. When the person receiving her is someone she is not connected to, or in the case of social skills, is someone she is romantically involved with, she appears to struggle with these concepts. Her empathy seems to also be poorly controlled when it comes to people she does care about per over experiencing emotions. She shows success in all five concepts of emotional intelligence but the deficits in self-regulating, empathy, and social skills draw the conclusion that her emotional intelligence is fair.

Critique of the theories

Both of these theories were good resources for assessing Cyndi in her Moral development and emotional intelligence, but both also contained short comings. An example from Gilligan's theory is the fact that Cyndi was well passed the first level of moral development but still met criteria for the first level. Though she derives fulfillment out of platonic friendships, she expressed a reoccurring theme of romantic relationships that taking more out of her than they give her. Due to this unfulfillment, Cyndi should still be in this stage of moral development. Looking through the rest of the theory, however, Cyndi consistently meets the rest of criteria to classify her into a level three of moral development. This issue may be relevant to the first interview where Cyndi discussed meeting criteria for Borderline Personality Disorder (BPD) and this being the reason for her issues in relationships. It may be possible that Gilligan's theory does not account for BPD and that it is possible to be morally developed without the component of fulfillment in intimate relationships.

Goleman's theory of intelligence is straight forward but does not provide information that is context dependent. Cyndi qualified for all 5 concepts of emotional intelligence but three of which were context dependent. The BPD issue may also come into play with this theory and possible short comings. For example, Cyndi issues with relationships appear to be a deficit in her social skills. As further touched upon, BPD causes issues in romantic relationships and therefore the potential that Cyndi has BPD means that the interpretation of her social skills may be biased and unaccounted for in Goleman's theory.

My own critique

All in all, I think my second interview went well. My questions were pertinent to the theories and generated good responses. I did, however, miss a couple of key things. Though this was asked in the first interview, I neglected to ask anything about isolation. This was a big

component of the first level and was something that could have strengthened my critique of Cyndi's relationship tendencies indicating that she should be stuck in level one of Gilligan's theory. Though I did a good job of eliciting that social support is important to Cyndi, I did not specifically ask about the importance of social acceptance or to what extent she relies on others. My questions were more focused on deriving fulfillment from relationships and whether she aligns with the judgment of others (confronting a friend that had an opinion she didn't agree with). In terms of questions that touched on the issue of being "cruel to be kind" or "tough love" to elicit her ability to reconcile the difference between hurt and care, her answers seemed to be more centered around personal moral justifications for hurting the friend via confrontation instead of the ultimate benefit it would have for the friend.

Though she discussed how tough love would ultimately benefit the friend she is confronting (willing to say something cruel if it is for the better), I never had her clarify that she is doing it for the better of her and her morals or for her friend. I did not ask anything about self-respect. This was a very important piece of the last level. Though answers, such as her tenacious drive to be responsible and stick to a moral code insinuated self-respect, I never explicitly asked her if she has respect for herself. I feel that I also could have had her give an example of being selfish and responsible at the same time to further illustrate her ability to discern between selfishness and responsibility.

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APPENDIX G: Model for Social Work Practice**Abstract**

The paper discusses the issue of the overrepresentation of mental illness and drug addiction in prisons. The paper discusses research of the amount of people with addiction issues and how being in prison can exacerbate addiction instead of facilitating recovery. Similarly, the paper the paper discusses the representation of people with mental illness and how prison inhibits treatment. The paper also gives high numbers of the co-occurrence of addiction use disorders and mental health diagnosis in inmates. The paper then discusses the study of “rat park” with implications of environments contributing greatly to addiction use disorders. The paper then delineates a prison alternative where inmates with mental health and substance use disorders would be taken to an island and have their recovery needs facilitated from a strength-based perspective. The paper then suggest that the results of the preliminary study could be used to grant funding for prison reform as well as challenge harmful stigma of prisoners.

Model for social work practice

Many social workers feel that the current United States social work system contains a plethora of structural issues that are not being addressed. One issue, in particular, is the overrepresentation of mental illness and drug addiction in prison inmates. The prisons not only perpetuate negative stereotypes of people who struggle with mental health and addiction as criminals, but they may even exacerbate inmates' conditions. This paper will explore a design for a prison alternative that would result in implications for restructuring the prison system to be more strength based and less stigmatizing.

There is an overrepresentation of people with substance use disorders as well as mental health issues in the US penitentiary system, which exacerbates both conditions. The National Institute on Drug Abuse states that prison population has risen from 1.8 million in to 7.3 million due to incarceration of people who use drugs (NIH, 2010). People imprisoned for using drugs not only make up over 80% of the US penal system, but there is evidence that the system may exacerbate their drug use (Dolan, 2007, pg 1). Dolan elaborates on how prisoners are likely to not only share information with each other on injection methods but are also inclined to use more serious drugs than they may have used otherwise (such as heroin in place of marijuana) due to the short time period of detectability in drug tests (p 2). Prins (2014) discusses how people with mental health issues make up 64% of American prisoners and how the criminal justice system seems to "exacerbate prevailing social marginalization and disrupt treatment and linkage to service system" (p.862).

Both substance use disorders and mental health issues do occur on their own, but are also likely co-occurring with inmates. Abram (1991) observed co-occurring mental health issues and substance use disorder from a sample of 64 inmates. Of the inmates, 84.8% of those with any

severe mental disorder abused alcohol and 57.9 abused drugs (p.1,038). To further exemplify the ineffectiveness of prisons, 43% of inmates released to the community will recidivate within 3 years of their release (Prins, 2014, p.868).

Seeing as prison systems fail to rehabilitate those who struggle with mental and substance abuse disorders (stack sources), one must speculate the motive for continuing the system. Finn (2017) brings up the idea of containment and control that is prioritized over charity and concern and how this has been the primary implication for social systems in the past and how the ideology is still seen today (p.27 and p.51). Therefore, the motives for incarceration appear to be a means of separating people who struggle with mental health and substance use disorders out of the community, regardless of the negative effects that the penal system has on the inmates. Social reform needs to take a structural approach for dealing with mental health and drug addiction that places rehabilitation as paramount.

Alexander (1980) did a study on rats addicted to morphine in socially isolated small environments with minimal stimulation as well as an extravagant “rat park” that contained other rats and stimulating rat toys. The research found that rats that had been in the confined environment for 44 days and addicted to morphine, used morphine far less in the “rat park” because it “interferes with species-specific behavior” (p.571 and p.574). As discussed above, the neglect of rehabilitation, isolated environments, and exacerbation of drug use in prison seem to promote antisocial behaviors. A structural reform for prisons that promoted recovery-oriented behaviors in a positive social environment would therefore be likely to inhibit drug use. One may also speculate that a positive environment that promoted substance use and mental health treatment would result in greater outcomes for both factors and reduce recidivism.

The prison alternative would need to start as an experiment to gain the funding for broader implementation. Forty inmates who suffer from drug addiction, mental illness, or a co-occurring of both factors, would be taken to a secluded isolated area for 6 months. This isolated area would be devoid of anything that could be used as a weapon, means of drugs or alcohol, and would be heavily monitored by staff on site. Staff will be heavily trained how to use positive reinforcement, unconditional positive regard, conflict resolution, and non-violent crisis intervention. Drawing from the model of peer support used in both mental health and drug addiction outpatient centers, staff will also consist of ex inmates who were incarcerated for similar issues. They will function as both role models and make it easier for inmates to confide in having gone through similar experiences.

Healthy food would be provided as well as ample means for recreation (pool/gym/basketball court). Inmates would be free to attend a multitude of social events as well as optional classes. They will, however, be required to take part in mandatory educational classes on substance use and mental health for education, regardless of if they do or do not have either a substance use disorder or mental health issues. The course material will consist of evidence-based curriculums (such as Illness Management and Recovery) to ensure quality intervention. These classes will not only educate them about their own conditions but also about others. Inmates will also be required to see a therapist or drug addiction specialist on a regular basis who may also refer them out to a psychiatrist but as a means secondary to behavioral health. Positive reinforcement systems, such as currency to buy special food items for attending extra group or taking part in work, will be put into place to promote prosocial behaviors. Inmates will also be given their own rooms that resemble a dorm room as opposed to a jail cell to reduce the

isolated feelings of criminalization. They will also be given an iPad to use to Skype their friends and loved ones to promote ongoing connection and reduce isolation.

After the experiment is over, former inmates will go on a probationary period where they will attend either a mental health outpatient center or a drug treatment center (both if they possess a co-occurring disorder) to monitor recovery progress. The sample will be compared to 40 inmates with mental health and substance issues who will attend 6-month sentences in traditional prison who will also go on to be monitored by out-patient treatment centers. If the experiment generates positive results by showing a reduction in mental health symptoms, drug usage, and recidivism, funding could be generated to either restructure prison systems based off this model of education and positive reinforcement or to create other secluded locations to avoid drugs being smuggled in.

Prisons are more about punishment of a criminal than the rehabilitation of a person. One could argue, however, that mental health and drug addictions are not something that people should be punished for. Genetic predisposition, low SES, and trauma are just some of the factors that influence the likelihood of severe mental health or drug addiction issues. Finn (2007) points out that this is due to privilege, which becomes normalized for those with limited oppression and creates an inability to recognize one's positionality amongst others with unequal opportunities (p.31). A failure to recognize opportunities facilitated by privileged that are not shared by others in society leads to blaming the less fortunate for their predicaments.

Positive outcomes from this study would not only promote structural change to the penal system, it would challenge the stigma from those in society more privileged. Instead of assuming that character flaws cause criminal behavior, the ability for inmates to succeed in a supportive environment would shed light to the maladaptively structured system. This theory also draws on

a strength-based perspective which counters self-stigma of the inmates. Inmates, in this system, are attaining value in themselves by working towards recovery instead of criminals that are destined to for a life of dysfunction and crime.

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Appendix H: Role of MSW Volunteers at PCC

Introduction

This project analyzed the responses of seventeen MSW students participating in Project Community Connect (PCC) to determine their interest in facilitating crisis intervention, acting as client guides, and participating in childcare. Data from twenty-four volunteers via exit surveys was also used. Interviews were conducted with Tiffany St. Flynn from Winds of Change, as well as Erica Johnson, an MSW student who assisted in planning the event. The goal of this analysis is to determine what MSW student volunteers are willing to contribute to future PCC events.

Crisis Intervention

MSW Students

- All seventeen MSW volunteers indicated willingness to support clients in crises or distress.
- Sixteen MSW volunteers indicated willingness to engage in crisis intervention training before the event; one did not answer the question.
- Only one MSW volunteer was currently comfortable engaging in crisis intervention, but still felt training would be beneficial.
- Several participants indicated that “training is a great idea”, and believed such training would increase their comfort in engaging in crisis intervention.

Volunteers

- Three volunteers pointed out the need for a crisis counselor.
- One PIT Count volunteer (6/24 did the PIT Count) suggested: “Crisis counselors for acute situations in which de-escalation would be beneficial to participants. Some of the questions in the PIT survey may be triggering for some individuals. I understand that these

questions are crucial for grant funding, and I think that crisis counselors may be able to ease some of the escalation that occurs as a result of these questions.”

Client Guides

MSW Students

- All seventeen MSW volunteers indicated willingness to guide clients through the event.
- One volunteer discussed how “being a guide would both direct participants to services as well as [be] a good way to build rapport with clients.”

Volunteers

- One volunteer guide said: “I really feel that I help the most as a guide, as I can help [participants] achieve their goals.” In the exit survey, guides indicated engagement with 38 clients showing that this is an important and well-used task.

Child Care

MSW Students

- Seven MSW volunteers expressed the need for child care when asked what services weren’t addressed properly. One mentioned the event needing “[m]ore activities for children who may have been bored.”

Volunteers

- Fourteen volunteers indicated willingness to participate in child care, two preferred not to participate in child care, and one did not indicate a preference.
- Thirteen volunteers indicated willingness to participate in a child care pre-training; two did not respond.

Response from Tiffany St. Flynn (Winds of Change)

St. Flynn mentioned several participants needing “someone to talk to”; these participants wanted to talk to her and her partner at the WoC table, making it difficult for them to attend to other participants seeking services. Tiffany believes trained MSW volunteer crisis counselors at the event would be a good way to direct/ manage clients in distress. She discussed how guides would also be useful for “helping people know what the event offered and knowing how to prioritize time at the event for some people seemed directionless.” St. Flynn supported child care at PCC, but did not see the lack of it as an issue this year.

Response from Erica Johnson (event planner and MSW student)

Johnson praised the inclusion of updated technology—the previous use of paper surveys was harder to calibrate—and the decision to maximize the skill sets of MSW students in conducting surveys. In the future, she believed it would be helpful to provide students with a limited number of engagement options, and to align them with activities tailored to their practicums when possible. She suggested using MSW students to survey participants about both their long-term and short-term needs, and potentially repurposing this information for research projects. Planning for community events, initiatives and/or reform/progress-oriented goals outside of practicum requirements, in her estimation, would also challenge MSW students to hone their skills for similar community-based events. Finally, she suggested that MSW students be trained to conduct other activities beyond surveys. She also advised greater preliminary communication with agencies hosting the event next year.

Conclusion

Both MSW students and volunteers expressed a clear interest in furthering this project’s three primary domains of interest (crisis intervention, event guides, and child care) through

expanded options and advance training. Interviews with participating agency and program personalities also indicate broad and generative potential for the role of MSW students (and volunteers) in community events. In general, task-specific training, skill-oriented options, and a more coherent synthesis of community-based learning opportunities with program materials/goals will serve the interests and needs of all participants in events like PCC.

Appendix I: CTR Presentation

Abstract

The presentation is on Recovery-Oriented Cognitive therapy (CT-R). Developed by Aaron Beck, the therapy was designed to help people who experience “low neuro-cognitive performance” as a result of psychotic disorders. The presentation discusses the difference between CT-R and Cognitive Behavioral Therapy for Psychosis (CBTp), all of the psychotic disorders, what are positive and negative symptoms. The presentation then discusses how the therapy asserts that negative symptoms (as well as some positive symptoms) of schizophrenia are heavily correlated with defeatist beliefs and how these beliefs can be challenged by accessing, energizing, developing, actualizing, and strengthening a client's adaptive mode. The presentation also discussed empirical support for the therapy, where it has been successfully implemented, as well as why CT-R aligns with social work values.

Grand desires vs aspirations

Goal: The client will understand the difference between their desires and aspirations.

Intervention: The client will be able to identify their desires and aspirations.

Activity: The client will be able to identify their desires and aspirations.

Example: "I want to be a doctor" vs "I want to be a doctor who helps people."

Book Institute for CTR, 2019.

Activity #21 Practice developing the adaptive mode

Client: Say some verbatim text.

Therapist: Welcome and try to elicit meaning through guided discovery questions to help clarify meaning and help the client "unpack" the goal.

Example: "What does that mean to you?"

Book Institute for CTR, 2019.

Distant goals vs aspirations

Goal: The client will understand the difference between their distant goals and aspirations.

Intervention: The client will be able to identify their distant goals and aspirations.

Activity: The client will be able to identify their distant goals and aspirations.

Example: "I want to be a doctor" vs "I want to be a doctor who helps people."

Book Institute for CTR, 2019.

Treatment oriented goals vs aspirations

Goal: The client will understand the difference between their treatment oriented goals and aspirations.

Intervention: The client will be able to identify their treatment oriented goals and aspirations.

Activity: The client will be able to identify their treatment oriented goals and aspirations.

Example: "I want to be a doctor" vs "I want to be a doctor who helps people."

Book Institute for CTR, 2019.

Dangerous or risky goals

Goal: The client will understand the difference between their dangerous or risky goals and aspirations.

Intervention: The client will be able to identify their dangerous or risky goals and aspirations.

Activity: The client will be able to identify their dangerous or risky goals and aspirations.

Example: "I want to be a doctor" vs "I want to be a doctor who helps people."

Book Institute for CTR, 2019.

Actualizing the adaptive mode

Goal: The client will understand the difference between their actualizing the adaptive mode goals and aspirations.

Intervention: The client will be able to identify their actualizing the adaptive mode goals and aspirations.

Activity: The client will be able to identify their actualizing the adaptive mode goals and aspirations.

Example: "I want to be a doctor" vs "I want to be a doctor who helps people."

Book Institute for CTR, 2019.

Measuring of Aspirations

Example of client worksheet (MGM Therapist)

Book Institute for CTR, 2019.

Strengthening the adaptive mode

Goal: The client will understand the difference between their strengthening the adaptive mode goals and aspirations.

Intervention: The client will be able to identify their strengthening the adaptive mode goals and aspirations.

Activity: The client will be able to identify their strengthening the adaptive mode goals and aspirations.

Example: "I want to be a doctor" vs "I want to be a doctor who helps people."

Book Institute for CTR, 2019.

Tackling negative beliefs about Energy

Goal: The client will understand the difference between their tackling negative beliefs about Energy goals and aspirations.

Intervention: The client will be able to identify their tackling negative beliefs about Energy goals and aspirations.

Activity: The client will be able to identify their tackling negative beliefs about Energy goals and aspirations.

Example: "I want to be a doctor" vs "I want to be a doctor who helps people."

Book Institute for CTR, 2019.

Tackling negative beliefs about capability

Goal: The client will understand the difference between their tackling negative beliefs about capability goals and aspirations.

Intervention: The client will be able to identify their tackling negative beliefs about capability goals and aspirations.

Activity: The client will be able to identify their tackling negative beliefs about capability goals and aspirations.

Example: "I want to be a doctor" vs "I want to be a doctor who helps people."

Book Institute for CTR, 2019.

Tackling negative beliefs about control

Goal: The client will understand the difference between their tackling negative beliefs about control goals and aspirations.

Intervention: The client will be able to identify their tackling negative beliefs about control goals and aspirations.

Activity: The client will be able to identify their tackling negative beliefs about control goals and aspirations.

Example: "I want to be a doctor" vs "I want to be a doctor who helps people."

Book Institute for CTR, 2019.

Tackling negative beliefs about connection

Goal: The client will understand the difference between their tackling negative beliefs about connection goals and aspirations.

Intervention: The client will be able to identify their tackling negative beliefs about connection goals and aspirations.

Activity: The client will be able to identify their tackling negative beliefs about connection goals and aspirations.

Example: "I want to be a doctor" vs "I want to be a doctor who helps people."

Book Institute for CTR, 2019.

Trauma and CTR

Goal: The client will understand the difference between their trauma and CTR goals and aspirations.

Intervention: The client will be able to identify their trauma and CTR goals and aspirations.

Activity: The client will be able to identify their trauma and CTR goals and aspirations.

Example: "I want to be a doctor" vs "I want to be a doctor who helps people."

Book Institute for CTR, 2019.

CTR and other populations?

Goal: The client will understand the difference between their CTR and other populations goals and aspirations.

Intervention: The client will be able to identify their CTR and other populations goals and aspirations.

Activity: The client will be able to identify their CTR and other populations goals and aspirations.

Example: "I want to be a doctor" vs "I want to be a doctor who helps people."

Book Institute for CTR, 2019.

CTR in social work practice

Goal: The client will understand the difference between their CTR in social work practice goals and aspirations.

Intervention: The client will be able to identify their CTR in social work practice goals and aspirations.

Activity: The client will be able to identify their CTR in social work practice goals and aspirations.

Example: "I want to be a doctor" vs "I want to be a doctor who helps people."

Book Institute for CTR, 2019.

References

Goal: The client will understand the difference between their references goals and aspirations.

Intervention: The client will be able to identify their references goals and aspirations.

Activity: The client will be able to identify their references goals and aspirations.

Example: "I want to be a doctor" vs "I want to be a doctor who helps people."

Book Institute for CTR, 2019.

Appendix J: EMDR Overview and Application for Special Populations**Abstract**

The paper starts with a quick introduction of the EMDR training in Kalispell. The paper then discusses how the training though useful left out what is needed to be done for populations of people who struggle with psychosis and dissociation. The paper explores the creation of EMDR, research that validates EMDR as an evidence based practice, Discusses crises intervention EMDR tactics, as well as differentiating the three types of EMDR. The paper then discusses learning what to do for people with psychosis as well as specified preparation work for people with dissociations.

EMDR Overview and Application for Special Populations

In Fall of 2019, I attended a five-day intensive training for Eye Movement Desensitization and Reprocessing therapy (EMDR) put on by the EMDR International Association (EMDRIA). During this training, I learned how to competently and confidently utilize EMDR as both a practicum student as well as future MSW/LCSW therapist. The training took us through the empirical evidence supporting EMDR and discussed the multiple variants of EMDR as well as the phases they encapsulate. We then were prompted as a group to analyze videos of EMDR being used by Roy Kiessling (the man who developed the manual for the course and has led much of the EMDR research), practiced EMDR on each other, and then discussed the use of EMDR with several special populations.

Though I found the training as a whole very useful and am fully committed to incorporate EMDR in my future practice, the training lacked some vital information and also brought up some important realizations. Such information training did not discuss working with people who are highly dissociative nor did it discuss working with people with psychosis. This is important information for me personally given that I currently work and plan to continue to work with people with severely disabling mental illnesses (SDMI). The training also made me realize that doing EMDR for someone who is not ready to process certain events may cause them to dissociate and not feel like themselves for weeks after the session. This realization arose from one of the training sessions where I (acting as the client) took on a past issue I was not ready to process.

Due to this only being a training, a lot of the preparation work for the EMDR was not comprehensively addressed. I felt myself dissociating during one of the sessions and did not feel like myself for almost a month after the training. Due to this situation and the lack of training on

relevant populations, I recognized the importance of thorough EMDR preparation as well as needing to venture outside of the training material to facilitate clients who experience dissociations and psychosis. I wanted to use this paper to refresh the information I learned last fall as well as exploring how to use EMDR with special populations not covered in the course. I believe that this paper will help me to solidify my understanding of EMDR as a whole and help me to prepare for working with people who experience psychosis and dissociations.

EMDR was developed by Francine Shapiro in the late 1980s. The idea of EMDR came from Shapiro walking in the park and realizing that eye movement seemed to decrease the negative emotions she was having about a recent distressing event. She later realized that eye movement on their own were not enough to create a therapeutic effect and added cognitive components to a procedure that prompted rapid eye movement resulting in the creation of Eye Movement destination (EMD; EMDR institute) Shapiro (1989) examined the effects of EMD on 22 participants that had traumatic experience from the Vietnam war, childhood sexual molestation, or sexual/physical assault. Measuring anxiety levels, self-esteem in relation to the traumatic event and presenting complaint, “a single session of EMD successfully desensitized traumatic memories and dramatically altered their cognitive assessment of the situation” (p.199). These effects maintained three months after the treatment. The study also found that alleviation of presenting complaints (such as flashbacks and nightmares) occurred for “all subjects” (p. 216). In 1995, Shapiro added the concept of reprocessing which facilitates the process of memory consolidation (handbook). After this therapy had been tested and shown to be effective, several studies came out to make sense of exactly how EMDR helps people to both desensitize emotionally triggering events as well as facilitating the process of memory consolidation through reprocessing.

Andrade, Kavanagh, and Baddeley (1997) discussed how the eye movement in the EMDR process disrupts the visual sketch pad (VSSP) in the brain. By disrupting this process, there is a reduction of emotions associated with images relevant to emotionally evoking experiences in the person's past. Stickgold (2002) discussed how memories are initially stored in the brain region called the hippocampus. They also discussed how the brain region called the amygdala links relevant emotions to these episodic memories and then relevant information from the memories is eventually extracted and stored in neocortex. This information is used to help the person understand future events. These hippocampal memories can then be easily faded or even forgotten after this process. However, if this extraction process fails and the memory is traumatic, the learning and forgetting process does not occur and can result in PTSD. Recovery must then come from cortical memory consolidation and integration to undo the initial failed process (which can be facilitated by EMDR).

Stickgold (2002) also discussed the association between rapid eye movement (REM) sleep and EMDR. The study explains the theory that REM sleep is the brain's opportunity to engage in complex memory reprocessing and integration. Memories are able to be consolidated into neocortical semantic memory networks without the interference from the hippocampus replay of episodic memory. However, as stated above, PTSD disrupts normal integration and consolidation. This results in trauma nightmares where the person reexperiences the trauma in their sleep. Like in REM sleep, EMDR uses bilateral stimulation (BLS) by alternating visual, auditory, or tactile stimuli causing constant reorientation of attention. This process facilitates memory consolidation without interference from hippocampal episodic recall. Stickgold also discussed how EMDR works even better than REM sleep with traumatic events by active participation by the frontal lobe (which would normally be inhibited in sleep) as well as

controlling levels anxiety/ fear and subsequent norepinephrine that altogether would disrupt the consolidation process.

EMDR is validated by a plethora of empirical research that supports its effectiveness for people who have experienced trauma that has led to the American Psychiatric Association giving EMDR the same status as cognitive behavioral therapy for treating acute and chronic PTSD and the Department of Veteran Affairs and Department of Defense naming EMDR as one of the four therapies of highest recommendation for PTSD. In 2011, the Substance Abuse and Mental Health Services Administration (SAMHSA) registered EMDR as an evidence-based treatment for PTSD, anxiety, and depression symptoms. In 2013, the Worldhealth Organization named trauma focused CBT and EMDR the only psychotherapies recommended for children, adolescence and adults with PTSD. When comparing EMDR to trauma focused CBT, EMDR does not involve detailed descriptions of the event, direct challenging of beliefs, extended exposure or homework (Kiessling, 2019). Not only does this reduce the likelihood of re-traumatization for the client, it reduces the occurrence of secondary trauma for the practitioners. Research also shows empirical support for the use of EMDR with clients who experience sexual disfunctions, body dysmorphic disorder, grief and mourning, chronic pain, conduct problems/self-esteem, phobias, pedophilia, panic disorder, generalized anxiety disorder, migraine headaches, phantom limb pain, unexplained somatic symptoms, attachment disorders, psychotic disorders, and depression (Kiessling, 2019).

After getting a brief history of the empirical support for the EMDR training, we learned two types of crisis intervention techniques using BLS that can be used immediately following a traumatic event or within a couple days of the event. These techniques are called Critical Incident Desensitization (CID) and Acute-Traumatic Incident Processing (A-TIP). CID uses BLS

to desensitizes strong emotion following crisis while measuring the progress through a Subjective Unit of Distress (SUD) rating. A-TIP takes this a step further by pairing the traumatic event with a false belief (exp. "I'm going to die") as well as prompting the client to pair the traumatic event with a preferred positive belief (exp. "I will survive"; Kiessling, 2019, p.20). The practitioner then desensitizes the negative belief with BLS then strengthens the positive belief with BLS (Kiessling, 2019).

After learning about CID and A-Tip, we discussed the three stages and eight phases of EMDR. The three stages include case conceptualization, processing, and integration. In case conceptualization, the first step is preparation where the clinician focuses on affect management for the client (phase two). Phase two comes before phase one to help safeguard against the client being triggered by the rest of the preparation process. This phase is where the client and the clinician create a "safe place" to visualize a calming place if the client feels overwhelmed during treatment process. The clinician also has the client create a "safe box" where the client creates a safe and comfortable place to store memories that are not ready to be processed (p.37). In phase one, the client's presenting complaint is identified and a treatment plan is created. The clinician and client discuss the negative belief associated with the complaint as well as events that the client feels validate that this negative belief is true. The client also identifies a positive core belief that counters the negative belief as well as identifying events or facts that validate the positive core belief. Next, the clinician and client begin stage two, the processing phase (Kiessling, 2019).

In the processing phase, the clinician chooses one of the three forms of EMDR based on the client's ability to process events while still being able to manage their emotional affect. The types include EMD restricted processing (EMD[^]), EMD contained processing (EMDr) as well as

EMD unrestricted processing (EMDR). Similar to A-TIP, all three forms of EMDR work through negative core beliefs and corresponding events by asking for SUD rating in relation to how upsetting an event is (scale from 1-10) while thinking of the core belief as well as how true a preferred positive core belief feels true (scale from one-seven). This part is known as phase three, Access and Activate. Each process then goes through phase four, desensitization, where rounds of BLS are used to desensitize the negative core belief (either till the SUD drops to a zero or stays unmoved for three rounds of BLS). Each form of EMDR then goes through phase five, instillation, where the positive belief is instilled (either till the SUD raises to a seven or stays unmoved for three rounds of BLS; Kiessling, 2019).

Though all of these EMDR variants are conducted in a very similar manner, the main distinction between them is the type of traumatic event processed, the length of BLS used in the procedure, how often a SUD rating is asked for, whether or not a body scan is asked for, and whether or not a client is prompted to focus on a specific event. EMD[^] focuses on recent and future events, uses increments of 5-10 rounds of BLS, prompting a client to focus on a target event and to stop the practitioner if anything other than the target even comes up, and asks for a SUD rating after every round of BLS. EMDr works through past events but has the client “contain” certain events that are not ready to be processed (Kiessling, 2019, p.43). The client is initially prompted to think of a target event but is allowed to explore “what they notice” as long as contained events do not arise (Kiessling, 2019 p.104). EMDr uses 10-15 seconds of BLS to desensitize and reprocess the negative core belief and the corresponding event. With EMDR, the processing is completely unrestricted, does not prompt the client to stay on a specific incident, continually prompts the client to observe what they “notices,” and uses BLS of 15-30 seconds.

Phase six, the body scan, is only used in EMDr and EMDR. The client is instructed to think of the target incident and the instilled positive belief while observing/reporting positive and negative sensations. Five-ten seconds of BLS are conducted while the client pairs the target incident, positive belief, and sensation together. The body scan ends when the client reports no more negative sensations. All three forms of EMDR go through phase seven and eight. In phase seven, closure, the client is “re-stabilized” if they need to be through CID, inner peaceful place, or other stabilizing exercises (like guided imagery). The last stage, integration, contains phase eight, reevaluation. This stage/phase happens in the next session. Previous processing outcomes are evaluated and the client and clinician move on to the next issue in the treatment plan to start again the next objective through the processing stage (Kiessling, 2019).

Though our training covered how EMDR is used with several special populations, the training did not cover how to interact with people who have issues with psychosis or are highly dissociative. Fortunately, in a phone call consultation with my EMDR instructor, I was able to ask what should be done for these populations. In regards to people with psychosis, my instructor discussed how the most important factor to decipher is if the event being processed is a true event and doesn't not revolve around a delusion. It is also important to explain what the EMDR process is and clarify that it is not a form of hypnosis. As for any client, it is also important that a client with psychosis is able to stay in their window of tolerance. A window of tolerance is where a client is able to stay in a “comfort zone” where the client can self sooth and is able to regulate their emotional state (Walker, 2019). Leaving the window of tolerance is characterized by either a hyper arousal fight or flight state characterized by anxiety, being overwhelmed or experiencing extreme anger or a hypo aroused freeze state characterized by shutting down, memory loss or dissociation. In regard to clients who are highly dissociative, they have a much

smaller window of tolerance. Treatment for these clients requires extensive preparation work to broaden their window of tolerance.

My EMDR instructor sent me a good amount of literature on how to help clients who are highly dissociative expand their window of tolerance. One particular document discussed specific exercises that can be done for clients with tendencies to disassociate before beginning EMDR sessions. First the document discussed the importance of establishing a cooperative therapeutic relationship to avoid activating the client's traumatized attachment system. Next, the clients draw their window of tolerance while the therapist explains that being in a window of tolerance allows the client to think and feel at the same time by turning towards triggering thoughts instead of away from them. Next, the clinician enhances the clients "meta cognitive skills" by having a client tell the story of their day, help the client identify different "parts" of themselves, and then discuss where in their body they feel the parts, what parts are thoughts, and what parts are emotions (Walker, 2019, p.9). The client and staff then reflect on what it was like turning toward symptoms without being overwhelmed. The document then discussed signs to look out for that are indicative of them having a greater window of tolerance (exp. being less confused, less hijacked by their emotions, and a better understating of what they are feeling and why; Walker, 2019).

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[powerpoint slides]

Appendix K: Clifford W. Beers and the Mental Health Hygiene Movement**Abstract**

This project examines the life of Clifford Beers and how his maltreatment in institutions led him to write a memoir called a *Mind that found itself* in the early 1900s. This book galvanized mental health reform by inspiring the creation of the *National Committee for Mental Hygiene* (NCMH). This project will examine the influence Adolf Meyer on Beers and the movement to adopt an approach oriented around prevention and after care. This project will also examine how the NCMH, later renamed Mental Health America, galvanized both deinstitutionalization as well as the creation of community mental health centers.

Clifford W. Beers and the Mental Health Hygiene Movement

Social reform for the unfair treatment of the mentally ill population has been an important topic that was seen as early as the early 1800's. Prolific figures, such as Dorothea Dix were setting the ground work for future reform. For example, Dix legislated in 1841 to make separate mental hospitals for the "incurably insane" that were living in "deplorable conditions" with hardened criminals in prisons (Viney, 2000, p.65). As Gray (2008) talks about, however, between 1840-1900, magazines, newspapers, and organizations had done their part to expose inhumane treatment of the mentally ill population, but efforts had been met with minimal result for any real changes in the conditions. One may speculate that this was due to dehumanizing ideologies that the public held about those deemed as "insane" as well as naivety to the inhumane treatment in institutions. However, Clifford Whittingham Beers would not only dispel these stigmas with his intrepid, witty, and likable personality, he would also expose the maltreatment of people with mental illness from a bottom up/insider approach.

Beer's journey went from being a person both labeled as "psychotic" as well as being a marginalized "mental health patient" to a well-established mental health reform pioneer. With the assistance and guidance of William James, Adolph Meyer, and other prolific social reformers, he would cooperatively develop a movement to address maltreatment in asylums, education on mental illness, mental health after care, and the prevention of mental illness. Using his experiences in asylums (written in his book, *A mind that found itself*) to gain support, his business experience, financial support from his family, his wit/charm, and his willingness to take constructive criticism from Meyer, Clifford Beers would pioneer *The National mental*

hygiene movement. This movement would eventually influence deinstitutionalization and the development of community mental health centers.

Beers was born in 1876 in Newhaven Connecticut. Beers did not grow up rich but had a “modest standard of living,” (Dain,1980, p.7). However, Beers and his siblings did experience significant hardships both from physical and mental illness. In his early years, he experienced a plethora of physical illnesses including cholera and measles. All five of Beer’s siblings died from physical and mental illness. One died at birth, one died from epileptic seizures in their teens, and the other three lived until adulthood but died in mental hospitals, two of which were from suicide (Dain,1980; Parry 2010). Despite hardship, Beers went to Yale University's Sheffield Scientific School to take business courses and graduated in 1897. He worked as a clerk in New York City but experienced bouts of depression and moved home. He would eventually try to kill himself by throwing himself out of a three-story window. While in the hospital recovering from the fall, Beer’s experienced psychotic symptoms (Dain,1980; Parry 2010). He claimed, “Certain hallucinations of hearing or false voices added to my torture” (Beers, 1908, p. 23). These symptoms led to his family having him institutionalized in 1900 (Dain, 1980).

On August 11th, 1900, Beers was sent to Stamford Hall, a proprietary mental hospital (Dain, 1980). At the time, cases of manic-depressive psychosis, such as Beers’ case, were not thought to be curable. Treatment at the time merely took care of physical needs of these patients and controlled their “violent” behavior with restraints (Dain, 1980, p.20). At Stamford Hall, Beers underwent more intense delusions of “detectives out to get him,” hallucinations, active suicidality, and was physically abused by a man named Dr. Hodgson for refusing to answer his questions. Beers was then moved to a different building with a private room. Though the showed signs of recovery by starting to talk more and read again, his family was not pleased with

his overall care. He was then moved to the family home of Frank Wordin, an attendant at Stamford Hall who witnessed Beers' maltreatment. Under Wordin's care, Beers' condition seemed to decline. He was allowed to roam around the community and sites that his hostile delusions made him want to "kill others and then himself" (Dain, 1980, p.21-25). At this point in Beer's life, he was still very symptomatic and was unable to advocate for himself and the maltreatment he endured. His delusional thinking and depression appeared to be exacerbated by both maltreatment as well as the absence of treatment as in the case of Wordin's loose boundaries. Beers would go on to be recommitted to institutions, seeing both the positive sides as well as the dark sides of the different asylums.

On June 11, 1902, Beers was committed to Hartford Retreat, an old corporate mental hospital in Connecticut. The mission of Hartford was "moral treatment" (Dain, 1980, p.26). At the beginning, Beers found Hartford a peaceful place where staff and patients were kind to him but was still concerned of others being detectives out to punish him for his crimes. Symptoms of depression began to turn into mania. Clifford Beers began to write long essays in regard to conducting a "thorough investigation" into the Hartford retreat for the maltreatment of their patients (Dain, p.93). He claimed that "though [he] had not been subjected to physical abuse during the first 14 months of [his] stay at the institution, [he] had seen unnecessary and often brutality by the attendance in restraint of the several so called violent patients" (Beers, 1908 p.93). Beers intentionally misbehaved by insulting a doctor to be placed on the violent ward as a "willing, in fact, eager prisoner" to observe the maltreatment first hand (Dain, 1980, p.94). Beers talked about how the ward was a very austere environment where he was denied request for pen and paper, books, phone calls, or the ability to send mail (Dain, 1980, p.95).

In an isolated environment with minimal stimuli and neglect from staff, Beers smashed the glass globe around his cell's light fixture which resulted in him being choked so hard that "he could not get up or talk for 24 hours" (Dain, 1980, p.32). A feigned suicide attempt led to him being restrained in a straitjacket for 21 days. One of the doctors, referred to as doctor A (who Beers had formally respected as a competent intellectual), vindictively tightened the straitjacket when Beers expressed that it was too tight. He was later beaten and choked by hospital staff while in the straitjacket for being even slightly disobedient. The cell he stayed in was also cold and did not have a toilet (Dain, 1980).

Throughout the analysis of Beers' time in mental asylums, it becomes hard to tell when and where Beer's was intentionally misbehaving and when he was merely symptomatic. In several instances, he claimed to act out for the subsequent exposure to the maltreatment in violent wards. As he starts to endure harsher treatment, however, Beer's seems to truly recognize the extent of the archaic and inhumane practices that happen to patients who struggle the most. This seems to slowly but surely bring him out of the role of "insane patient" and into the role of "mental health advocate."

In one specific instance, after long days spent restrained in a straitjacket in a padded room, Beers refused to take his medications. Doctor A used a wooden peg to keep Beers' mouth open while using a rubber tube to force feed him medications. Before the act was done Beers stated, "Put that medicine into me in any way you think best. But that time will come when you'll wish you hadn't. When that time does come it won't be easy to prove that you had the right to force a patient to take medicine." (Beers, 1908, p.139). Beers (1908) went on to talk about how "coming from an insane man, this was rather straight talk" and that this made the doctor "noticeably discontented." (p.139). Also, worth mentioning is that throughout the whole

experience, Beers' letters to his brother George were not sent out. When his brother did hear of the abuse Beers endured, he was transferred to the Connecticut hospital for the Insane (Dain, 1980p.35).

Power is an important concept to be recognized at this point. Not only was there power being asserted on Beers by the hospital attendees but also Beers realizing the power that he held within himself. Finn (2016) discusses how power can be both viewed as negative (such as domination), but that it can be seen in those who are subjected to the dominance recognize their "power from within" to galvanize change (p.36). Beers is subjected to the dominance of the asylum staff by both the abuses he endures as well as the hinderance of his letters being sent out to his brother. Conversely, he is beginning to recognize that he himself has power when admonishing the doctor for the inhumane treatment he is made to endure. Beers seems to realize that there is no rational reason for such harsh treatment and that he must be the one to expose what is happening in the asylums. Beers would go on to intentionally being moved to the violent ward at Connecticut hospital for the Insane as well, so he could document wrong doings at other hospitals.

At the Connecticut hospital for the Insane, Beers at first seemed to enjoy the hospital and respected the staff. He especially spoke of his appreciation for Doctor Thomas. Eventually, however, Beers barricaded himself and his roommate in his room with threats to staff who entered (Dain, 1980). He was then taken to the violent ward claiming to the doctor that "I raised this rumpus to make you transfer me to the violent ward. What I want you to do now is to show me the worst you've got" (Beers,1908, p. 151). Beers was left in extensive isolation without shoes, placed in a cold room without a bed in his underwear, and was under fed (Dain, 1980).

In this most horrendous section of the violent ward, known as the “bull pen,” Beers began to realize the power dynamic of the “brute-force” type staff that inflicted abuse and neglect upon patients (Beers, 1908, p.153). Dain (1980) discusses the nature of the hospital staff being completely “untrained, uneducated, void of good intentions, making them subsequently lazy, neglectful, and likely to act with brutality” (Dain, 1980p.40). Beers elaborates on the nature of the counterintuitive abuse inflicted on those around him;

“The violent, noisy, and troublesome patient is abused because he is violent, noisy and troublesome. The patient too weak physically or mentally to attend to his own wants is frequently abused because of the very helplessness which makes it necessary for the attendants to wait upon him” (Beer, 1908, p.169)

He continued to talk about the tremendous amount of assaults he witnessed in the violent ward on men whom he considered “mental and physical wrecks” for merely swearing at guards who “swear like pirates themselves” (Dain, 1980, p.201). Beers also brings attention to the fact that these brutal beatings definitely shortened the lives of the patients and that is a “polite way of saying that murder has been committed here” (Dain, 1980, 201).

Looking forward to 1971, the Sandford prison consisted of randomly selected college students assigned to be prisoners or prison guards. The guards were given freedom to operate the prison however they wanted. This resulted in the guards inflicting unnecessary physical and psychological abuse and claiming to enjoy “being powerful and [that they] had abused this power” as well as the once psychologically healthy prisoners exhibiting symptoms similar to “learned helplessness” (Zimbardo,1973, n.p.). Given limited supervision, inadequate training, and an “us versus them mentality,” there seems to be a propensity for violence. Beers realized

that these unsupervised and incompetent asylum attendees were not only neglecting the needs of the patients, their brutality was exacerbating their conditions.

Beers was eventually transferred back to the non-violent ward after three months. He continued writing extensively on exposing asylums as well as on ideas for mental health reform. Beers wrote many letters intended to be sent out to both the president of the US as well as the Red Cross but the asylum never sent the letters out. (Dain, 1980). Specifically, Dain (1980) discusses how a recovered assessment from the asylum that was written by Dr. Thomas depicts Beers' actions as a mere a ploy to gain privileges and wrote that Beer's was merely "expansive, mischievous, boastful, incoherent, irritable, and very active" (Dain, 1980, p.44). Beer's was able to get in contact, however, with a lawyer friend named Paul McQuaid who informed him that hospital staff who went beyond force to restrain a client would be guilty of assault and the interception of his mail was a violation of federal statute (Dain, 1980).

Holding on to Beers' letters and belittling his efforts to articulate what he felt was wrong with the asylum is an example of containment and control. Zinn (1990) discusses how "containment and controlling" of subjugated groups of people has been historically valued by those in power over (p. 51). Though the doctors undermined Beers as "expansive and mischievous," one could speculate that they knew he was a viable threat to both their facility and their creditability to the public of providing quality care to their patients. Withholding his letters and undermining his character may have temporarily contained his efforts for reform but he would soon make connections with those in power and see his vision of mental reform through.

Beers was granted to go out on an outing where he left a well written plea for mental health reform to the governor of Connecticut. Though delayed, the governor responded not only that he would visit the Hartford retreat to investigate wrong doing, but also have John W. Coe, a

close friend of the governor, would come see Beers. Though the meeting did not bring about reform of institutions that Beers hoped for, he was urged to work on reform himself once he was able to leave the hospital. The meeting also helped him realize that talking to “sane men” who would point out distortions in his thinking was good for him (Dain, 1980, p. 48). As for the visit’s direct implications to the Connecticut state hospital, it brought about the discharge of unprofessional attendants in the violent ward for “brutalization” (Dain, 1980, 49). Beers wrote to a head attendant that “insane men appreciate kind treatment and if you will make them your friends, you will find them obedient.” (Dain, 1980, p.68).

Beers left the hospital September 10th, 1903. He spent time in New York and reestablished himself in the business world by keeping contact with Hoggson Brothers throughout his illness. He obtained a job with the brothers scouting out banks that needed to be remodeled or built as well as “selling radical departure in building plans to conservative bankers” (Dain, 1980; Winters, 1969, p. 419). He desired to work on mental health reform and compile his writings while simultaneously reestablishing himself as a business man (Dain, 1980). However, taking the advice from his brother who noticed he was “elated,” he voluntarily committed himself back to the Stamford Retreat in 1905 (Dain, 1980, pg. 54). Here, he would go on to establish more concrete ideas of mental health reform as well as finishing his book, *A mind that found itself*. His friends and family urged him to stick with focuses of business instead of mental health reform when Beers came out of the hospital after a couple of weeks reminding him that “literacy impulse usually indicated the onset of excitement” and a subsequent mental health relapse (Dain, 1980, p.56). Regardless of their suggestions, Beers finished his book, continued plans for reform, and started to reach out to big names in both psychology and business to pioneer a mental health movement (Dain,1980).

The publication of his book and outlines of his mental health reform plan first went to the president of Yale university, Arthur Hadley, as well as the lawyer philanthropist, Joseph Choate. In his letter to Choate to set up a meeting to discuss reform plans, it becomes clear how his audacious, tenacious, and clever style was a big factor for his success with both publishing and enacting support for a mental health movement (Gary, 2008). He is quoted saying he felt “entitled to at least five minutes” of Choate’s time and in response to Hadley’s slight criticism of his reform plan being too comprehensive responded by saying “not until I have staggered an imagination of the highest type will I admit that I am trying to do too much” (Gary, 2008, n.p). Both men supported Beers in pursuing both publishing of his book as well as pursuit of the organization. Beers would also send a manuscript of his book to two influential people in psychology. These people were Harvard author, scholar and psychologist, William James, as well as the well-known Psychiatrist, Adolf Myer (Gary, 2008; Winters, 1969).

The manuscript was sent to William James in 1906 (Winters, 1969). Though he hadn’t had the chance to read it immediately, when he did read it a couple months after, he was riveted by Beers’ writing (Gary, 2008). James’s letter of enthusiasm towards Beers’ manuscript appears at the beginning of *A mind that found itself*. The letter was incredibly flattering and validating stating James’s “great admiration for [the book’s] style and temper” and that Beer’s had correctly illuminated “weak spots” of the mental health field’s treatment of the mentally ill as well as supplying concrete “instructiveness for doctors and attendants alike” at asylums. James also stated in regard to Beers’ concern with needing to re-write the book that he should not do it telling Beers that “you can hardly improve your book” (Beers, 1908, p. vii-viii). Adolf Meyer, on the other hand, had some constructive criticism for Beers’ idea of reform that would play a big

role in revisions for the book itself as well as for Beers' future plans for Mental Health Reform (Winters, 1969).

Adolf Meyer was the director of the pathological institute in New York in 1906. His leadership focused on the shift of the attitudes of medical professionals on mental illness. Specifically, he advocated for the integration of both hospitals and the mental health patient's community to increase the quality of their care. He also stressed the important of preventive measures for psychiatrist as a civic duty. Beers approached Meyer in September of 1907 with a draft of *A mind that found itself* (Winters, 1969). In a review of Beers' book, Meyer expresses how a tragic story of someone struggling with mental illness has resulted in a "boon" for Beers' illness and experience in asylums has "matured, if not created, a man for a cause" (Meyer, 1908, p.611). Meyer went on to talk about how the book has the power to arouse "sentiment among all" and how Beers supplies ideas of "concrete action to improve a system too readily considered good enough as it is" (Meyer, 1908, p.612). Meyer does warn readers about the negative and even counterproductive affects that such serious and brutal accounts of mental health have by undermining the good that does exist within the mental health system. Specifically, he talks about how content of the book "might inflame the imagination of the suspicious public and foster indiscriminate distrust of the hospitals as they exist" (Meyer, 1908, p.613).

Before publishing the book, Meyer strongly recommended that Beers modify the last section of the book titled *The remedy*. In this section, prior to Meyer's suggestions, Beers advocated for "militant schemes of investigation" as well as "drastic legislative reforms". Meyer expressed that the likely reasons for the deficits and brutality in the asylums were more than likely due to a "lack of funds, inadequate equipment and understaffing." He, therefore, felt that the greatest emphasis in mental health should be more geared towards "mental hygiene" which

would focus on prevention and mental health education for both mental health workers as well as the public instead of a specific aim to improving the conditions in the mental hospitals (Winters, 1969, p. 416-417). Beers, deferentially open to critique of Meyer's professional advice, re-wrote *The remedy* section of the book which included ideas of a mental hygiene organization that would be a "permanent agency of reform and education" that would aid in the prevention of mental health disorders (Beers, 1908, 2018).

As one may have gathered, regardless of Beers' diversities, he was a white man and had connection to those in power. One could speculate that this made him relatable to other white men in power and subsequently taken seriously. Though he had been undermined as a mental health patient and was told to stick to business by his family and friends, he may have been completely devoid of any encouragement or support if he had been of color or poor. Though Beers would continue to face some adversity, one could speculate that his privilege played a role in the success of his book as well as his hygiene movement.

A mind that found itself was published on March 16th of 1908. Beers, only 32 years old, had gone from a man practically debilitated by mental illness to a renowned author of his own book that would lay the foundation of a mental health reform movement. In terms of starting a mental hygiene movement, it becomes apparent how much Meyer's influence has on Beers in making his vision realistic and pragmatic. Though financial concerns surface as a problem throughout the journey of the hygiene movement, the coordination between Beers' skills as a business man and the influence of Meyer helped create Beers' first mental health movement, The Connecticut Society for Mental Hygiene.

Beers began to gather followers as well as financial support to start his movement. Men such as William James, Russel Chittenden, Ansen Phepps, as well as Adolph Meyer had all

agreed to be a part of the mental hygiene movement. Winters (1969) discusses how Beers' experience with working with the Hoggson brothers aided in his ability to attain financial support for the movement. Winters also talks about how Beers' "eagerness and good spirits, his capacity to laugh at himself, his receptiveness to the ideas of others, and his evident sincerity won him many friends" (p.420). Still, Beers was unable to gain enough financial support to create the national movement that he had envisioned. There was also backlash from the book in Time magazine, misrepresenting Beers as "sane in an insane asylum" as well as wanting an "investigation" to verify that Beers' story was true. In light of these factors, Meyer made the pragmatic suggestion for Beers to create a local mental hygiene movement which would be known as Connecticut Society for Mental Hygiene. This would cost less money and let the backlash of the media dissipate before continuing forth with a national movement. It would also function as a guinea pig to gauge what tactics would work for a national movement. (Winters, 1969).

The first meeting of The Connecticut Society for Mental Hygiene was held on May 6th, 1908. Its goal was to: 1) improve care and treatment of people in mental hospitals; 2) educate both public and medical staff on the validity of mental health recovery; 3) Prevent both mental disability and hospitalization (Gray, 2008). Meyer, however, had reservations with the direction of where Beers' energy and efforts were going. Meyer specifically had qualms with Beers' active campaigning. Meyer felt that if the efforts were more focused on the quality of the reform movement by delineating specific plans and less on eliciting financial support, more money would ultimately be generated for the movement. He also disagreed with Beers' idea of the movement being a laymen's movement and felt that the hospital staff should be fully engaged with the movement instead of passively cooperating. This way, the movement would take the

blaming nature off of the staff as well as utilizing the insider insight of the staff by cooperation. Though Beers felt it was counterintuitive to have members reforming a system that they had already created, he showed deference to Meyer's suggestions (Winters, 1969). One could speculate that Meyer's redirection of Beers to focus on a smaller scale movement, develop more concrete reform plans, and to involve hospital staff were key reasons for the hygiene movement's success and the reason that it could expand nationally. Meyer's redirection of Beers' efforts would be a continuing process that lead to the further shaping of the Hygiene movement. It would also cause some discontentment for Meyer's perception of Beers.

A mind that found itself, as well as Beers' likeable personality, were two big driving forces in the support that Beers was able to cultivate. His book had made such an impression on Henny Phipps, a wealthy philanthropist, that Phipps donated 50,000 dollars to the movement as well as motivating him to create the first inpatient hospital for the mentally ill that was attached to Johns Hopkins hospital (Gray, 2008). Though Beers had cultivated a great amount of support, financial issues were still a persistent problem. He claimed that "with help of friends and relatives, [he] virtually financed *Connecticut society for mental hygiene*" as well as the finances to publish his book (Winters, 2008). This pressure seemed to drive Beers back to the idea of eliciting support over furthering to develop plans for reform (Winters, 1969). At this point Meyer lacked confidence in Beers' ability to focus on plans for the movement and threatened to leave but was urged by Beers to stay and "keep a steady hand" in the mental health hygiene principles that Meyer had laid out (Winters, 1969, p.425). Meyer decided not to leave, and the long-awaited National committee was financed enough to have its first meeting (winters, 1969)

The National committee for mental hygiene held its first meeting on February 19th, 1909. As the Chairman, Meyer took the lead on specific plans for cooperative efforts with asylum staff

to address difficulties, aftercare and prevention for mental health, as well as educational campaigns. The plan was set for a \$1,000,000 endorsement that would be asked for from John D. Rockefeller. Beers, on the other hand, was sending his books to philanthropists he did not know in the hopes of gaining more support. Meyer criticized these actions as being unwise when the organization was low on money. He also criticized Beers' in his persistent in eliciting support instead of working on reform plans. Meyer specifically stated to Beers that "it is not the number of people you get into the thralls of membership dues that is going to count, but getting some work underway" (Winters, 1969, p.429).

Meyer also asserted that a primary focus on after care was the most pragmatic approach for the movement stating that "the best standard and starting point is working with those actually recovering and getting ready to adjust themselves again" (Winters, 1969, p.433). Meyer felt that direct work with educating and preparing the community for the rehabilitation of people with mental illness would not only be a useful task for the hygiene movement but could lay the foundation for legislative measures in the future. Meyer also felt that after care should focus more on the incorporation of medical staff taking the lead and less on a sympathy's inhuman treatments of asylum patients and the subsequent demonization of hospital staff.

The idea of aftercare was considered "of prime importance" to Beers but he was still obstinate to the idea of collaborating with hospital staff with implementations of aftercare in hospitals (Winters, 1969, p.129). It seems that the Beers' treatment had demonized the system that he had once been subjected to and made it hard to see how after care could help what he perceived as a broken system. Meyer, however, stressed the weight of restructuring the system that was already in place over the mere sympathy raising from literacy efforts. He felt that implementing after care in a hospital would subsequently result in reports of how well the

hospital was being run, would be the strongest approach for both funding and mental hygiene (Winters, 1969). Beers, influenced again by Meyer, began to appreciate the importance of aftercare and “came to share completely Meyer’s view of its fundamental importance” (Winters, 1969, p.435)

Emerging himself fully into after care, Beers brought hospital staff representatives into the *Connecticut society* as well as creating a book advocating for both after care and the importance of hospital workers taking the lead in mental hygiene reform. The movement as a whole was reoriented towards after care and prevention and away from legislative activity. Though one could speculate that Beers’ new direction for the mental hygiene would appease Meyer, Meyer felt that Beers’ plans were unrealistic and also felt that he was being undermined as a “mere psychiatrist” who’s sense of business and organization was also not respected (Winters, 1969, p.440). Meyer resigned from *National committee* in 1910.

Though Meyer seemed to be a bit harsh on Beers overall, one could speculate that his influence on both Beers and the hygiene movement greatly contributed to the movement’s success. Though the support from men like William James (as well as Adolf Meyer) helped Beers gain the confidence to publish *A mind that found itself*, Meyer directing Beers to focus away from investigation and legislative reform and more on prevention and after care, led to the eventual endowment of the 1,000,000 dollars from Rockefeller (Cohen, 1983). Though Meyer left the movement, the hygiene movement continued on the platform of prevention and aftercare.

In 1913, Beers founded the first outpatient mental health clinic in the United States (Brown, 2014). By the early 1920’s, the movement had expanded from advocacy for just “insanity” to all forms of maladjustment not only in asylums but also in courts, prisons, as well as the work place (Cohen, 1983, p.126). By 1930, Beers organized the International Congress for

Mental Hygiene. This meeting was attended by representatives from 53 counties and led to the development of the International Committee of Mental Hygiene (Parry, 2010). Though Beers passed away in 1943, his hygiene movement (now called Mental Health America) had direct influence on the deinstitutionalization movement (Parry,2010; Bassuk & Gerson, 1978; Mental Health America, 2018). Mental Health America joined and supported the Commission on Mental Illness and Mental Health (CMIMH). The CMIMH evaluated services for mentally ill and proposed an approach to mental health reform to the president that would optimize prevention and after care as well as achieving a 50% reduction of mental health patients in asylums (Bassuk & Gerson, 1978; Mental Health America, 2018). This led to the development of the Community Mental Health Center's act of 1963 which Mental Health America enacted and had signed by President Kennedy (Mental Health America, 2018). This act authorized construction grants for community mental health centers and greatly reduced the mental health population in asylums (Bassuk & Gerson, 1978; Mental Health America, 2018). Therefore, Beers' movement was a powerful influence towards deinstitutionalization.

As stated before, Beers passed away in 1943. Though he had married a woman named Clara Loise Jepson in 1912, they decided not to have children due to the concern that the children would be passed down genetic traits for mental illness (Parry, 2010). Throughout the movement, Beers dealt with financial struggles (Winters, 1969; Quinter 1989). Though launching the American Foundation for Mental Hygiene in 1928 helped him accumulate some funds for the movement, he became overwhelmed and depressed by fundraising and then committed himself to the Butler Hospital in Providence Rhode Island (Quinter 1989; Parry,2010). He died there on July 9th, 1943 of bronchopneumonia and cerebral thrombosis (Winters, 1969).

Beers evolution from an abused man suffering from mental illness to one of the most prolific mental health advocates is miraculous at the very least. His ability to persevere through the countless abuses he endured as well as intentional misbehaving to document the wrong doing of asylum staff make him a mental health martyr. He was able to objectively observe both his experience and the experiences of those around him to write a book that would educate the public of why reform was needed. Though Beers many hardships have been articulated (mental illness, abuse, and financial issues), he was an educated and decently well-off white man who was thus relatable to those in power from who he could elicit support. Nevertheless, his charm, wit, business experience, and persistence were considerable factors in his success. Direction from Meyer did not only seem to be a significant factor for the movement's success, but it help shape both the mission of Beers as well as the movement itself. Thanks to the movement's influence, there are significantly less people in institutions as well as an overarching emphasis on mental health recovery and prevention in today's society.

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Appendix L: Advanced Practice Final

Abstract

The paper discussed the Montana state budget cuts of 2018 where group home stay for the population of people with Severely Disabling Mental Illnesses (SDMIs) on Medicaid would be only get an initial 120 days in the group home and need to reapply for 90 day extensions via prior authorizations (PAs) and continued stay reviews (CSRs). The paper then discusses the issues with the insurance auditing company (Magellan) not following their own guidelines, the history of managed care, issues of parity between the reimbursement of mental and physical health, high cost of mental health care exacerbated by emergent services, as well as the stigma bestowed upon the Medicaid and SDMI population. The paper proposed a client led research team to formatively evaluate the current CSR process by having both the client team members and participants generate ideas to make the CSR process more accommodating for client's who need to continue outpatient care.

Adjusting the Continued Group Home Stay

In November 2017, Montana state cut approximately 120.7 million to state funds in general with the Department of Human Health and Services (DPHHS) taking on some of the worst cuts. Specifically effecting the population of people with severely disabling mental illnesses (SDMI), a cut of approximately 18 million was cut to targeted case management was made (Montana budget policy center, 2018). This led to the reimbursement rate for 15 minutes (one unit) of case management to decrease from \$18.22 to \$7.03 (roughly 61%). The CBPRS reimbursement rate for one unit had been reduced from \$7.03 to \$6.82 due to a 3% cut to all Montana Medicaid health services. All of these cuts were in effect by January 2018 and resulted in agency wage reductions anywhere from two-three dollars an hour at Winds of Change (WOC) mental health. This ultimately led to many staff quitting their jobs and even leaving the field of social work (A. Mothka, personal communication, December 5th, 2018).

On March 1, 2018, representatives of WOC attended a second hearing for more proposed Medicaid cuts. The state also proposed circumscribing hours of Community Based Psychiatric Rehabilitation and Support Staff (CBPRS) to two hours a day and case management to two hours a month. The legislation would also propose that length of group home stay not be left to the discretion of the agencies who run the group home, but instead allot clients with SDMI an initial 120 days in the group home and then reapply for 90 day extensions. At the hearing, one of the biggest criticisms from providers was that, “the State had not reached out to them about the cuts during the process” (Drake, 2018, para. 7). Representatives discussed how all of the cuts were due to the great amount of money that had been used to fight fires. Social work representatives at the hearing advocated for the concept of possibility by asserting the relevance of involving social workers in decisions to where and how Medicaid cuts should be distributed. One woman from

substance use treatment center called Rimrock stated, “We understand that cuts have to be made, but if you involve social workers, we will not only be able to help you make cuts that retain quality of care, they will save the State money in the long run.” Protestors advocated specifically for education to the public of how services work. One mental representative talked about the counterintuitive nature of a 120-day group home stay stating how the short stay is tantamount to, “being prescribed two weeks’ worth of antibiotics, but only being reimbursed for two days.”

Though the hearing did result in dropping the proposed two hour a month cut to case management, the CBPRS two hour a day cut and the 120/90 day cut to group home stay went through. The Addictive and Mental Health Division (AMDD) of DPHHS hired a third party insurance company, known as Magellan, to be in charge of approving or denying prior-authorization forms for people entering therapeutic group homes as well as the continued stay reviews (CSR) for clients requesting continued care. As of May 1, 2018, the CSR process was put in place. Magellan required that agencies with existing clients that were currently receiving therapeutic group home care have half of the CSRs in by May 18, 2018 and the other half in by May 28, 2018 (Addictive and Mental Disorder Division, 2018). Magellan guidelines stated that if CSR’s “do not appear to meet medical necessity criteria,” then the client would be denied with a 60 day grace period starting from the end of their previously allotted time which circumscribed the length of time is a form of managed care (AMDD, 2018, p. 59).

Literature Review

Managed care is an approach to health care that attempts to utilize resources effectively while cutting cost, triage patients into appropriate care, facilitate access to services and ensure that quality services are being provided (Merrick, 2006; National Alliance on Mental Illness, 2011). The five main subsets of managed care include: utilization and clinical management;

provider network management; quality assurance; rates and claims; and customer service, appeals and grievances. Utilization and clinical management implies that a third party monitors services and ensures that clients who are receiving services are actually utilizing services and are only being authorized for services if the client meets medical necessity criteria (NAMI, 2011). This is reflected in the Magellan guidelines for group home stay in the statement that, “documentation should support and provide evidence of all aspects of the Medical Necessity Criteria, including (but not limited to) need for intensive intervention at requested level of care and evidence that patient can be reasonably expected to improve with treatment” (AMDD, 2018, p.60). Though managed care is intended to benefit clients in the health care system, research indicates that managed care has adverse consequences for the wellbeing of clients.

Perla (2017) found in a survey of mental health care providers that managed care did not improve treatment over 50% of the time, treatment has been conducted differently when managed care is implemented over 50% of the time, and majority of the respondents believe the alterations have an impact on clients at least somewhat negatively (via quality of care, access to treatment, and effect on partner-provider relationship), and the majority of respondents were dissatisfied with managed care while simultaneously being satisfied with their jobs. The National Alliance on Mental Illness (NAMI) conducted a report in 1997 that addressed how managed care had tragic results for people with mental health issues. Specifically, the report discussed the use of out of date treatment guidelines (such as suicide attempts not qualifying as a medical emergency), as well as illuminating how managed health care practices are economically counterintuitive by neglecting to facilitate a client’s ability to become and stay as well as possible. Yet, more than twenty years later in 2019, third party insurance companies are still using out of date treatment guidelines and even denying client’s group home level care not

based off of medical necessity. For example, a client at WOC was denied from group home services based of being treated with benzodiazepines with the diagnosis of posttraumatic stress disorder (PTSD). The Magellan doctor cited a 1995 article that claimed that the medication was unethical for treating PTSD. Though the WOC medication provider countered this argument with a research article from 2017 that claimed Benzodiazepines were an acceptable treatment for PTSD, the doctor disregarded the information and stood by the position that our group home was unsuitable due to malpractice (K. Jennings, personal communication, September 17th, 2018). WOC recently had another client denied based on the reasoning that, “managing suicidal ideation without 24 hour staff supervision was an unrealistic goal for someone with borderline personality disorder.” In order to understand the continuation of oppression that has arisen from managed care, one must look at deficits in parity acts, lack of accountability of insurance agencies, as well as the stigma of mental health and people on Medicaid.

Originally, insurances companies did not want to cover mental health, but realized there was economic gain in the context of employers covering mental health due to increased productivity and retention of employee. However, due to an enormous amount of spending in mental health insurance, the insurance companies introduced managed care (Cohn, 2015). Managed care has its roots in the federal Health Maintenance Organization Act of 1973. The act set to balance quality health care with efforts to reduce cost of care, as well as expand the amount of managed health care systems via health maintenance organizations (HMOs). With these organizations, clients pay a pre-determined fee in exchange for a range of services (DeLeon & VandenBos 1991). Expanding in the 1990s, an emphasis was put on a market driven system that intended to improve quality of services while decreasing cost. By 1998, out of 180 million US residence with mental health insurance, 142 million were governed by managed care

(Kearny, 2017). However, an issue arose with mental health discrepancies between managed care for physical health and mental health. This brought about the concept of parity.

In the early 1990s, Senators Peter Domenici and Paul Wellstone began advocating for federal parity, which would subvert the differences between insurance coverages for physical and mental health. This led to the Mental Health Parity act of 1996, which required that the same lifetime and annual money restrictions on mental health be tantamount to that of physical health care. However, this law did not address the discrepancies in co-pays, as well as inpatient days/outpatient visits between mental and physical health care. In July 2008, the Mental Health Parity and Addiction Equity Act addressed the difference in paying for outpatient mental health services versus other outpatient services and the Wellstone-Domenici law in 2010 addressed the inpatient days/outpatient visits issue. The law also included a standard that people utilizing services must be in need due to a medical necessity (Barry Goldman, & Huskamp, 2016; Kearny, 2017). In 2013, a final rule was implemented that also removed the statement that treatment needed to be “clinically appropriate standards of care” due to it being “confusing, unnecessary, and subject to potential abuse” (Barry Goldman, & huskamp, 2016; Kearny, 2017, p. n.a.). The 2013 finale rule also ensured that parity would be consistent for people utilizing intermediate levels of mental health (such as partial hospitalization and intensive outpatient). In 2014, the Affordable Care Act (ACA) expanded the Wellstone-Domenici law expanded Medicaid eligibility in certain states. The ACA also required insurance providers to cover mental health instead of giving them the option to cover it (Scarborough, 2018). However, the states that had these expansions had to have both Medicaid managed care plans, as well as a fee for service. The intent was to have parity across all Medicaid health care plans (Barry Goldman, & Huskamp, 2016; Kearny, 2017). Lastly, an act called the Cures Act was brought about in 2016 to further

address parity. The act facilitated parity with such acts as allocating five million dollars to assertive community treatment for severe mental illnesses (such as schizophrenia), grants for early intervention of psychosis, as well as efforts to increase the access to physical health care providers (Scarborough, 2018).

Unfortunately, regardless of the multiple laws enacted to facilitate parity, parity for mental health has not been maintained as it was intended to be. Though attacks on the affordable care act by Donald Trump and the Republican cabinet pose a threat to parity, major issues such as the opioid epidemic have galvanized and facilitated support for mental health reform in Congress (Scarborough, 2018). What seems to be a greater threat to mental health parity is the lack of accountability put on insurance companies.

Though many loopholes were accounted for in the updates of the laws (such as discrepancies in co-pays as well as inpatient days/outpatient visits), difference in state laws led to inconsistencies with federal parity by insurance companies (Barry Goldman, & Huskamp, 2016; Kearny, 2017; Scarborough, 2018). For example, differences with prior authorization requirements for mental health were different than that of physical health more than half of the time (Barry Goldman, & Huskamp, 2016; Kearny, 2017). Insurance companies will also ignore recommended treatment. A survey done by NAMI found that 29% of insurance refused to approve recommended health treatment, which is more than twice of the respondents for physical health treatments (Cohn, 2015). The issue seems to be that there is no accountability for the insurance companies to follow parity guidelines and therefore they find subtle ways to undercut parity and arbitrarily denying claims (Scarborough, 2018). In order to work towards resolving these issues, it is important to understand why insurance companies are disproportionately denying coverage to people with mental illnesses over physical illnesses. This issue appears to be

facilitated by the fact that mental health care is more expensive than physical health care, as well as issues of stigma.

Not only does mental health care cost more than physical healthcare, the cost for mental health care has increased exponentially. Between 2006 and 2009, mental health care went from costing 57 billion to over 150 billion (Scarborough, 2018). With this information, it is understandable that efforts have been made to reduce spending in mental health care. However, much of the spending can be attributed to emergency services instead of preventative and outpatient care. Between 1955 and 1997, spending in mental health increased by 30% due to the over utilization of emergency services (Alakeson, Pande, & Ludwig, 2010). Though the Deinstitutionalization Act of 1963 was put into place to help people with mental health issues integrate into the community, community mental health centers were never properly funded nor were they fully resourced to facilitate the needs of the population suffering from mental illness. Increase of managed care has resulted in poorer access to mental health services, which in turn has led to a greater occurrence of mental health crisis and subsequent emergency care (Alakeson, Pande, & Ludwig, 2010). Along with the costly nature of the current mental health system, people with mental illness are highly stigmatized.

One could speculate that part of the reason people are obstinate to funding outpatient mental health is the desire to be distant from people suffering from mental health issues. Parcepe and Cabassa (2013) conducted a meta-analysis on stigma in the United States and found that on average, adults desiring a greater distance from people with schizophrenia, depression, and alcohol dependence versus people with “normal” troubles (p.390). Desire for distance, as well as perception of violence towards people with mental illness were greater for younger (18-24) white men of high socio-economic status. Perceptions of autonomy of people

with mental illness were also stigmatized. For example, adults with schizophrenia were perceived as less competent to make treatment related and financial decisions (even more so than people with depression). Though positive contact with someone with schizophrenia, depression, or an alcohol disorder reduced the desire of people to be distant from the population, the populations being at a lower income level resulted in the perception that the population, “should be punished for violent behavior” (390). When looking at Medicaid recipients specifically, the population is often perceived as lazy, intentionally unemployed, undeserving of help, and dependent of help (Martinez-Hume et al., 2016).

In terms of receiving mental health care, Parcepe and Cabassa (2013) found that informal sources of care such as support from family, friends, or a spiritual guide were more preferred for people with depression or experiencing a “nervous breakdown” (p. 392). However, attitudes regarding mental health care have shifted more toward “formal” mental health treatments (especially for people with severe mental illness; p.392). Unfortunately, with the current mental health system, formal mental health care comes with many obstacles to receive and continue to receive care through Medicaid. Perceptions of compromised autonomy, being an underserving population, and costing the US citizen taxpayers a substantial amount of money appear to result in a great deal of reluctance for insurance companies to reimbursement outpatient care for the SDMI population. Ironically, the extreme cost of health care and helplessness of clients is greatly facilitated by limited access to and continuation of outpatient care. Concerning the CSR process for group home stay in particular, clients are not given ample time to cultivate the skills necessary to live independently, the list for Section 8 housing is anywhere from three to five years long, clients are severely discriminated against by independent housing agencies (due to factors such as rental history, credit score, and unfair felony charges),

and likely discharged into homelessness or into maladaptive living situations (such as living with abusive family members or in houses that facilitate drug use). The current study will explore how the CSR process has affected client's perception of recovery and wellbeing through their own words. With both this information, as well as asking the participants directly what they would like changed about the current CSR process, the study will formatively evaluate the current CSR progress to be more accommodating for client's who need to continue outpatient care. The goal of the study is that a client led formative evaluation will result in a CSR program that better facilitates recovery and well-being, decreases ER visits/homelessness, and directly challenges the stigma of SDMI Medicaid clients mentioned above.

Methods

Organizational Context, Type of Program Evaluation, and Hypothesis

Winds of Change is a for profit company that facilitates the recovery of up to 44 group home clients with SDMI diagnoses. The current CSR program allots clients into the group home with a prior authorization that grants a stay of 120 days. If a client and their clinical team feel that it is necessary for the client to stay longer, a CSR must be completed to grant a 90-day extension. The goal of this study is to conduct a formative evaluation on the current CSR process. As discussed in Royse, Thyer, and Padgett (2016), a formative evaluation is used to form an existing program by providing recommendations to make the program more effective. Though doing away with the CSR processes altogether may be ideal for a client's recovery and well-being, formatively evaluating the process is more likely to be "not as threatening" and "better received" by the other parties (p.126). As discussed earlier, the study hypothesis that the insurance companies have been obstinate to funding outpatient care due to perceptions of SDMI Medicaid clients being unable to make their own treatment decisions, lazy, intentionally

unemployed, undeserving of help, and dependent of help (Martinez-Hume et. al., 2016, Parcepcpe & Cabassa 2013). By challenging all of these assumptions with a client lead study that discusses both the impacts on wellbeing and perception of recovery, as well as meaningful critiques of the current CSR process, the research team predicts that a greater understanding of how outpatient managed care can better facilitate client recovery will be cultivated and subsequently changes in the processes will lead to stable mental health recovery in independent living.

Sample

Seeing as the experiment is interested in the effects of the current CSR process on client's well-being and recovery, a three Purposeful Samples will be conducted. With Purposeful samples, the goal is to have participants who have "certain characteristics" (p.214). The samples will consist of current clients at Winds of Change Mental Health that fall under one of the three categories:

- 1) Were group home clients before the CSR processes was in place.
- 2) Were group clients before the CSR process, as well as during the CSR process.
- 3) Have only been group home clients with the CSR process in place.

Sampling the three different types of clients will ensure that the drawbacks (as well as potential advantages) of the current CSR process are documented from the words of the clients. Though the first group has not experienced the CSR process, they may be able to speak to the possible advantages, as well as disadvantages of not having the added pressure of living independently. Each group will ideally consist of at least 10 clients resulting in a cumulative sample of 30 participants who will fill out consent forms as well as HIPPA compliance if focus groups are used. The forms will be based of off generic consent and HIPPA compliance forms that will be modified by the Critical PAR team. The sample criteria will ensure that three groups

of participants will be representative of the SDMI population by selecting a number of clients with various diagnoses. The samples will, therefore, encompass people with psychotic disorders, trauma disorders, mood disorders, and personality disorders. Though the vast majority of the SDMI population in the WOC group home program are currently diagnosed with multiple disorders, each sample of ten will mindfully select an even balance of clients who collectively represent all of the SDMI diagnoses without over representing one population (such as borderline personality disorder). This is to ensure that consumers of researches do not write of research results as biased by being overpopulated by a certain type of client. Any clients who are unable to be selected a participant will be invited to assist the Critical PAR team with other tasks (such as printing out lists of questions) so they are not excluded from the processes. Information on diagnosis, race, gender, age, group home admission/discharge date, and CSR dates will be documented and stored for possible quantitative information.

Design

The study will take on a quasi-experiment designed given that participants will be unable to be randomly assigned into the various three groups. In order to accurately collect qualitative data for how clients are affected by the current CSR process, the most appropriate approach to uncovering problems and working towards effective solutions would be to invite clients to be the driving force in conducting the study. Therefore, the study will take on an emerging design and incorporate Critical Participatory Action Research (Critical-PAR). Critical PAR is an epistemology that acquires research data by incorporating the dialectical critical participation of the general public (especially those who have been the most marginalized; Sandwick, Fine, Greene, Stoudt, Torre, & Patel, 2018; Torre, Fine, Stoudt, & Fox, 2012). As stated above, stigma of SDMI Medicaid clients appears to greatly contribute to insurance companies denying clients

continued stays at the group home. Critical PAR challenges stigmatizing themes by utilizing a team of mostly clients. This team will be bringing to light the true stories of group home client's and their desire for recovery even in the face of a broken system. In this way, by using the voices of clients, the study will illuminate both the capability that clients have to advocate for themselves as well as their active roles in their recovery. The other advantage to using Critical PAR is its effect on Impact Validity in which it has an ability to have "scholarship transform into action, facilitating the movement of research findings into policy and organizational efforts" (Sandwick, Fine, Greene, Stoudt, Torre, & Patel, 2018, p.480). As for design notation, the experiment is only measuring qualitative data in regard to coded themes wellbeing and perception of recovery. The design will gather qualitative data through interviews (with either single subjects or focus groups) for each of the three groups concurrently as opposed to sequentially (Royse, Thyer, & Padgett, 2016).

Data Collection and Instrumentation Measures

A series of semi-structured interview questions will be used by the research team while interviewing the participants. These open-ended questions will be developed by a team of five clients (at least three clients who have experienced the CSR process and two who have provided official or unofficial peer support to those who deal with the CSR process), as well as the group home therapist and the clinical case manager in charge of writing the CSRs. The set questions will be generated by the team to measure and compare the three groups past and present wellbeing, perception of recovery progress with their time in the group home, as well as suggestions for how the process could be improved (such as longer stays or face-to-face interviews with the insurance agency). In order to generate these questions, the team will be prompted to think about their experience of how they themselves or clients around them have been impacted.

Specifically, clients in the action team who have been subjected to the CSR program will be prompted to consider what questions would be relevant knowing how the CSR process effected their wellbeing and perception of recovery. The interviewing team will also have the freedom to ask open-ended follow up questions to pick up any unaccounted missing useful factors. All three groups will be asked the same set of questions, but differences may arise from follow up questions in the interview process. Whether or not the interviews are conducted in focus groups or via single subjects will be decided by the research team (Royse, Thyer, & Padgett, 2016). Though there may be HIPPA and multiple relationships with using focus groups, the sample sizes are ideal for utilizing this method of data collection. Focus groups should be 6-12 people to be representative of a population without creating a large environment where clients don't feel comfortable sharing experience (Onwuegbuzie, 2018). Utilizing Focus groups would have the potential benefits of promoting participants to feel "empowered or raise their level of consciousness about themselves or the topic (Walker, 2014, slide 2). Advantages, disadvantages, and potential biases of either approach will be discussed by the team until there is consensus on which approach to take.

Data Analysis

Data will be analyzed using a Constant Comparative Analysis design. The team will find themes of the research topic in the participants words, compares the themes brought up by the participants, will have inter-relater reliability between the members of the research team, agreement of how themes are coded between the research team, as well as the results written in narrative form to correctly portray data gathered from participants (Lincoln and Guba, 1985; Nicotera, 2008). Coded themes of wellbeing and perception of recovery for clients who were group home clients before the CSR processes was in place, were group clients before the CSR

process as well as during the CSR process, and clients who have only been group home clients with the CSR process in place will be entered into Dedoose software to analyze similarities and difference that emerge between the three groups to provide evidence of the effectiveness or lack of effectiveness of the CSR process. This data will help inform the team of formative critiques of the current CSR process. The team will also code and analyze common themes of CSR improvement suggestions from participants to further narrow down pragmatic solutions for formatively evaluating the CSR process (such as greater length of extensions and televised meetings with the insurance agency). These themes will be accurately reflected by actual quotes of client's who are part of the Critical PAR team as well as the participants.

Financial Pragmatics and Ethical Issues

Financing the project and incentivizing client participation will not be an issue. Staff conducting research will bill CBPRS or therapy with objectives in a client's treatment plan that indicate the therapeutic benefits of conducting or participating in research (assuming a client feels that participation would be beneficial to their recovery). An example of an objective may be: "Client will participate in critical action research to advocate for social justice." Clients that are part of the Critical PAR team will be payed via the kite program that pays client's an hourly rate to work for the company. Clients who participate in the research will be incentivized by receiving all four group credits for the week. Unfortunately, this research project may come with some ethical issues. The team will need to be mindful of issues with HIPPA or multiple relationships predominantly with clients on my research team and clients they will be interviewing. As discussed in Royse, Thyer, & Padget (2016) in the fourth guideline, anonymity is an important aspect of research that needs to be upheld. Though responses can be coded and not contain identifying information, anonymity may be compromised by having a critical PAR

research team with other clients. Many of the clients have lived together, consider each other friends, or have had significant conflict with each other. Though clients will have signed confidentiality waivers, they will continue to go on having different relationships with their peers after the research study has ended that may be potentially compromised. This may be mitigated by having an open discussion with the critical PAR research team to brainstorm ways to try to avoid HIPPA and multiple relationship issues. For example, the team may decide to avoid the focus group design and have single subject interviews with only the therapist and clinical case manager. This way, the team would still design the questions and analyze the data, but identifying information tied to the data would not be available to the team.

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Appendix M: 100 years Documentary**Abstract**

The paper discusses how it was the perfect opportunity to explore decolonization. The paper discusses tuck and Jang (2012)'s idea of settler colonialism being a total appropriation of both external and internal factors for the indigenous way of life and how the 100-year documentary exemplifies this notion. The paper discusses the abusive and manipulative tactics of the government extracting oil from Navajo lands with false promises of monetary reimbursement. The paper then discusses how Elouise Cobell sued the federal government for the largest amount of money in US history. The paper then discusses how the reading, the documentary, and the ICWA class have shed light to gaining a better understanding as a social worker who will one day work with indigenous people in Montana.

100 Years Documentary

When I realized what this assignment was, I was glad to take the opportunity to learn more about decolonization. Though this has been a theme that has come up in the program before, I hadn't really gotten a chance to explore the concept in great detail in this class due to focusing more on critical participatory action research. Reading Tuck and Yang in greater detail then watching the documentary was tough for me. Though I was enraged by the way the Navajo people were lied to, I also had to stomach the fact that even as a social worker who wants to fight all forms of oppression, my entire existence is predicated off of settler colonialism. My home was a home that was taken from others. We took their land and we destroyed their way of life. Tuck and Yang (2012) discussed how settler colonialism is total appropriation of both external and internal factors of an indigenous people's way of life. Settler colonialism is taking both the resources as well as the indigenous way of life away from the native people. In doing so, the "settler becomes the law supplanting indigenous laws and epistemology." Unfortunately, the oil companies on the Navajo reservation show just how insidiously the US government has protected the subjugation of the native people.

The documentary discussed the history of the US decolonizing native people to be more and more dependent on the US government. 150 million acres of reservation land was shrunken to 55 million acres. The oil is being drilled was on Navajo land. The documentary discussed how Navajo people were receiving as little as "89 dollars to 6,000 dollars worth of oil drilled." Along with receiving an egregious lack of money, the drilling ruined their drinking water as well as the quality of their soil for growing crops. The documentary also discussed how companies were in charge of tracking how much oil they were extracting from native lands, emptying oil reservoir in the night to make it look like less oil was extracted, and the book

keeping for native money put in trusts was either unable to be tracked down or was stored in places with deplorable conditions (shacks with mulch). The loss of native trust money was recognized by the government in 1915 as fraud “beyond comprehension,” and yet, nothing was done about the issue.

The documentary then discussed how Elouise Cobell took on the US government with the largest class action lawsuit in the history of the US to rightfully claim the trust money for her people. The 14-year tenacious journey of passing what went from a settlement of 27.5 billion to 3.4 billion dollars showed how the dehumanizing nature of native people through sleazy government tactics is still practiced today. For example, the argument by the Bureau of Indian Affairs (B.I.A) of the native trusts being “different types of trust” that didn’t have to follow normal trust regulations. Another example was how the judge was fired from the case based off of “bias” as well as firing the federal “whistle blower” who uncovered missing money and unbalanced books for Native trust.

Though I am glad the lawsuit went through and it was the largest amount granted in US history, I still felt very unsettled about the end result. Though the native people had allies in their fight for their money (such as the judge and the court of appeals when the B.I.A wished to appeal the lawsuit), there was a great deal of effort to hide information and subvert efforts for the native people to rightfully claim their money. As stated in Tuck and Yang (2012), settlers become the law. However, in this case, we see that even with laws set in place, the settlers further subjugate and oppress the indigenous people with lies and manipulation and then have the audacity to deny culpability when they are called out. Between the documentary, Tuck and Yang’s illumination of how decolonization and social justice work are not synonyms, as well as knowledge from my ICWA class, I am realizing how I must continue to immerse myself in decolonizing literature to

fully be a comprehensive social worker (especially if I plan on working in Montana with the native populations). The reading and documentary made me even more aware of the extent that native people have been exploited and continue to be exploited by the government. I hope to aid in the much needed fight for their social justice.

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