SOCIAL WORK SPEAKS

12th Edition

NATIONAL ASSOCIATION OF SOCIAL WORKERS POLICY STATEMENTS

2021–2023

NASW PRESS

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National Association of Social Workers
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Title Changes from the 11th Edition

Parental Kidnapping is now Parental Abduction

School Violence is now School Safety

Sovereignty, Rights, and the Well-Being of Indigenous Peoples is now Sovereignty, Rights, and the Well-Being of Indigenous Peoples Living in the United States

Voter Participation is now Voter Rights and Voter Participation

Foreword

The policy statements in this book set the parameters for official positions of the National Association of Social Workers (NASW) on a broad range of critical public policy and professional issues. Thank you for your support.

Social Work Speaks is a comprehensive collection of policies adopted and revised by NASW's key policymaking body, the Delegate Assembly, comprised of 277 professional social workers representing NASW's diverse membership. The Delegate Assembly sets broad organizational policy, approves program priorities, and develops a collective stance on public and professional issues. Since NASW's inception in 1955, policy statement adoption has been an integral part of its governance process.

This edition of *Social Work Speaks* includes all the revised policies approved by the 2020 Delegate Assembly as well as those approved by previous assemblies. These position statements guide NASW's advocacy on local and national policy efforts.

THE PROCESS

The policy revision process for the 2020 Delegate Assembly continued to use online tools that began with the first virtual Delegate Assembly in 2008. Panels for each policy revision included delegates who volunteered to serve because of their expertise and other NASW members who were subject matter experts. The panels worked with NASW's social work staff to review policies and identify areas that needed to be updated.

After initial revisions, policy statements were made available online for public comment by NASW membership. This allowed members to make suggestions to improve the updated policies. Policy review panels met by teleconference and used online collaboration tools to incorporate member comments and finalize policy statements.

With input from members, NASW's public policy statements represent the collective thinking of thousands of experienced social work practitioners. Once policies were finalized, all delegates participated in an online voting process, resulting in the adoption of 14 revised policy statements on November 6, 2020.

These include Adolescent and Young Adult Health; Community Development; Confidentiality and Information Utilization; Crime Victim Assistance; Family Violence; Foster Care and Adoption; Hospice Care; Juvenile Justice and Delinquency Prevention; Mental Health; Parental Abduction (formerly, Parental Kidnapping); Rural Social Work; School Safety (formerly, School Violence); Sovereignty, Rights, and the Well-Being of Indigenous Peoples Living in the United States (formerly, Sovereignty, Rights, and the Well-Being of Indigenous Peoples; and Voter Rights and Voter Participation (formerly, Voter Participation).

LEGISLATIVE ACTIVITY

Before taking a position on any federal legislation, NASW staff compares the proposed legislative policy with policies published in *Social Work Speaks*. In many cases, the proposed legislation contains some provisions that support NASW's positions and some that are inconsistent with, or only partially support, the NASW recommendations. NASW weighs the potential for revising the proposed legislation, the overall value of possible policy gains, political concerns, and other factors before a decision to support the legislation is made.

LEGAL ACTION

The NASW Legal Defense Fund initiates or participates in a number of amicus curiae (friend of the court) briefs annually in precedent-setting cases that advance social policy and the social work profession. In deciding which cases to support with a brief in a federal or state court, NASW looks to its Delegate Assembly– adopted policy statements for guidance.

POLICY STUDY AND ANALYSIS

Social Work Speaks may be used as a text or as supplementary reading for overview, introductory, or macro courses in social work and public policy. It may also enhance instruction for a wide range of specialty courses because many of the policy statements address specific fields of practice.

For lobbying or analysis, NASW policy statements should be considered in the context of their purpose and the time in which they were adopted. Social workers developed the statements to serve as broad parameters for advocacy work and to help professionals who are concerned with social or professional issues focus their thinking. Readers may find that they need more specificity than what the statements contain. Professional social work literature, including additional resources published by NASW, will serve as an important extension of these policy statements.

FUTURE POSITIONS

NASW must be able to address ongoing changes in professional, political, economic, and social issues. We value the involvement of social workers in policy development and invite NASW members to make suggestions for new position statements or recommend the revision or elimination of existing policy statements at the following link:

https://www.socialworkers.org/About/Delegate-Assembly/New-Comment

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Acknowledgment of Social Work Speaks NASW Policy Statement Panelists

Thank you to the delegates and social work experts who participated in the revision and development of the following NASW policy statements for the 2020 Delegate Assembly. These policy statements set the parameters for NASW's positions and actions on a broad range of public policy and professional issues.

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PUBLIC AND PROFESSIONAL POLICY STATEMENTS

Adolescent and Young Adult Health

ISSUE STATEMENT

Many adolescent and young adult health problems are preventable. Health disparities affect socially disadvantaged populations at greater rates. Disproportionalities in health outcomes are linked to higher rates of disease, injury, violence, behavioral and mental health problems, and substance use among adolescents. Policies, programs, and research are needed that promote high-quality adolescent health services through family and school programs, improve access to health services for reproductive and behavioral health and substance use, and increase interventions for prevention of injury and violence.

Family and School Environments

Parents play critical roles in the lives of their adolescent children. For this reason, family-based programs are effective ways of supporting parents to assist adolescents in navigating life challenges (Community Preventive Services Task Force, 2012). Programs that incorporate family-based interventions such as parenting skill-building activities can reduce risky behaviors and improve health outcomes in many areas including smoking, alcohol and drug abuse, sexual initiation, and criminal behavior. However, despite increased availability of multiple family-based programs, parents often face challenges in participating in such programs because of competing daily life demands. Programs that are flexible to parents' schedules and offer additional support through child care, transportation, and meals can help ease this challenge.

Schools often provide adolescent health care by providing programs that are in natural learning environments. Schools can implement and improve school-based policies and programs that strategically reinforce healthy behaviors and educate adolescents about reducing risky behaviors (Banspach et al., 2016). Research has demonstrated that school-based health centers in low-income communities improve both educational and health outcomes. Improved educational outcomes include school performance, grade promotion, and high school completion.

Regardless of where services are provided, opportunities for improving access to and use of clinical preventive services for adolescents include new coverage options provided by the Patient Protection and Affordable Care Act (ACA) of 2010 (P.L. 111-148), thus ensuring that health care services are youth-friendly and developmentally appropriate. Adolescent health services ideally include ensuring (a) availability of quality programs and services; (b) availability of programs and services developmentally tailored to the needs of early, middle, and late adolescence; (c) accessibility (for example, transportation and ease of use); (d) welcoming environments for adolescents; and (e) an atmosphere in which adolescents' opinions and experiences are valued (Banspach et al., 2016). Ultimately, parents, educators, and health care providers share the common goal of helping adolescents achieve healthy, successful futures.

Reproductive Health and Pregnancy

By the 12th grade, close to six in 10 U.S. high school students have had sexual intercourse. Kann et al. (2016) reported that 30.1 percent of students in high school are currently sexually active, with 43 percent of those student reporting they did not use a condom during their last sexual activity. Despite three out of four adolescent pregnancies being unintended (Finer & Zolna, 2016), 13.8 percent of adolescents reportedly did not use any form of protection to prevent pregnancy (Kann et al., 2016). Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youths represent a diverse population affected by many sexual health inequities, including increased risk for HIV and other sexually transmitted infections (STIs). Providers should be competent in recognizing symptoms of STIs and aware of the most up-to-date screening guidelines for LGBTQ youths. Sexual health visits should also focus on prevention, including safer sex practices, HIV pre-exposure and post-exposure prophylaxis, family planning, and immunization for hepatitis and human papillomavirus (Wood, Humara, &

Dowshen, 2016). Office visits present opportunities to educate all adolescents, not just LGBTQ youths, regarding prevention of STIs, unintended pregnancy, and whether they feel safe in their relationships as well as how to avoid risky sexual situations (Marcell, Burstein, & Committee on Adolescence, 2017). There is consensus among scholars that adolescents should be thoroughly educated at the beginning of adolescence to help prevent risky sexual behavior that may have lasting negative effects on reproductive health.

Behavioral Health

Typical development is defined by healthy transitions through adolescence. Yet a substantial number of youths experience serious psychological distress or engage in risk behaviors such as substance use and delinquency, with the potential for sustained psychological, behavioral, and social problems in adulthood (Coley, Arenson, Xu, & Tanner, 2017). Research has long pointed to family and community poverty as a risk factor for heightened behavioral and mental health problems. However, scientists and the media have also raised concerns over elevated levels of mental health problems, substance use, and delinquency among economically advantaged youths, pointing to extreme levels of competition, achievement stress, peer pressure, and social isolation created by a culture of affluence (Coley et al., 2017).

The findings challenge a disproportionate focus on the risks experienced by individuals from low-resource schools and call attention to threats also associated with greater aggregate socioeconomic resources in schools. As income inequality has grown and becomes more separating, the likelihood that youths are surrounded by peers in similar economic circumstances to themselves may level the risks and occurrence of mental health disorders associated with both poverty and affluence (Coley et al., 2017). Those patterns heighten the relevance for school-based programs and policies seeking to support mental and behavioral health among youths.

Substance Use

Early adolescent substance use dramatically increases the risk of lifelong substance use disorder (SUD). Although many adolescents use drugs recreationally, only a small percentage transition to substance abuse disorders. Risk-taking and subsequent drug experimentation during this developmental period increases the likelihood of developing a lifelong addiction. Teenagers who initiate substance use before the age of 14 years are at greatest risk for substance dependence. As individuals continue to mature between 13 and 21 years, the likelihood of lifetime substance abuse and dependence drops by 4 percent to 5 percent for each year that initiation of substance use is delayed, further suggesting that early drug use conveys the greatest risk (Jordan & Anderson, 2017). Drug exposure beginning in early adolescence can increase the risk of SUD long term especially by adolescents who use alcohol, marijuana, and cocaine. Many factors, including gender, race and ethnicity, socioeconomic level, parental education, region, and population density, affect the introduction and severity of alcohol and illicit drug use among adolescents.

Digital media provide increased opportunities for both marketing and social transmission of risky products and behavior. Displays of alcohol use on social media have been found to be indicative of personal use among young people and are likely to enhance normative perceptions among followers of those posts (Romer & Moreno, 2017). Screening tools to assess adolescent substance use are widely available for use in social work practice. Capitalizing on opportunities to screen for substance use in various settings where adolescents receive care can increase the identification of risk behaviors and inform and facilitate delivery of preventive care or referrals appropriate to individual needs (Levy &Williams, 2016).

Injury and Violence

Youth injury and violence are major public health problems that adversely affect adolescents, families, and communities (David-Ferdon et al., 2016). An estimated 70 percent of deaths among adolescents and young adults result from four main causes: auto accidents (23 percent), other unintentional injuries (18 percent), homicide (15 percent), and suicide (15 percent) (Kann et al., 2016). Since the earliest year of data collection by the U.S. Department of Health and Human Services, the prevalence of violent behaviors has increased whereas health risk behaviors have decreased over time.

Adverse childhood experiences (ACEs) are traumatic events such as abuse and neglect, witnessing domestic violence, or living with someone with SUD (Hughes et al., 2017); the ACEs study conducted by the Centers for Disease Control and Prevention (CDC, 2013) found that the more ACE risk factors individuals have, the more likely they are to engage in violent activities, have a mental illness, or use illegal substances. Experiencing adolescent violence such as mass shootings is an example of an ACE and is associated with poorer mental health outcomes later in life (Beland & Kim, 2016). These factors are strong contributors of injury and violence among adolescents. Adolescents with ACEs may be less able to successfully navigate this transformational stage because of the damaging effects of traumatic experiences on their emotional and cognitive development and lack of positive supports. Developmentally and culturally appropriate interventions provide opportunities for adolescents to learn skills in how to regulate their behaviors, thus building resilience instead of defaulting to violence (Soleimanpour, Geierstanger, & Brindis, 2017).

Health Insurance Coverage

Adolescent health care brings about unique challenges in that adolescents are less likely to use medical or behavioral services because of lack of confidentiality, lack of monetary resources, transportation issues, and lack of knowledge regarding available preventive services whether insured or uninsured (Washington & Sambo, 2015). Although the ACA included several provisions to help adolescents obtain health insurance coverage and gain access to key preventive health care services, struggles within the legislature keep it from being secure. (Twietmeyer, Brindis, Adams, & Park, 2016). The ACA allows dependents up to age 26 to stay on insurance policies and expands discount drug programs. Children cannot be excluded for preexisting conditions, and there are no lifetime limits or rescinding coverage for youths (Reisman, 2015). In addition, states have relied on building partnerships and provider networks to increase coverage among adolescents (Twietmeyer et al., 2016).

Shifting health care financing strategies are transforming medical and behavioral health care as a strategy for improving access to high-quality care for adolescents, which is particularly critical for this population because of high-risk behaviors and intentional injuries (Asarnow, Rozeman, Wiblin, & Zeltzer, 2015). Most office medical visits by adolescents can be an opportunity for physicians to use established screening tools that encompass both mental and behavioral health issues, thus keeping medical care more affordable to adolescents and their families. Although strides have been made with adolescent health insurance coverage, the 5.2 percent of uninsured adolescents pose concern for untreated medical conditions that will progress into adulthood (CDC, National Center for Health Statistics, 2017).

POLICY STATEMENT

NASW supports

- effective policies and programs that promote positive health outcomes for adolescents and youths while considering social determinants such as race or ethnicity, gender, sexual identity, age, disability, socioeconomic status, and geographic location
- programs that address health disparities resulting from poverty, environmental problems, lack of access to affordable health care services, unequal distribution of educational resources, and individual factors
- access to high-quality health care and preventive services
- programs that recognize the importance of families and schools by incorporating them into service delivery models
- adolescent health policies and programs that address a wide range of health issues including reproductive health, behavioral health, substance use, injury and violence, and health insurance coverage
- adolescent health being a national, state, and local policy priority
- policies that promote key factors to strengthen young adult health care service delivery systems and include

  - a continuum of evidence-based prevention, early intervention, and treatment approaches to meet the unique physical and behavioral needs of adolescents
  - access to behavioral, mental, and physical health evaluation and treatment as appropriate
  - team-based, integrated, and interprofessional approaches
- accessibility of school-based and community-based adolescent health clinics that
  - are available to all adolescents regardless of ability to pay, insurance coverage, or other factors
  - respect the confidentiality and self-determination needs of adolescents
  - provide services in a culturally appropriate manner
- specialized training of staff on working with vulnerable populations, including LGBTQ, homeless, and undocumented adolescents
- educate youths and families about the appropriate use of digital media, including
  - the importance of limiting screen time and types of media
  - high-quality programming and media-free times
  - ongoing communication about online safety
- implementation of comprehensive tobacco-free campus policies to prevent and reduce tobacco use in young people
- adequate funding for workforce development training to address adolescent health care needs
- implementation of firearm laws and policies that protect communities from gun violence
- full implementation of the ACA to include
  - providing information about state expansion of Medicaid eligibility up to age 21
  - maintaining health coverage for dependents up to the age of 26.

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Adolescent Pregnancy and Parenting

ISSUE STATEMENT

Adolescent parents and their children encounter tremendous hardship due to many factors. Children born to adolescent parents face particular challenges, including poorer educational, behavioral, and health outcomes throughout their lives, compared with children born to older parents (Office of Adolescent Health [OAH], 2016b). Adolescent parents also face challenges due to the difficulties of parenting at a young age. Adolescent pregnancy and parenting costs U.S. taxpayers between $9.4 and $28 billion a year through public assistance payments, lost tax revenue, and greater expenditures for public health care, foster care, and criminal justice services (OAH, 2016b).

The social work profession is situated to respond to the numerous issues relating to adolescent pregnancy and parenting. Because social workers assess problems and needs from ecological, human development, and behavioral perspectives, the profession is positioned to have a broad effect on the issues relating to adolescent pregnancy and parenting. These issues are complex, multifaceted, and do not have a single root cause. As such, no single methodology exists for preventing adolescent pregnancy, for supporting adolescent parents in parenting their children, or for overcoming the challenges that adolescent parents face.

Rates

Between 1990 and 2010, the U.S. teenage pregnancy rate declined by 51 percent—from 116.9 to 57.4 pregnancies per 1,000 teenage girls (Kost & Henshaw, 2014). Despite the national teenage pregnancy rate declining over the last two decades, the United States still has the highest rate among other developed countries with reliable statistics, according to a study published by the Centers for Disease Control and Prevention (CDC) (Ventura, Hamilton, & Mathews, 2014).

Many factors account for the differences in adolescent pregnancy rates across Western industrialized countries. To better understand the issue, it is valuable to look at where the United States ranks in comparison with other developed, industrialized countries. "Among the 21 countries with complete statistics, the pregnancy rate among 15- to 19-year-olds was the highest in the United States (57 pregnancies per 1,000 females) and lowest rate in Switzerland" (Alan Guttmacher Institute [AGI], 2015). U.S. adolescent girls are 2.5 times as likely to give birth as adolescent girls in Canada, around four times as likely as adolescent girls in Germany or Norway, and almost 10 times as likely as adolescent girls in Switzerland (Kearney & Levine, 2012). A common misperception is that this can be explained by lower rates of sexual activity among adolescents in other countries; however, an examination of rates of sexual activity among adolescents in the United States and other developed countries shows little difference (Kearney & Levine, 2012.)

According to Healthcare Veda (2009), teenage pregnancy in developed countries is most prevalent in the United States and the United Kingdom. The United States could gain valuable knowledge about preventing and addressing the issue of adolescent pregnancy by examining the resources and methods that other developed countries use.

Contributing Factors

The causes for adolescent pregnancy are still debated, but there is evidence of various contributing and complex sociocultural factors that play a role. One such sociocultural factor is a higher proportion of adolescents growing up in socially and economically disadvantaged situations. High rates of teenage pregnancy have also been associated with sociocultural disadvantage across other developed countries (AGI, 2015).

Healthcare Veda (2009) reported that in developed countries the main causes of teenage pregnancy are the result of inadequate sex education among teenagers, alcohol abuse, sexual abuse, higher rates of poverty, and lower education levels. Other factors are adolescent sexual behavior such as peer pressure, lack of parental guidance, inadequate knowledge about safe sex, exploitation by older men, and socioeconomic factors.

Developing and undeveloped countries also struggle with this issue, but the contributing factors of teenage pregnancy there are quite different. According to Healthcare Veda (2009), financial constraints, domestic or sexual violence, child marriage, and media exhibiting sex and pornography to market goods are some of the factors that cause unwanted pregnancy among teenagers in developing and underdeveloped countries.

Sexual Abuse and Maltreatment

There is a strong link between adolescent pregnancy and history of maltreatment through sexual abuse, sexual assault, and sexual exploitation (Healthcare Veda, 2009). The National Child Traumatic Stress Network (NCTSN) (2009) reported that approximately one in six boys and one in four girls are sexually abused before the age of 18. A study by the American Academy of Pediatrics (AAP) found that young women with a history of maltreatment, including intimate partner violence, were twice as likely to experience teenage childbirth after controlling for demographic confounds and known risk factors (Noll & Shenk, 2013). The AAP study showed that birthrates were highest for sexually abused and neglected women; moreover, sexual abuse and neglect were both independent predictors of teenage childbirth after controlling for demographic challenges, other risk factors, and other forms of maltreatment occurring earlier in development. These results provide evidence that sexual abuse and neglect are unique predictors of subsequent adolescent childbirth.

Adolescent women are also at risk of unhealthy dating relationships and *intimate partner violence*, defined as “physical, sexual, or psychological/emotional violence within a dating relationship, as well as stalking” (CDC, 2013). Unhealthy dating relationships can include coerced sex, rape, and birth control sabotage, which can increase the risk of pregnancy.

Racial and Economic Disparities

Like many social issues, adolescent pregnancy and parenting affect minority populations disproportionately. Although the decline in U.S. adolescent pregnancy has been sharpest in the African American population, in 2014 African American and Hispanic teenage birthrates were still more than two times higher than the rate for non-Hispanic white teenagers, and American Indian/Alaska Native teenage birthrates remained more than 1.5 times higher than the non-Hispanic white teenage birthrate (CDC, 2016).

Despite decreases in adolescent pregnancy across the country over the last 20 years, differences across U.S. states are quite dramatic. A teenage girl in Mississippi is still four times more likely to give birth than a teenage girl in New Hampshire—and 15 times more likely to give birth compared with a teenage girl in Switzerland (Kearney & Levine, 2012). Low education levels are closely associated with early childbearing (World Health Organization [WHO], 2016). Low education and low income levels of a teenager's family may contribute to high teenage birthrates (CDC, 2016). Teenage girls in child welfare systems are at higher risk of teenage pregnancy and birth than other groups, and young women living in foster care are more than twice as likely to become pregnant than those not in the foster care system (CDC, 2016).

Adolescents and their families affected by unintended pregnancy continue to face educational, economic, and health challenges. Teenage pregnancy seriously affects education attainment and other life opportunities (WHO, 2016). Even though rates of adolescent pregnancy are declining among all races and ethnicities, adolescent pregnancy affects minority and lower-income communities in a different and significant way.

Advances in Contraception

Improvements in teenagers' contraceptive use have had a major effect on the decline in adolescent pregnancy over the last 12 years (AGI, 2014). Advances in methods of contraception, including contraceptives that last longer and encourage effective compliance, are responsible for approximately 86 percent of the decline in adolescent pregnancy according to new data taken from a National Campaign to Prevent Teen and Unplanned Pregnancy (NCPTUP) (2014) survey conducted in 19 states from 2004 to 2008.

NCPTUP (2014) estimated that for every U.S. dollar we spend on contraceptives for teenagers, almost $6 is saved just on medical care for unplanned pregnancies. This NCPTUP study also reported that in 2008, the cost of unplanned pregnancies in the United States was almost $11 billion. The same research reported that the best methods of contraception are expensive or difficult to access, and not all contraception options are equally effective. These findings underscore the problems with access to contraception and education on how to use contraceptives effectively (NCPTUP, 2014). Many new forms of contraceptives are marketed each year, and access to these new forms is controlled by cost, health insurance coverage, and legislation regarding youth access with or without parental consent.

Male Involvement

Not all of the fathers of adolescent pregnancies are adolescents, some are adults. However, in the United States an estimated 9 percent of young men between the ages of 12 and 16 will become fathers before their twentieth birthday (OAH, 2016a). Programming and research on adolescent parents has traditionally focused on adolescent mothers. The stereotypes (for example, that adolescent fathers are not involved with their children and are irresponsible and care primarily about sexual fulfillment) often drive prevention and intervention programming, which may have negative effects on adolescent fathers who want to participate and access resources.

OAH (2016a) reported that children in father-absent homes are almost four times more likely to be poor. In 2011, 12 percent of children in married-couple families were living in poverty, compared with 44 percent of children in mother-only families (OAH, 2016a). These findings suggest that programs must be more inclusive of fathers, and different methods of outreach and engagement are needed to involve fathers in services and programming. Parents and other caring adults in an adolescent boy’s life can have an impact by encouraging healthy behaviors and growth by setting good examples and establishing open lines of communication.

Adolescent Maternal and Child Health

According to WHO (2016), adolescent girls who give birth each year have a much higher risk of dying from pregnancy-related causes compared with women in their 20s and 30s. These risks increase greatly as maternal age decreases, with adolescents under 16 facing four times the risk of maternal death as women over 20 (WHO, 2016). Babies born to adolescent mothers also face a significantly higher risk of death compared with babies born to older women, as adolescent mothers tend to access prenatal care later in the pregnancy or sometimes not at all (WHO, 2016). Young teenage women are by far the least likely to receive timely prenatal care. In 2014, 25 percent of births to adolescent women under age 15, and 10 percent of births to adolescent women ages 15 to 19, were to those receiving late or no prenatal care (Child Trends, 2015).

These findings can be related to economic challenges, limited access to health care, and the fear and secrecy that might surround adolescent pregnancy. The ability of adolescent mothers to engage in confidential medical services including contraceptive, abortion, and prenatal services without parental consent is critical to the overall health of the adolescent mother, the pregnancy, and (if she chooses to maintain the pregnancy) the baby. State legislation on parental involvement in a minor’s medical decisions regarding pregnancy, including access to abortion services, varies by jurisdiction.

Repeat pregnancies are another factor in adolescent maternal health. Repeat teenage child-bearing further constrains the mother’s education and employment possibilities. In 2014, one in six (17 percent) births to 15- to 19-year-olds were among young women who already had one or more babies (OAH, 2016c). The implications of additional children stretch not only to the health and economic well-being of the adolescent mother, but also to her ability to parent multiple children with limited resources.

Fetal Alcohol Spectrum Disorders

Alcohol use during pregnancy is the leading preventable cause of birth defects and intellectual and neurodevelopmental disabilities (Williams & Smith, 2015). *Fetal alcohol spectrum disorders* (FASDs)—the general term that encompasses a range of life-long adverse cognitive, behavioral, and physical effects associated with prenatal alcohol exposure—affect up to 5 percent of U.S. children (CDC, 2015; Williams & Smith, 2015) and are disproportionately present among youths in foster care and juvenile justice systems (Lange, Shield, Rehm, & Popova, 2013; Popova, Lange, Bekmuradov, Mihic, & Rehm, 2011). Adolescents are at particular risk for behaviors that lead to FASDs. Almost half of 12th graders (47 percent) report alcohol use within the past 30 days (CDC, 2014, Table 45); 29 percent report binge drinking within that same period (CDC, 2014, Table 47); and 22 percent of sexually active students report that they drank alcohol or used drugs before last sexual intercourse (CDC, 2014, Table 73). At the same time, three out of four adolescent pregnancies are unintended (Finer & Zolna, 2016), and young women, who may be unaware of their pregnancy or late to obtain prenatal care (Child Trends, 2015) may continue to drink into the second trimester or beyond.

Clinical and interprofessional care teams have an opportunity during routine health care visits to screen for risk and initiate evidence-based behavioral interventions to reduce the risk of alcohol-exposed pregnancies among sexually active youths. Adolescent parents of children affected by FASDs will benefit from access to screening, identification, and treatment resources, with services provided in a developmentally appropriate and culturally relevant manner with an emphasis on reducing stigma.

Adolescent Maternal Educational Attainment and Poverty

The negative effects of an adolescent pregnancy on educational attainment and future employment and earning power are well documented. Teenage pregnancy is one of the primary causes of increasing U.S. child poverty rates (NCPTUP, 2016). About 60 percent of all teenage mothers and their children are likely to live in lifelong poverty, and children of teenage parents are more likely to become teenage parents themselves, according to the CDC (2016).

There is a positive correlation between completing high school and college and income stability. For teenagers already affected by poverty, adolescent parenting increases the probability that they will maintain poverty status over the long term. Adolescent mothers have an increased likelihood of ending up on social welfare, with almost one-half receiving welfare benefits within five years of the birth of their first child (NCPTUP, 2016).

Generational Impact

Adolescent parenting is one of the major risk factors associated with early childhood development (Urban Child Institute, 2014). Research has demonstrated that teenage mothers are less likely to finish high school and more likely to live in poverty and remain unmarried, and that their children will, on average, face a variety of challenges (Kearney & Levine, 2012). The Urban Child Institute (2014) reported that children of teenage parents are more likely to drop out of school, have more health problems, face unemployment, and become teenage parents themselves.

POLICY STATEMENT

The teenage birth rate in the United States continues to be one of the highest in the developed world. Teenage childbearing is internationally recognized as a public health problem associated with a range of risks for both young mothers and their children, making it an important target for public health prevention and intervention efforts (Coyne & D’Onofrio, 2012).

Within the context of culturally appropriate and sensitive practice, and on the basis of NASW values and ethical principles, NASW supports the following:

- measures that promote economic, educational, and health equity across all socioeconomic levels
- multidisciplinary interventions that are confidential, safe, legal, affordable, and culturally sensitive and responsive to the needs of adolescents that include access to comprehensive health education and

evidence-based strategies to prevent drug- or alcohol-exposed pregnancies and other health consequences of high-risk behaviors

- comprehensive and developmentally appropriate health and sex education for all adolescents, including, but not limited to, health education, reproductive health, family planning, contraceptive services (including abstinence and all forms of contraceptive advances), and sexual relations (including development of critical thinking about personal sexual decisions to promote positive sexual development and reduce adverse social, economic, and health consequences of risk behaviors)
- measures that promote direct access to effective contraceptive technology to adolescents
- adequate access to family planning services, including home visitation services to support adolescents who are pregnant with decision making regarding health and pregnancy, including prenatal care, general health care, abortion information and services, adoption information and services, and so on
- adherence to Title IX of the Education Amendments of 1972, which protects pregnant and parenting adolescents from discrimination in the public schools, denial of access to education, and exclusion from participation in school activities (U.S. Department of Justice, 2016)
- comprehensive services to adolescent mothers and fathers, encouraging responsible involvement of young fathers in their children’s lives whenever appropriate and possible, including, but not limited to, education; parenting skills; and social, emotional, psychiatric, and psychological support for the entire family
- comprehensive services to the children of adolescent parents, including, but not limited to, prenatal care, health care, child care, and early education to promote the children’s social and emotional well-being
- ongoing research to identify risk factors that are specifically associated with teenage pregnancy and childbearing
- continued training of the social work profession and other relevant professions in cultural sensitivity services provision to address the needs of adolescent pregnancy and parenting.

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Affirmative Action

ISSUE STATEMENT

Affirmative action has been a tool for correcting historical injustice in access to employment, higher education, and housing for many years. The legal definition of *affirmative action* is "the process of a business or governmental agency in which it gives special rights of hiring or advancement to ethnic minorities to make up for past discrimination against that minority. . . . Affirmative action programs are governed by a number of overlapping laws. A common principle is that whether for admissions or employment, affirmative action programs such as targeted recruitment and goals are encouraged to remedy past effects of discrimination; quotas are disfavored. Affirmative action in American employment law has evolved through a series of governmental proclamations, court decrees, and voluntary programs instigated by employers in the private sector. Private employers who receive no public funding are not required to adopt affirmative action policies. Affirmative action policies are enforced by the entities adopting them if they are voluntary, while affirmative action policies required by government mandates can be enforced through the legal system" (USLegal.com, n.d.-a). It should be pointed out that the aforementioned definition of affirmative action makes the point that affirmative action is distinctly different from quotas. This is because the idea of the use of quotas to remedy past discrimination had been abandoned after successful court challenges to the use of such practices. The Supreme Court has affirmed its opposition to quotas as remedies for past discrimination by ruling that the use of quotas in education and employment is unconstitutional, except on rare occasions when judges order them to correct blatant discrimination. Affirmative action plans gained acceptability because of their flexibility in setting goals that reflect the percentage of qualified minorities and women in the region (Minority Jobs.net, n.d.).

The fate of quotas in higher education met its end with the landmark Supreme Court case *Regents of University of California v. Bakke* (*1978*). In this case, the Supreme Court ruled that a university's use of racial quotas in its admissions process was unconstitutional but that a school's use of affirmative action to accept more minority applicants was constitutional under some circumstances (PBS, n.d.).

With that in mind, the advent of affirmative action as public policy originated in the 1930s, when it was applied to prevent union versus nonunion discrimination against employees who were engaged in union organizing. Thus, in 1935, the National Labor Relations Act stated the following: "An employer who was found to be discriminating against union members or union organizers would have to stop discriminating and also take *affirmative action* to place those victims where they would have been without the discrimination" (Skrentny, 1996).

The Franklin D. Roosevelt administration further ingrained affirmative action when, in responding to pressure from the prominent African American union leader A. Phillip Randolph, it issued Executive Order (EO) No. 8802 in June 1941. This EO created the Fair Employment Practices Commission, designed to promote full participation in federal defense programs by all people regardless of race, creed, color, or national origin (Biermann, 2004).

During the post–World War II period, the civil rights community was instrumental in continuing the movement toward making affirmative action a part of national policy. For example, President John F. Kennedy issued EO 10925 dealing with equal opportunity in employment. EO 10925 was eventually included in the Civil Rights Act of 1964 (P.L. 88-352), passed by President Lyndon B. Johnson. Section 703 (a) of the Civil Rights Act of 1964 made it unlawful for an employer to "fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions or privileges or employment, because of such individual's race, color, religion, sex, or national origin." The final bill also allowed sex to be a consideration when sex is a bona fide occupational qualification for the job. Title VII of the act created the Equal Employment Opportunity Commission (EEOC) to implement the law (National Archives, n.d.).

Over time, affirmative action policies were mostly precipitated with the use of EOs, or through court decisions. The following is a brief overview of some of these actions:

- **1961.** President Kennedy’s EO 10925 used affirmative action for the first time by instructing federal contractors to take “affirmative action to ensure that applicants are treated equally without regard to race, color, religion, sex, or national origin” and created the Committee on Equal Employment Opportunity.
- **1963.** Executive Order 11063 issued by President Kennedy addressed affirmative action in housing; this EO later led to the enactment of the Fair Housing Act of 1968 (P.L. 90-284).
- **1965.** President Johnson issued EO 11246, requiring all government contractors and sub-contractors to take affirmative action to expand job opportunities for minorities. He established the Office of Federal Contract Compliance in the Department of Labor to administer the order.
- **1967.** President Johnson amended EO 11246 to include affirmative action for women. As a result, federal contractors were required to make good faith efforts to expand employment opportunities for women and minorities.
- **1969.** President Nixon initiated the “Philadelphia Order,” which was the most forceful plan at that point in time to guarantee fair hiring practices in construction jobs. Philadelphia was selected as the test case because as Assistant Secretary of Labor Arthur Fletcher explained, “The craft unions and the construction industry are among the most egregious offenders against equal opportunity laws . . . openly hostile toward letting blacks into their closed circle” (USLegal.com, n.d.-b). President Nixon said, “We would not impose quotas but would require federal contractors to show ‘affirmative action’ to meet the goals of increasing minority employment” (USLegal.com, n.d.-b).
- **1970.** Using a set of affirmative action principles developed by Rev. Leon Sullivan, the Pastor of Zion Baptist Church in Philadelphia, Pennsylvania, President Nixon used an EO to implement the Philadelphia Plan (USLegal.com, n.d.-b).
- **1983.** President Ronald Reagan issued EO 12432, which directed each federal agency with substantial procurement or grant-making authority to

develop a Minority Business Enterprise development plan.

- **1995.** President Bill Clinton reviewed all affirmative action guidelines by federal agencies and declared his support for affirmative action programs by announcing the administration's policy of "Mend it, don't end it."
- **2003.** Supreme Court cases *Grutter v. Bollinger* and *Gratz v. Bollinger* decided in 2003 to address affirmative action programs in university admissions, but their impact reached beyond the educational arena. In *Grutter v. Bollinger*, the Supreme Court stated that race could be used as one factor for the University of Michigan's admissions, but in *Gratz v. Bollinger*, the court indicated that points given to prospective students based solely on race were unconstitutional because this process violated the Equal Protection Clause. NASW participated in amicus curiae briefs supporting the University of Michigan's affirmative action principles (Cornell University Law School, n.d.).
- **2013.** *Fisher v. Texas* was a challenge to the University of Texas's affirmative action policy. Abigail Fisher claimed that she was unfairly passed over for admission in favor of lesser qualified minority applicants. The case eventually went to the Supreme Court, not as a direct challenge to the Bollinger decision, but to ask the court to rule against affirmative action plans that are based solely on race. The Supreme Court ruled that a university's use of affirmative action will be constitutional only if it is "narrowly tailored." The court in Fisher made it clear exactly what this meant: Courts could no longer simply rubber-stamp a university's determination that it needs to use affirmative action to have a diverse student body. Instead, courts would need to confirm that the use of race was "necessary" and that there was no other realistic alternative that did not use race but would also create a diverse student body (Howe, 2012).

With the recognition that voluntary affirmative action plans were not sufficient to achieving significant gains in righting past discrimination in employment, the Civil Rights Act of 1964 created the EEOC. The EEOC continues to play an important role in monitoring hiring practices by setting policy guidelines and interpreting affirmative-action-related court decisions for employers nationwide to follow. The designation of race/ethnicity, gender, age, and disability as *protected classes* within the EEOC's guidelines is important to ensuring unambiguous safeguards against workplace discrimination for groups that have historically been discriminated against. The protected-class designation also helps employers to set affirmative action goals. The EEOC processes millions of workplace discrimination cases each year.

As the country continues to evolve as a multiracial and multicultural society, there are still pressures on employers, realtors/rental housing providers, and education institutions to commit to fair and nondiscriminatory admissions, housing, and hiring practices. Despite many years of agitation and advocacy by the civil rights community, the United States has not eliminated workplace discrimination, segregated housing patterns, and the lack of racial diversity in major colleges and universities. American history is filled with many examples of individual, organizational, institutional, and societal discrimination and disparities that adversely affected whole groups of people on the basis of their ancestral heritage, culture, ethnicity, skin color, primary language, age, class, gender, disability, sexual orientation, religion, spirituality, and other parts of their identity.

Affirmative action is consistent with the social work profession's mission, "to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. . . . Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living" (NASW, 2008, back cover).

Affirmative action promotes mindfulness and action with regard to diversity. It has provided effective means for forcing changes in entrenched patterns of policy and practice, including those that were discriminatory and unjust. Furthermore, affirmative action programs have encouraged people to face and acknowledge factors related to unequal opportunities and access, including privilege, indifference, insensitivity, bias, and prejudice.

POLICY STATEMENT

Basic Tenets of Affirmative Action

The basic tenets of affirmative action are broad and inclusive. The NASW affirmative action tenets reflect a firm commitment to actions leading to inclusive plans, processes, and results. Affirmative action seeks to address historical discrimination and the effects of such. It also seeks to achieve substantially greater inclusion of and equity for diverse groups who have been historically or are currently oppressed, underserved, and underrep-resented. These groups include people of color; people with disabilities; people who are gay, lesbian, or transgender; women; seniors; and people disadvantaged or oppressed because of life circumstances.

In formulating NASW's Affirmative Action policy statement, the following guidelines apply: *Affirmative action* is a concept of mindful and deliberate steps taken to attain a national consensus to value respect and accept multicultural diversity. These steps include defined processes through which the following are available to all:

- fair access to employment, housing, and education;
- equal chance to compete for employment and education opportunities;
- assurances that the process for applying and competing for opportunities is free of bias; and
- a system that achieves equitable and balanced results that leads to diversity.

As a major national policy that has been in place for over 50 years, affirmative action has been effective in shaping and honing policy directives that have brought improvements in gaining access to employment, education, housing, and government contracting. Therefore, this policy statement reinforces the recognition of a continuing need for strong affirmative action principles and implementation of affirmative action programs in all arenas of government and the private sector including small groups, organizations, institutions, communities, societies, cities, and states, as well as implementation nationally. NASW supports affirmative action as a viable tool for upholding its ethical code to act to prevent and eliminate discrimination. In addition, NASW supports the following principles and actions:

- Full endorsement of local, state, and federal policies and programs that give all people equal access to resources, services, and opportunities that they require—everyone should be given equal opportunity regardless of age, ancestral heritage, class, color, disability, gender, immigration status, language proficiency, national origin, race, religion, or sexual orientation.

- Articulating recommendations and advocating for changes in local, state, and federal policies and programs to further open access and promote equality and social justice.
- Supporting existing local, state, and federal policies and programs that open access and promote equality and social justice.
- Joining forces with others to support affirmative action and social justice programs and counteract anti–affirmative action efforts or initiatives.
- Creating, leading, and participating in coalitions for affirmative action and social justice.
- Generating (or working with others in establishing) tactics and strategies for the passage of policies that strengthen affirmative action, civil rights, equity, and social justice.
- Writing position statements, court briefs, and other documents in support of affirmative action, civil rights, equity, and social justice.
- Publishing public information materials in support of affirmative action, civil rights, equity, and social justice agendas.
- Conducting and supporting research about affirmative action and as a means to promote equity and social justice.
- Identifying and supporting people running for public office who are proponents of affirmative action.
- Being vigilant in upholding and promoting affirmative action and social justice initiatives.
- Identifying measures to indicate what areas have been successfully or not successfully accomplished.
- Supporting the development of policies that demonstrate accountability in working to achieve affirmative action in professional social work organizations.
- Advocating for affirmative action practices within professional social work organizations to devise and implement plans to increase membership diversity reflective of the multicultural population demographics.

NASW believes that there is a continued need for federal oversight of discriminatory practices in hiring, access to housing, and access to higher education. Therefore, we support an EEOC that vigorously investigates charges of unfair denial of employment or discriminatory firing of people of color, people with disabilities, and the elderly, or because of one's gender.

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Policy statement approved by the NASW Delegate Assembly, August 2014. This policy statement supersedes the policy statement on Affirmative Action approved by the Delegate Assembly in 2005 and 1996. For further information, contact the national Association of Social Workers, 750 first Street, NE, Suite 800, Washington, DC 20002-4241. Telephone: 202-408-8600; e-mail: press@socialworkers.org

Aging and Wellness

ISSUE STATEMENT

The chronological aging both of the U.S. population as a whole and of the Baby Boom generation in particular presents social and political implications for both the country and the social work profession. Older adults contribute significantly to their families and communities, thereby strengthening society. At the same time, ageism and other social determinants of health influence the aging process and, consequently, older adults' ability to enjoy healthy aging and to remain engaged in society (Robbins, 2015; U.S. Department of Health and Human Services [HHS], Office of Disease Prevention and Health Promotion, 2016a, 2016b). Creating and maintaining age-friendly environments and person-centered systems that support older adults' health, well-being, and self-determination is integral not only to wellness in later life, but also to the well-being of the entire U.S. population. Realizing this goal is a primary focus of social work practice, administration, education, research, and policy advocacy in aging.

People age 65 and older constituted nearly 15 percent of the U.S. population in 2015—an increase of nearly 3 percent from 2005 (U.S. Census Bureau, 2005, 2015). By the year 2060, nearly one-quarter of the U.S. population will be 65 years or older (U.S. Census Bureau, 2014). As the U.S. population ages, it is also becoming more racially and ethnically diverse, with populations of older adults of color increasing from about one-fifth in 2012 to nearly two-fifths in 2050 (U.S. Census Bureau, as cited in Ortman, Velkoff, & Hogan, 2014). Cultural diversity among older adults is reflected, increasingly, in geographical location and living arrangements; national origin, migration background, and documentation status; socioeconomic class; gender, gender identity, and gender expression; sexual orientation; religious and political belief and affiliation; physical, psychological, and cognitive ability; and literacy, among other factors (NASW, 2013, 2015c).

Healthy aging was one of four interrelated themes addressed by the 2015 White House Conference on Aging (WHCOA) (2015). A growing body of evidence indicates that civic engagement; creative expression; and lifelong learning, including brain health, can enhance late-life wellness (Administration for Community Living [ACL], National Institutes of Health, & Centers for Disease Control and Prevention [CDC], 2014; Chen, Lee, Staley, Wang, & Dugan, 2015; Corporation for National and Community Service, 2012; Hanna, Noelker, & Bienvenu, 2015; Thöne-Geyer, 2014). At the same time, numerous factors affect older adults' ability to engage in these activities and to enjoy good health.

The prevalence of chronic conditions (including Alzheimer's disease and other forms of dementia) and functional limitations increases with age, severely affecting older adults' quality of life (Alzheimer's Association, 2016; Anderson, 2010; Centers for Medicare & Medicaid Services, 2013a, 2013b; HHS, 2010). Access to health promotion activities and disease prevention services throughout a person's life span can prevent functional limitations and is essential to healthy aging (National Institute on Aging & World Health Organization, 2011). The Patient Protection and Affordable Care Act (ACA) of 2010 (P.L. 111-148) has improved access to many such services (Henry J. Kaiser Family Foundation, 2013).

The ACA also includes multiple provisions to enhance integration of health care with mental and behavioral health care. The number of older adults who live with a mental health condition or substance use disorder (including misuse of prescription drugs) is growing as the population ages, and the suicide rate among older adults remains disproportionately high (CDC, 2015; Institute of Medicine [IOM], 2012). Furthermore, social isolation has been identified as one of 12 grand challenges for the social work profession, with particular ramifications for older adults (Lubben, Gironda, Sabbath, Kong, & Johnson, 2015)—and scientific research increasingly links social isolation with poor physical health (Ellis Nutt, 2016; Valtorta, Kanaan, Gilbody, Ronzi, & Hanratty, 2016).

Yet another focus of the ACA, and of multiple other governmental and nongovernmental initiatives, is coordination of care (Volland, Schraeder, Shelton, & Hess, 2012–2013). Numerous problems—including preventable hospitalizations, emergency department and urgent care use, skilled-nursing facility placement, and medication errors—have been linked with inadequate care transitions between service providers and settings (Burton, 2012; Golden & Shier, 2012–2013). The impact of such problems on government spending has been well documented (Burton, 2012), but the financial and human costs to older adults and family care-givers are equally staggering (King et al., 2013; Rooney & Arbaje, 2012–2013). The engagement of older adults and family caregivers in health care is integral to improving care transitions, but much work remains to support that involvement (Levine & Feinberg, 2012–2013).

Although transitional care efforts have focused primarily on the health care continuum, transitions between service sectors pose another barrier to wellness. The need to integrate the health care and social services sectors is especially evident in the growing need for long-term services and supports (LTSS), which was another theme of the 2015 WHCOA. At least 6.7 million older adults currently use LTSS, a figure anticipated to grow exponentially by the year 2050 (Commission on Long-Term Care, 2013). Family caregivers (sometimes known as *care partners*) remain the primary providers of LTSS, often at significant financial, physical, and emotional cost (National Alliance for Caregiving & AARP Public Policy Institute, 2015; O’Shaughnessy, 2013; Reinhard, Feinberg, Choula, & Houser, 2015). Many families do not qualify for LTSS coverage through Medicaid, and those who do qualify find their options for home and community-based services (including access to direct care workers) limited. The Older Americans Act (OAA), last reauthorized in 2016 (P.L. 114-144), provides invaluable assistance to older adults and family caregivers. However, inadequate funding precludes full realization of the OAA’s mission (NASW, 2016b). The need for a sustainable LTSS financing system is widely recognized, and the need to link such financing with strengths-based, social models of care that support older adults’ self-determination is gaining traction.

Affordable, accessible housing is an integral component of the LTSS continuum, and “healthy housing” is increasingly recognized as essential to older adults’ well-being (Commission on Long-Term Care, 2013; Gershon, n.d.; Rockett Eldridge, Crocker, Klink, & Saul, 2016). Yet, affordable housing for older adults is in short supply, especially in rural areas; housing instability and homelessness among older adults are both increasing; and most homes and communities lack the features and services needed as people age (Bipartisan Policy Center [BPC], Senior Health and Housing

Task Force, 2016; Commission on Long-Term Care, 2013; Harrell & Guzman, 2013; Knopf-Amelung, 2013; Oberdorfer & Wiley, 2014). Increased access to government-subsidized housing, home repair and modification, assistive technology, and housing that integrates health care and LTSS can improve older adults' quality of life and health outcomes (BPC, Senior Health and Housing Task Force, 2016; LeadingAge, 2015a, 2015b; Magan, 2015; Molvig, 2012; Weiss, Malone, & Walsh, 2015).

Closely related to the rising costs of health care, LTSS, and housing is economic security among older adults, another theme of the 2015 WHCOA. Even with the crucial benefits provided by Social Security, nearly one in three older adults lives below or within two times the federal poverty level, with higher rates for women, communities of color, and older adults who provide kinship care (DeNavas-Walt & Proctor, 2015; Generations United, 2015; Social Security Administration, 2016). Furthermore, many middle-class adults find their economic security dwindling as they age (Butricia & Waid, 2013). One indicator of this trend is the growth in food insecurity among older adults of various income levels (Ziliak & Gundersen, 2016).

Many older adults want or need to maintain paid employment, at least on a part-time basis, beyond the traditional retirement age. Although the Age Discrimination in Employment Act (1991) provides valuable protections, age-related workplace discrimination toward adults in their 40s through 70s remains a significant barrier to both participation and economic security (Kohrman, 2015; U.S. Equal Employment Opportunity Commission, 2015, n.d.).

Employment status notwithstanding, an alarming and growing number of older adults (estimates range from 4.2 to 14 percent per year) experience economic insecurity as a result of financial exploitation (Acierno et al., 2010; Holtfreter, Reisig, Mears, & Wolfe, 2014; Lifespan of Greater Rochester, Weill Cornell Medical Center of Cornell University, & New York City Department for the Aging, 2011; National Adult Protective Services Association, 2016; Setzfand & Watson, 2015). Financial exploitation and other forms of elder mistreatment—namely, physical, sexual, and emotional (or psychological) abuse, as well as neglect, abandonment, and self-neglect—are reported by at least 5 million older adults every year (ACL, Administration on Aging [AoA], 2016b). The elder justice movement has progressed significantly since 2010—thanks, in large part, to the leadership of the ACL within the Obama administration (ACL, AoA, 2016a; HHS, 2014; WHCOA, 2015). The passage of the Elder Justice Act of 2009 (S. 795) as part of the ACA signified a milestone, but inadequate appropriations have hindered implementation of the law.

The causes of elder abuse, neglect, and exploitation are many and complex; yet, ageism is certainly a contributing factor (Volmert & Lindland, 2016). Although the effects of ageism are pervasive, recognition of ageism remains absent from much public discourse on aging, and efforts to change such discourse are under way (Lindland, Fond, Haydon, & Kendall-Taylor, 2015; O'Neil & Haydon, 2015; Robbins, 2015). At the same time, ageism is but one of many social determinants that influence late-life wellness. Structural biases and oppression related to class, ethnicity, race, sexual orientation, gender, and gender identity, among other factors, impede access to economic, health, and social resources throughout the life span, and the intersectionality of these cumulative effects often diminishes older adults' well-being (Murphy, Hunt, Zajicek, Norris, & Hamilton, 2009; National Academies of Sciences, Engineering, and Medicine, 2016; OWL, 2012; Services and Advocacy for Gay, Lesbian, Bisexual & Transgender Elders, 2016; HHS, Office of Disease Prevention and Health Promotion, 2016a, 2016b; Woolf et al., 2015). Yet, the influence of social determinants on both the aging process and older adults' support networks constitutes a critical gap in the public's understanding of aging (Lindland et al., 2015). Policies and programs that respond to the distinct needs and strengths of communities that experience health and other socioeconomic disparities—especially older adults of color; lesbian, gay, bisexual, and transgender elders; veterans; older adults in prison and reentering their communities following a prison sentence; older adults with intellectual and developmental disabilities; older adults with chronic mental illness; and older adults with a migration background—are particularly needed.

Equally central to supporting the rapidly growing, culturally diverse aging population is a well-trained interdisciplinary workforce (Dawson & Langston, 2016). The social work profession, with its strengths-based, person-in-environment perspective, is well positioned to provide person-centered services to older adults; to respond to the many complex ethical issues that arise in service delivery; and to lead programmatic, policy, and research efforts that enhance wellness among older adults (Council on Social Work Education, 2009; NASW, 2010, 2013, 2015a, 2015c). The

IOM has affirmed the increasing need for gerontological social work competencies across the profession and for social workers specializing in aging, highlighting the profession's initiatives to address the shortage of practitioners (IOM, 2008, 2012). However, multiple factors—such as deprofessionalization of social work services, lack of title protection, disproportionately low Medicare reimbursement rates, and restrictions on mental health services provided by clinical social workers—decrease older adults' access to professional social work services (NASW, 2015b, 2016a). The profession is working with policy-makers to address these barriers and, in so doing, to enhance the well-being of people as they age.

POLICY STATEMENT

Integral to the well-being of society is how it perceives and responds to aging, including how society supports the contributions and well-being of older adults. Moreover, social determinants of health have a profound influence on each person's aging process and support network.

Accordingly, NASW promotes age-friendly environments, including the provision of coordinated, person-centered, culturally and linguistically competent services to older adults across settings. NASW also supports legislation, policies, programs, research, and funding that promote late-life wellness by reflecting the following elements and goals:

- optimal physical, mental, emotional, social, spiritual, and functional well-being of all people as they age
- eradication of health disparities, economic and food insecurity, and ageism and other forms of systemic bias and oppression
- comprehensive health coverage for all older adults, regardless of ability to pay; full implementation of the ACA; preservation and strengthening of Medicaid, Medicare, and services for military service members and veterans; and a proactive public health agenda
- integration of and parity in reimbursement for health, mental health, and behavioral health services for older adults across the continuum of care, with particular attention to transitions between service providers and settings

- prevention and amelioration of social isolation, depression, and substance use disorders (including prescription drug misuse) among older adults; reduction in suicide among older adults
- self-advocacy, lifelong learning, creative expression, civic engagement, and equal employment opportunity among older adults; strengthening of intergenerational relationships
- a social insurance financing system that provides comprehensive and affordable LTSS (including transportation, technology, and accessible, service-enhanced housing) that enable older adults to maintain maximal independence in the setting of their choice; preservation and strengthening of the OAA
- educational, emotional, financial, and physical support for family caregivers, recognizing each older adult's definition of "family"; support for older adults who provide kinship care
- expansion of public and commercial systems of economic security for older adults, with particular attention to preserving and strengthening Social Security
- prevention of and intervention for elder abuse, neglect, and exploitation across settings; implementation of the Elder Justice Act
- dignity, quality of life, and self-determination, as defined by each older adult, during serious illness and at the end of life; engagement in an ongoing process of advance care planning; timely access to palliative and hospice care
- interprofessional education, training, and research in aging; interdisciplinary collaboration within and across service settings and systems
- aging-specific educational content, field placements, and research opportunities for social workers at the bachelor's, master's, and doctoral levels; mentoring, supervision, competency-based continuing education, credentialing, loan repayment, and loan forgiveness for social workers in aging
- integration of and reimbursement for professional social work services across the continuum of care and services accessed by older adults; title protection for social workers; continued development of the evidence

base for the multifaceted social work role in aging; social work leadership of programmatic, policy, research, and interprofessional educational initiatives in aging

- collaboration with older adults and family caregivers, across cultural communities, in the design, implementation, and evaluation of aging-related programs, policies, and research.

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Capital Punishment and the Death Penalty

BACKGROUND

Although more than two-thirds of the countries of the world have abolished the death penalty in law or practice since adoption of the Universal Declaration of Human Rights over 60 years ago, the practice of capital punishment persists in the United States. Although 16 states and the District of Columbia have abolished capital punishment (Death Penalty Information Center [DPIC], 2011), 34 states, the U.S. government, and the U.S. military continue to practice capital punishment.

According to the DPIC (2010a), 46 individuals were executed in the United States in 2010, representing a 12 percent decrease compared with 2009 and a 54 percent decrease since 2000. New death sentences were imposed on 114 individuals in 2010, compared with 234 in 2000.

Two Supreme Court decisions, *Ford v. Wainwright* (1986) and *Atkins v. Virginia* (2002), are believed to be significant factors in these declining numbers. *Ford v. Wainwright* established that it is unconstitutional to impose the death penalty on an individual deemed insane or incompetent to stand trial; that is, unable to understand the legal circumstances and participate in his or her defense as a result. In *Atkins v. Virginia*, the court ruled that execution of an individual with "mental retardation" (now referred to as *intellectual disability*) was a violation of the 8th Amendment ban on cruel and unusual punishment. Yet, while over two decades have passed since *Ford* and one since *Atkins*, mental health advocacy groups (that is, National Alliance on Mental Illness, Mental Health America) estimated that 5 percent to 10 percent of individuals on death row have a serious mental illness (American Civil Liberties Union [ACLU], 2009a; Mental Health America, 2011).

According to national polls, public support for the death penalty has shifted dramatically in recent years, with a growing number of people favoring penalties other than death, such as life without parole, restitution to victim families, and reallocation of limited funds to crime prevention initiatives (DPIC, 2010b). Concerns related to execution of innocents and doubts about the effectiveness of the death penalty in deterring crime are among the reasons cited for declining support. Even police chiefs have indicated that the death penalty is ineffective in reducing crime, placing the death penalty as a low priority in how limited funds for law enforcement should be allocated (Dieter, 2009).

Despite international calls to abolish the death penalty (United Nations Commission on Human Rights, 2005; United Nations General Assembly, 2007) and waning public support for capital punishment, it is significant to note that the United States remains the only country in the Americas to conduct executions. Between 1930 and 2009, 6,050 individuals have been executed in the United States, and more than 3,200 people currently on death row await execution (Amnesty International, 2010; DPIC, 2010a). Only China, Iran, Iraq, and Saudi Arabia execute more people than the United States (Amnesty International, 2010).

ISSUE STATEMENT

Several complex issues emerge in discussions of capital punishment and the death penalty. Given the complexity of the concerns related to capital punishment and the finality of an execution, the appropriateness of using the death penalty in the United States and other countries warrants consideration of several topics.

Equal application of the law and protection of the dignity of every human being are fundamental to a system that upholds social justice. Evidence that application of the death penalty is too arbitrary, too prone to error, and unfairly administered supports the argument that our current criminal justice system is not reliable enough to serve principles related to social justice (“National Coalition to Abolish,” 2010). As noted by Amnesty International (2010), attorney competence, race, economics, local politics, geography, and the plea bargaining process are among the array of factors that affect prosecutorial decision making related to seeking the death penalty.

Considerable evidence exists that the U.S. criminal justice system has sentenced innocent people to death and that some have been executed (DPIC, 2011). Since 1973, 138 people have been exonerated and released from death row as a result of acquittal, dismissal of charges, or pardon. These individuals spent an average of 9.8 years incarcerated and awaiting execution prior to exoneration (DPIC, 2010b). Although it is impossible to determine with certainty how many innocent individuals have been executed, the DPIC (2011) has identified nine cases involving execution of individuals where strong evidence of innocence exists. In addition, four individuals have been issued posthumous pardons in Colorado, South Carolina, and Georgia, based on evidence of innocence.

Another aspect of social justice is the apparent racial disparity that exists in application of the death penalty at all levels— charging, sentencing, and executing. Of the nearly 3,300 inmates on death row today, 56 percent are people of color and 44 percent are black (DPIC, 2011). Race has been shown to be a factor in multiple ways, on both the defendant and victim sides of the equation. First, evidence exists that prosecutors are more likely to initiate the death penalty process in cases where the victim is white (Davis, 2007). Furthermore, according to the ACLU (2009b),

> studies consistently demonstrate that, everything else being equal, a defendant is approximately four times more likely to get the death penalty for killing a white person than for a black person. The racial configuration by far the more likely to result in a death sentence is a black defendant and a white victim.

Over 75 percent of the murder victims in cases resulting in an execution were white, even though nationally only 50 percent of murder victims generally are white (National Association for the Advancement of Colored People, 2010). The issue of race also applies to racial composition of juries, with studies across various death penalty states demonstrating that in “black on white” murder cases juries with six or more white male jurors issue a death sentence 78.3 percent of the time (ACLU, 2009b). Finally, another level of racial disproportionality is reflected in executions. The U.S. Census

Bureau (2010) estimated that 12.9 percent of the 2009 population was black. With 34 percent of inmates executed since 1976 being black, the racial disproportionality represented in executions is readily apparent.

According to Amnesty International (2009), approximately 90 percent of people facing the death penalty cannot afford their own attorneys, and many states continue to fail to meet standards developed by the American Bar Association for appointment, performance, and compensation of counsel for indigent prisoners. Amnesty International (2010) stated that poor legal representation is a persistent issue. The failure to provide adequate counsel to capital defendants and death row prisoners is a defining feature of the death penalty in the United States. The decision regarding whether a defendant will be sentenced to death typically depends more on the quality of the defense legal team than any other factor. Although some lawyers have provided outstanding representation to capital defendants, few defendants facing capital charges can afford to hire an attorney, so they are appointed attorneys who are frequently overworked, underpaid, and inexperienced in trying death penalty cases (Amnesty International, 2010). In some cases, lawyers representing defendants in capital trials have slept through parts of trial, shown up in court intoxicated, and failed to do any work at all in preparation for the sentencing phase (Amnesty International, 2010).

Although legal cases have established that individuals shown to meet the standard of mental retardation or incompetence at the time of trial should not be subject to the death penalty, other or lesser conditions of mental illness and neurological impairment as well as competence at the time of the crime have not been fully addressed judicially or legislatively. Therefore, individuals with such conditions are left to substantiate these issues during the guilt/innocence and penalty phases of trial, relying on effectiveness of counsel, affordability of experts, and understanding of jurists to weigh the mitigating evidence. The aforementioned issues related to effectiveness of legal counsel, impoverishment of capital defendants, and bias in jurist decision making raise serious questions about the degree to which mental illness and other brain impairments are adequately addressed during death penalty trials. With research evidence that nearly all death row inmates suffer from brain damage due to illness or trauma and that a vast number of them have experienced severe physical or sexual abuse, there is little doubt that the current system does not adequately account for and protect capital defendants suffering from mental illness, neurological impairments, and trauma histories that may have factored into a defendant's actions at the time of the crime (ACLU, 2009a; Beck, Britto, & Andrews, 2007).

Proponents of the death penalty point to deterrence of crime as a reason to uphold the death penalty. However, data released by the DPIC (2010c) reveal that states with the death penalty have had consistently higher murder rates over the past 20 years than those states without the death penalty. Furthermore, research has shown that "the murder rate in non–death penalty states has remained consistently lower than the rate in states with the death penalty, and the gap has grown since 1990" (DPIC, 2011). In addition, studies have shown that the United States continues to have a higher murder rate than other developed countries that do not use the death penalty (Amnesty International, 2010).

Although recognizing that deterrent sanctions may be a valid and necessary part of our system of criminal justice, statistics used to argue both sides fail to uphold the notion that the death penalty acts as a deterrent to homicide. In fact, Federal Bureau of Investigation reports show that, in general, homicide rates are lower in non– death penalty states. The South, which accounts for 80 percent of executions, repeatedly has the highest murder rate, and the Northeast, which accounts for less than 1 percent of executions, has the lowest murder rate (DPIC, 2011). Although these figures do not disprove that individuals may be deterred from committing murder by the existence of the death penalty, they do suggest that the death penalty is not likely to be a more effective deterrent than an alternative such as life imprisonment.

In a climate of concern about state and federal budgets, it is critical to consider fiscal issues in assessing application of the death penalty. Fiscal analysts have noted that the costs associated with the constitutionally required complex procedures in death penalty trials and subsequent appeals result in significantly higher costs in capital cases than in those involving life without parole (Death Penalty Focus, 2011). The ACLU has documented numerous incidences in which death penalty costs have presented significant budgetary challenges for jurisdictions, depleting funds that might otherwise be allocated to other priorities, such as job creation, public safety, and schools. The most comprehensive study found that the death penalty costs North Carolina $2.16 million more per execution than the cost of a non– death penalty murder case, with a sentence of imprisonment for life occurring at the trial level (DPIC, 2011). Thus, even with limits on appeals, the higher costs at the trial level would remain. A DPIC (2011) report suggested that since the reinstitution of the death penalty in 1976, the United States has spent $2.5 billion more than if the country used life imprisonment as the maximum punishment. In addition, data show that the costs for housing an inmate on death row in California is $90,000 per year greater than the housing costs associated with confinement of those serving life without possibility of parole (ACLU of North Carolina, 2008). The California Commission on Fair Administration of Justice (2008), in a study of the California criminal justice system, estimated that the state's current annual costs related to the death penalty approached $137 million annually. This compares with a system that would establish a maximum penalty of lifetime incarceration instead of the death penalty costing an estimated $11.5 million per year.

NASW's broad ethical principle that social workers respect the inherent dignity and worth of each person contraindicates support of the death penalty. Capital punishment represents an official, societally sanctioned act of killing as a way to deal with lethally violent behavior. Although homicide is unquestionably an act that diminishes the value and worth placed on human beings, the legitimization of killing through capital punishment also diminishes the value and worth of the perpetrator. Both forms of killing are thus a violation of individual dignity and worth.

Capital punishment and the death penalty undermine the ability of professional social workers working within the criminal justice system to enhance a defendant or convicted client's capacity and opportunity for ongoing change. Although murder is a reprehensible crime, infliction of the death penalty on people convicted of murder permanently forecloses their capacity for redemption and reform. Although returning individuals who have committed murder to the community may not serve the best interests of society, life terms served in prison create the potential for these incarcerated individuals to recognize and recover from the emotional wounds that fueled their addiction, violence, and criminal behavior. In addition, alternatives to capital punishment provide opportunities for the needs of offender families, victim families, and communities to be served (Beck et al., 2007). The very act of executing the condemned by capital punishment denies the inherent worth of the individual. Thus, capital punishment is antithetical to the theory of restorative justice and the view that rehabilitative restoration is valuable for the condemned and for society. Restorative justice has as its foundation the belief in the capacity of an individual to experience true remorse accompanied by a difference in mindset and behavior. Capital punishment completely eliminates any consideration of and possibility for a convict to change.

Finally, this ethical principle, and the corresponding standard in the *Code of Ethics* (NASW, 2008), urges social workers to be cognizant of their dual responsibility to clients and to the broader society and to seek to resolve conflicts between clients' interests and those of the broader society in a socially responsible manner consistent with the values, principles, and standards of the profession. Rather than being a deterrent to violent crime, capital punishment legitimizes and expands the cycle of violence in society at large by promoting violence as a solution to intractable human problems and behaviors. By opposing the death penalty, social workers seek socially responsible alternatives aimed at stopping the cycle of violence that is damaging and destroying human capacities and relationships in society and in the world.

Proponents of capital punishment often point to the penalty as a form of retribution for the families of victims. However, crime victims' families respond to the death penalty in a variety of ways. Whereas some argue for vengeance or atonement, others argue against the death penalty because it continues the cycle of violence. There are organizations aimed at assistance for crime victims that is congruent with social work values and ethics. For example, Murder Victims' Families for Reconciliation opposes the death penalty and supports the redirection of money currently spent on executions to victim-assistance programs. Restitution Incorporated helps death row inmates sell their artwork to support families of their victims or for crime prevention programs, and some groups seek actual reconciliation between murderers and victims' families (Murder Victims for Human Rights and National Alliance on Mental Illness, 2009).

POLICY STATEMENT

NASW supports

- abolition of the death penalty and an immediate moratorium on executions for those already sentenced.
- a system that encourages multi-stakeholder involvement in establishing opportunities for restorative justice rather than retributive justice.
- a system that ensures that criminal defendants, especially in death penalty cases, receive thorough mental health, psychosocial, and trauma assessments.
- involvement of social workers as qualified professionals in the collection and assessment of mitigation evidence in guilt/innocence and penalty phases of capital trials.
- inclusion of social workers as qualified expert witnesses related to mental health and trauma history (such as domestic and community violence, trauma, substance use) issues in the backgrounds of capital defendants.
- allocation of limited budgetary resources to cost-effective sentencing and prevention initiatives.
- restorative justice programs that support the belief in the possibility for change and the option for rehabilitation and restoration.

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Child Abuse and Neglect

ISSUE STATEMENT

Child abuse and neglect in our nation was termed a "national emergency" by the U.S. Advisory Board on Child Abuse and Neglect in 1990; in 2013, the Institute of Medicine (IOM, 2013) finally identified it to be a serious public health issue. Child abuse and neglect continues to have major repercussions for the individuals who experience and perpetrate child maltreatment, for the service delivery systems that are intended to prevent and address this serious problem, and to society itself. The impact of child abuse and neglect cascades throughout one's lifetime with a combination of economic, social, mental health, and health consequences (Felitti, 2002; IOM, 2013). The total lifetime economic impact of just one year of confirmed cases of child abuse and neglect is estimated to be $124 billion, according to the Centers for Disease Control and Prevention (Fang, Brown, Florence, & Mercy, 2012). Gelles and Perlman (2012) estimated that, in 2012, child abuse and neglect cost the nation $80 billion.

Child abuse and neglect is defined in the Child Abuse Prevention and Treatment Reauthorization Act (P.L. 111-324) as "any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm" (p. 6). The legislation and most state child protection laws specifically focus on harm caused by parents or caregivers and do not include other people, such as acquaintances and strangers, making a distinction between civil and criminal definitions and actions.

Despite child abuse and neglect being a serious social problem, accurate statistics are difficult to determine in regard to its scope and severity. This is due to differing definitions across states and underreporting of the actual incidences of such maltreatment (IOM, 2013; Sedlak et al., 2010). One important annual source of data, based only on formal abuse and neglect reports to Child Protective Services (CPS) agencies, is the National Child Abuse and Neglect Data System maintained by the Children's Bureau of the U.S. Department of Health and Human Services, Administration for Children and Families (HHS, ACF) with the most recent report being *Child Maltreatment 2012.* According to that report, 3.4 million CPS referrals were made involving 6.3 million children, with 678,810 children found to have experienced abuse or neglect (9.2 per 1,000 children). The majority of children found to be abused or neglected were white (44 percent), African American (21 percent), or Hispanic (21.8 percent). About one-fifth of these children were younger than one year of age. An estimated 1,640 children died from child maltreatment in 2012, with almost three-quarters of these deaths occurring in children younger than three years of age. Boys had a slightly higher rate, and 85.5 percent of child fatalities comprised white (38.3 percent), African American (31.9 percent), and Hispanic (15.3 percent) victims, indicating some racial disparity (HHS, ACF, 2013). The child death rate is an undercount, with estimates that there may be as many as 2,500 child abuse deaths each year (Every Child Matters Education Fund, 2010; Government Accountability Office, 2011).

The National Incidence Study (NIS) looks at the scope of the problem using data sources beyond child abuse and neglect reports and uses standardized definitions of abuse and neglect. The fourth NIS report (NIS-4), issued in 2010, noted an overall decrease in estimates for children who were sexually abused, physically abused, or emotionally abused but no change in neglect, and with the estimated number of children in danger of emotional neglect actually increasing (Sedlak et al., 2010).

Child neglect affects the largest number of children, with over 78 percent of cases experiencing neglect. Neglect may be physical, medical, emotional, or educational, or a combination of all, and may also occur along with physical or sexual abuse (Child Welfare Information Gateway, 2013). The most common occurrences of physical neglect include abandonment; medical neglect; inadequate nutrition, clothing, or hygiene; or leaving a young child unattended (Children's Bureau, Office on Child Abuse and Neglect [OCAN], 2006).

About 18.3 percent of cases experience physical abuse, and less than 10 percent experience sexual abuse (HHS, ACF, 2013). Although multiple sources of statistics suggest that the prevalence of sexual abuse and physical abuse have decreased over the last decade, there have not been similar decreases in rates of neglect or of child deaths (HHS, ACF, 2013; IOM, 2013). For those substantiated reports of child abuse and neglect, it is estimated that around 80 percent of children remain in their own home after an investigation, with the greatest likelihood for out-of-home placement being for infants (IOM, 2013).

Child maltreatment exists in a complex web of family interactions, and increasingly there has been a focus on the lifelong implications of abuse and neglect, due to findings from the Adverse Childhood Experiences Study (Felitti, 2002), among other research. Risk factors for abuse and neglect can include children's exposure to community violence, children who are bullied, children with disabilities, and children in households where there is substance abuse or maternal depression, or a history of abuse and domestic violence (Children's Bureau, OCAN, 2003; IOM, 2013). Conflict can arise when trying to protect women who are not only being abused by their partners, but also secondarily traumatized by having their children removed because of the dangerous home environment. Parents with disabilities are at high risk for having their children removed from their homes (National Council on Disability, 2012). Despite risk factors, it is also important to understand how protective factors and resilience affect outcomes for those who have experienced abuse and neglect (Children's Bureau, n.d.).

Child welfare agencies and their staff are under increased scrutiny to address institutional racism and racial inequity in decision making (Center for the Study of Social Policy [CSSP], 2010; Child Welfare League of America, 2013). It should also be recognized that population-level analyses do indicate greater child and family risk for some racial and ethnic groups (Drake et al., 2011; Putnam-Hornstein, 2012). It is important to address racial equity in child welfare agency practices as there are concerns about African American, Native American, and Hispanic children being inadequately or inappropriately involved with the child welfare system (Annie E. Casey Foundation [AECF]/ Casey Family Programs, n.d.; IOM, 2013). There is also evidence that African American and Native American children are more seriously abused and at greater risk of death from accidental injury, even after becoming involved with child welfare services (Putnam-Hornstein, 2012). Clarity about the prevalence of child abuse and neglect is further complicated by the difficulty of assessing environmental, economic, and social risk factors. These issues call attention to the importance of examining cultural processes, social stratification, ecological variations, and immigrant and acculturation status at every step—from child abuse reporting to prevention and intervention services, to agency and court decision making (CSSP, 2009, 2010; IOM, 2013). The growing number of military and veterans families with young children; overinvolvement of children with disabilities; and risk factors for lesbian, gay, bisexual, transgender, and questioning youths further demand careful attention to these factors (IOM, 2013; Social Work Policy Institute, 2013).

Policy Developments

Organized efforts to protect children are long-standing, with the history of organized protection of children in the United States dating back to 1874, when the cruelties perpetrated on Mary Ellen Wilson resulted in referral to the American Society for the Prevention of Cruelty to Animals, spurring creation of the New York Society for the Prevention of Cruelty to Children in 1875, with 250 such societies by 1900 (McGowan, 2013). The creation of the Children's Aid Society in New York City in 1853, moving children from childhood labor and homelessness in New York City to farm families, also brought attention to children in need of protection (Children's Aid Society, n.d.; for an overview, see http://www.childrensaidsociety.org/about). However, this narrative pertains to protection of white children, as African American children and Native American children were not served by these agencies. For Native American children, between 1870 and the 1930s, there were often forced disruptions of family connections through placement in boarding schools, where the school staff sometimes abused the children.

The creation of the Children's Bureau in 1912 brought federal focus to children, highlighting child labor, infant mortality, poverty, and delinquency. The Social Security Act, passed in 1935 (P.L. 74-271), intended to protect children living in poverty through the creation of Aid to Dependent Children and a foster care program for children unable to stay with family. As services expanded in both private and public agencies, there was tension between protection of children by placing them out of the home and family support—helping families to preserve the home for the child (McGowan, 2013). This tension continues today.

The publication of “The Battered-Child Syndrome” (Kempe, Silverman, Steele, Droege-mueller, & Silver, 1962), describing physical abuse, ignited public concern focusing on the potential value of reporting and investigating child abuse. In 1974, the Child Abuse Prevention and Treatment Act (CAPTA) (P.L. 93-247) was passed, and has been reauthorized and amended regularly, most recently in 2010 (42 U.S.C.A. §5106g). Legislation making the reporting of child abuse mandatory created a societal responsibility for the protection of children and established parameters for the degree to which parents could use physical or other means to punish their children. Concerns about physical punishment of children that might border on abuse are concerns that continue today.

CAPTA provides funding for prevention, assessment, investigation, prosecution, and treatment activities and the development of community-based prevention efforts. Beyond CAPTA, states also use other federal funds (for example, Title IV-B; Title IV-E Waiver Demonstrations; Temporary Assistance for Needy Families; the Maternal and Child Health block grant; Children’s Justice Act; the Social Services block grant; and Medicaid), along with state and foundation dollars, to finance an array of child abuse prevention and intervention strategies (AECF, 2010; McGowan, 2013).

The codification of safety as one of the three child welfare goals—with the other two being permanence and well-being—occurred in the Adoption and Safe Families Act of 1997 (P.L. 105-89). This law also created time limits for children in out-of-home care before calling for termination of parental rights, and created new mandates around permanency planning, a practice that began with the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) (see NASW’s Foster Care and Adoption policy statement). The Indian Child Welfare Act (P.L. 95-608), passed in 1978, requires active efforts to prevent out-of-home placement of American Indian and Alaska Native children and returning children to family, tribe, or tribal culture in a timely way (Whitekiller, Cahn, Craig-Oldsen, & Caringi, 2013); however, the intent of the law is yet to be fully realized (Cro-foot & Harris, 2012). Also unrealized are the requirements of CAPTA that all substantiated cases of child abuse of children under the age of three be referred to early intervention services and that all children born prenatally drug exposed receive a referral to Child Protective Services (CPS).

In 2010, several legislative efforts strengthened child protection, including the Maternal and Child Health Early Intervention Home Visiting provision of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), using evidence-based home visiting programs to support high-risk families, and the Fostering Connections to Success and Increasing Adoptions Act of 2010 (P.L. 110-351) expanded kinship guardianship and provided funds for Family Connections grants to keep children in out-of-home care. The 2010 CAPTA reauthorization required state plans to include information on how states offer “differential response”— making referrals to community services for children not in imminent harm—and required states to report information about their CPS workforce. These emerging differential response or “alternative response” efforts are now underway in at least 21 states (National Quality Improvement Center on Differential Response in Child Protective Services, 2011).

Numerous evidence-based prevention and intervention services programs have been identified that work, such as parent education and training, professional practice reforms (screening, family engagement), early home visiting, public awareness campaigns, parent management training, and trauma-focused clinical interventions (IOM, 2013).

Concerns are continually raised, however, that implementation of these interventions in child welfare systems are often plagued by high caseloads, staff turnover, and staff without the competencies to implement the interventions. Although federal policy has focused on working to keep children in their homes and to find children permanent and stable homes, there is continued concern about insufficient attention to prevention. The majority of federal funds support out-of-home care, and despite policy proposals to change financing of child welfare services and to focus on prevention and support to families, these changes have not been realized (AECF, 2013; American Public Human Services Association, 2012) (see NASW’s Foster Care and Adoption Policy statement).

Although child abuse and neglect work is a multidisciplinary field, the social work profession has a long-standing and important role to play. Social workers bring a unique body of knowledge, including concepts of working with people in their environments and the primacy of the family, understanding that helping the child means working with the whole family and with other environmental factors in a culturally responsive way. It means that they understand the devastating impact of poverty on children. Trained social workers understand the consequences of having natural and healthy developmental processes interrupted by traumatic events. Social workers are taught that prevention should be at the front end of all interventions. Prevention of child maltreatment is obviously a better strategy than dealing with the aftermath of child abuse and neglect.

POLICY STATEMENT

NASW asserts the following positions:

- Children have the right to be treated with respect as individuals and to receive culturally responsive services. Children have the right to express their opinions about their lives and have those opinions considered in all placement and judicial proceedings.
- Communities, including family members, kinship networks, and neighborhoods, must be involved in supporting children and caregivers to ensure a safe, secure, and consistently stable living environment.
- Immigrant children should have the same rights and protections as children who are citizens of this country.
- Systems in place to protect children should be adequately staffed and fully funded.
- A BSW degree is recommended as the minimum requirement for staff in all child welfare services, including child protective services. At the supervisory level, an MSW degree is recommended.
- Services provided should reflect culturally responsive evidence-based practices to address the problem of child abuse and neglect, and workplace organizational culture and climate and supervisory and administrative support should be aligned to implement such practices.
- Policies and procedures in human services organizations should address and ensure the safety of social workers and other professionals working with abuse and neglect cases and should include strategies for helping the staff deal with secondary trauma as well as processes to assist staff who

are dealing with the death or serious injury of a child or children involved with the agency.

- Child abuse and neglect investigations and substantiations are best conducted using a specially trained, multidisciplinary team, including social workers, law enforcement, and health and mental health professionals.
- Standardized definitions of child abuse and neglect must include identification of emotional, medical, and psychological abuse and neglect, and risks and harm to children exposed to violence, as well as abuse that occurs through current and emerging technologies; they must state the responsibility to provide intervention for such conditions no matter the etiology.
- Systematic changes are needed in child abuse reporting systems to ensure more standardized and effective intake and assessment systems.
- Services to prevent and ameliorate child abuse and neglect, and the systems in which they are embedded, must be culturally responsive to the diverse characteristics of parents, caregivers, and communities; and must address disparities, disproportionality, and structural racism in decision making and service access.
- All states must create and enforce laws that protect child witnesses of domestic violence and provide appropriate care for nonoffending parents and the children.
- Authorities should leave nonoffending parents or guardians and their children in their own homes, when it is safe, and remove the batterers to preserve the stability of children’s care-giving and residence in domestic violence cases.
- Staff with social work degrees should be employed in schools, mental health programs, hospitals, and other human services organizations that deal with children and their families.
- All comprehensive medical assessments should address abuse and neglect issues.
- Child maltreatment issues should be part of the curriculums of all programs that train early childhood, school, and health and mental health professionals.

- Family-centered residential treatment programs for substance-abusing parents should be available to facilitate opportunities to help parents and children maintain the parent–child bond.
- Public awareness, media, and educational campaigns are needed to highlight the significance of child abuse and neglect issues, and the related legal requirements of reporting systems.
- Sexual abuse and physical abuse prevention programs should be mandated in all schools from kindergarten to high school, and all parents should have access to training and support to learn nonviolent disciplinary techniques.
- The United States should ratify the United Nations Convention on the Rights of the Child.
- Funding should be dramatically increased for research, prevention, and services in all areas of child maltreatment, including attention to the intersection with poverty and strategies to achieve racial equity.
- To truly help protect children by preventing child maltreatment, social workers and other professionals must help families by identifying and addressing the individual, familial, and community challenges they encounter so that children's basic needs are met and parents have the energy and emotional resources to use nonviolent disciplinary practices.
- Child maltreatment issues and concerns do not operate in isolation. To improve service delivery in the area of child abuse and neglect, those systems that run parallel—mental health, substance abuse, domestic abuse, homelessness, education, and health care—need to be enhanced to effectively develop a service continuum directed at safety for children.

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Child Welfare Workforce

ISSUE STATEMENT

The nation's most vulnerable children, youths, and families are served by child welfare systems. These systems are designed to protect children from abuse and neglect, ensure their well-being, achieve permanency, and strengthen families (Child Welfare Information Gateway, 2012; NASW, 2013). The array of services provided by child welfare systems can include in-home services and supports, out-of-home care such as kinship care, family foster care, group or residential placements, and adoption. Although all states must be in compliance with federal and state requirements, child welfare services and programs vary across the country. Each state or county can differ in child welfare service delivery approaches; funding streams; and the education, licensing, and training requirements for child welfare staff. In addition, each jurisdiction can differ in whether services are provided by public or private child welfare agencies. Regardless of a child welfare system's administrative structure, a qualified, skilled, dedicated, and culturally competent workforce is critical to effective child welfare service delivery and positive outcomes for children and families (Torrico Meruvia, 2010; Zlotnik, Strand, & Anderson, 2009).

Child welfare workers are faced with critical life-and-death decisions daily—all while working in fast-paced, stressful work environments. Too often, child welfare workers have tremendously high caseloads and inadequate supervision, training, and resources (Torrico Meruvia, 2010). In addition, workers lack adequate salaries and professional development opportunities and are responsible for too many administrative burdens. They also run the risk of violence, and experience secondary traumatic stress and emotional fatigue while on the job. All of these factors can affect child welfare systems' recruitment and retention of qualified child welfare staff. In fact, a majority of states have reported challenges of both the recruitment and the retention of their child welfare workforce (Whitaker, Reich, Brice Reid, Williams, & Woodside, 2004).

The long-term impact of child welfare decisions demands a skilled child welfare workforce with working knowledge of child, youth, and adult development, role and impact of trauma, parenting and family dynamics, and evidence-based interventions (NASW, 2013). Historically, social workers have played critical roles in child welfare systems (NASW, 2005; NASW, 2013), and research demonstrates that a social work education is most appropriate for effective child welfare practice (Child Welfare League of America, 2002; NASW, 2013). Schools and departments of social work also play important roles in preparation of BSW and MSW students for child welfare careers, as well as in other professional development, research, and consultative roles (Zlotnik, 2013). Yet, fewer than 40 percent of child welfare workers have social work degrees (Barth, Lloyd, Christ, Chapman, & Dickinson, 2008). The critical decisions that affect the lives of thousands of children, youths, and families require a degree of professional expertise.

POLICY STATEMENT

NASW asserts the following positions as an organization:

- Effective services to children and families in child welfare demand the values, knowledge, and skills that are intrinsic to social work education; therefore, a BSW degree is recommended as the minimum requirement for child welfare workers. An MSW degree is recommended at child welfare supervisory and administrative levels.
- Children and families who are served through the child welfare system have a right to high-quality services delivered by skilled professional social workers who maintain high standards of professional ethics and practice in child protection, kinship care, foster care, group care, and adoption, with an emphasis on keeping children connected to families of origin.
- The social work profession’s core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity,

and competence (NASW, 2008) guide effective and culturally and ethnically responsive child welfare service delivery.

- Title protection allows only workers with a social work degree to use the title of social worker and ensures a high level of education, training in the field, and a solid grounding in the *Code of Ethics*.
- New child welfare system reform efforts are needed to ensure the safety, permanence, and well-being of children and families involved in child welfare and support the child welfare workforce.
- Federal funding invested in education, training, and loan forgiveness programs supports the recruitment and retention of social workers in child welfare.
- A skilled and culturally competent child welfare workforce is the underpinning of effective service delivery. To effectively recruit and retain a qualified and committed workforce, child welfare organizations must
    - create a safe organizational culture and climate that prioritizes worker safety;
    - support child welfare workers through consultative and supportive supervision;
    - promote the development and use of culturally responsive, evidence-based, and research-informed practices that improve the lives of children and families;
    - assess and address issues of disproportionality and disparities in the population it serves and its impact on the workforce;
    - support reasonable workload and caseload limits, in accord with nationally established standards;
    - provide professional development opportunities, payment of licensure fees, and financial incentives for practice in underserved communities;
    - promote job flexibility options such as telecommuting and alternative work schedules;
    - invest in the use of advanced and emerging technologies to enhance service delivery and management of workloads;
    - secure adequate salary levels for child welfare workers;

- collaborate with partner organizations to advocate to fully fund child welfare funding streams to support the workforce and improve and increase services for vulnerable children, youths, and families.

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Civil Liberties and Social Justice

ISSUE STATEMENT

In democratic societies, *civil liberties* are defined as basic rights guaranteed to individual citizens by law. For example, in the United States freedom of speech and action are fundamental civil liberties. *Social justice* is often defined in terms of societal fairness regarding the distribution of wealth, access to opportunities that lead to individual achievements and well-being, and equal privileges for all citizens within a society. Thus, advancing social justice through the protection and preservation of individual civil liberties as granted by the first amendment of the U.S. Constitution is viewed as an essential tenet that guides our national ethos. A primary value of the social work profession is seeking to ensure that everyone has equal access to resources and equal protection of laws, regardless of race, ethnicity, sexual orientation, disability, or socioeconomic status.

Voting Rights

The right to vote remains one of the main civil liberties that people of color and justice-involved individuals are concerned about. Primarily, these populations need protections against voting suppression and the gerrymandering that limits their voting power. For example, since the 2008 election of President Obama, the voting rights of vulnerable mostly black and Hispanic populations have been threatened by voter ID laws. Currently, 36 states have enacted voter ID laws that disproportionately affect elderly, racial and ethnic minority, and low-income individuals. Requirements to obtain a government-issued photo ID places geographical and financial barriers to voting on minority citizens who have only recently begun to gain influence in the political process. Other threats to the right to have one’s vote counted include lowering early voting periods and purging voter rolls of people convicted of a felony at some point in their lifetime.

The most significant voting rights protection that has been compromised is the Voting Rights Act of 1965 (P.L. 89-110) when, in the *Shelby County v. Holder* case (2013), the U.S. Supreme Court declared Section V (the pre-clearance formula) of the Voting Rights Act unconstitutional.

Lesbian, Gay, Bisexual, and Transgender (LGBT) Civil Liberties Issues

The evolution of the LGBT struggle for equal rights has seen some gains such as the Supreme Court's ruling in 2015 that made same-sex marriage (*Obergefell v. Hodges*, 2015) the law of the land. Also, during 2016 there were favorable federal mandates that allowed for restroom accessibility (Davis & Apuzzo, 2016) for transgender people. However, the LGBT community continues to face discrimination and intolerance from a sizable segment of American society, and civil rights advocates need to stay vigilant in protecting the civil rights of this population.

Racial and Ethnic Disparities in the Criminal and Juvenile Justice Systems

Recent shootings of unarmed African American men have awakened discussions around police excessive use of force (Wihbey & Kille, 2016). The year 2016 marked the 20th anniversary of *Whren v. United States* (1996), in which the Supreme Court ruled that any traffic offense committed by a driver was a legitimate legal basis for a stop. Decisions like Whren have provided a legal foundation for racial profiling and implicit bias toward racial minorities that are evident in society today.

In 1994 federal legislation amended the Higher Education Act of 1965 (P.L. 89-329), excluding incarcerated individuals from eligibility to receive federal Pell Grant funding. In 2015 the U.S. House of Representatives introduced the Restoring Education and Learning (REAL) Act, which would repeal the 1994 exclusion and restore Pell Grant eligibility to prisoners. The movement has continued with the release of a 2016 Senate companion bill (S. 3122) to the REAL Act.

The need to eliminate all forms of racial disparities in the criminal and juvenile justice systems has become one of the most important civil rights and social justice issues of recent times. A movement toward criminal justice reforms has the support of both conservative and progressive policymakers and elected officials. The need for criminal justice and juvenile justice reforms covers a range of areas, including

- ending racial profiling
- eliminating disparities in sentencing based on race and ethnicity
- eliminating mandatory minimum sentences
- reforming the bail bond system
- ending racial disparities in adjudicating and incarcerating juveniles
- restoration of voting rights and civil liberties of justice-involved individuals.

Reforms in the Use of Restrictive Housing (Solitary Confinement)

The issue of the use of restrictive housing in prisons, jails, and juvenile detention centers has become a national problem. Through advocacy and insightful corrections administration, there has been a steady movement toward finding safe alternatives to solitary confinement. In 2016, many states and the federal Bureau of Prisons have taken steps to make major changes in the use of restrictive housing. Officials are beginning to recognize the serious mental health impact of prolonged isolation. In addition, juvenile justice officials have begun to eliminate the use of restrictive housing for juveniles (Eilperin, 2016) except for cases with dire safety concerns.

Death Penalty

In the 1972 *Furman v. Georgia* case, the Supreme Court ruled in favor of the reinstatement of the death penalty in many states. However, there is an ongoing concern over the use of the death penalty, particularly around possible "cruel and unusual punishment" violations. For example, the use of lethal injection to carry out executions is often seen as being cruel and unusual punishment. In addition, there is continued opposition to the death penalty because of evidence that racial and socioeconomic disparities continue to persist in its application.

Balance of Governmental Power

The social work profession vigorously seeks to affirm a national commitment to recognizing that freedoms are fundamental to all individuals and our society. There have been times in American history when constitutionally protected freedoms have been under attack at the local, state, and federal levels. A key question is how to balance the necessary exercise of the government's executive power for the common good with fundamental freedoms. For example, there are those who assert that the executive branch of government has a responsibility to exercise its authority to intervene to protect public safety, even if it may violate individual civil liberties and social justice goals to do so. Others vehemently defend the idea that individual civil liberties and freedom should never be compromised, regardless of the circumstances. Therefore, it is critical that there is a balance between the executive, legislative, and judiciary branches to reach consensus when such ambiguities arise.

A case in point is the recent state of the Supreme Court since the death of Justice Antonin Scalia in 2016. Historically, the Senate had expeditiously moved to fill the vacancy. However, the Senate majority party took the extraordinary steps to refuse to hold hearings on the nominee to replace Justice Scalia. This decision essentially blocked the ability to reach consensus between the executive and legislative branches of government. It also jeopardized the ability of the court to decide major pending social justice and civil liberty cases. The issue for social workers is to become cognizant of the governmental processes that can affect individuals' civil liberties.

Criminalization of HIV/AIDS

In a 2011 analysis conducted by the Centers for Disease Control and Prevention (n.d.) and the U.S. Department of Justice, researchers found that 33 states have enacted 67 laws that specifically apply to individuals living with HIV/AIDS. The analysis questions whether the laws meet their intended purpose and appeals to states to reexamine HIV/AIDS-specific legislation considering new therapeutic and preventive advances that reduce HIV transmission risk.

Prevention of Islamophobic and Anti-Immigration Policies

Since 2001, with the bombing of the World Trade Center, there has been a rise in anti-Islamic incidents in the United States. Recent terrorist attacks in this country have made the situation even worse (Luz, 2001). The pervasive calls for border security (mainly at the Mexican border) to stem the flow of undocumented immigrants have fomented fervent anti-immigrant feelings among many Americans. There are an estimated 11.5 million undocumented immigrants in the United States (Pew Research Center, n.d.). The issue of choosing mass deportation or providing a path to citizenship for these mostly Mexican immigrants has been highly politicized (Schneider, 2006).

First Amendment Rights

NASW embraces first amendment rights as being the cornerstone of a just society. The right to dissent from prevailing opinions of the majority—in political and cultural arenas—is a fundamental principle of a democratic society. In times of fractious political discourse, such as that seen recently, it is important that free speech is constitutionally protected. Free speech ensures that the balance of power between the executive, legislative, and judicial branches of government is maintained.

POLICY STATEMENT

NASW considers the protection of individual rights and the promotion of social justice essential to the preservation of our collective well-being as a society. Therefore, NASW urges social workers and other policymakers to focus on the following core NASW values.

Criminal and Juvenile Justice and Civil Liberties

NASW supports the following:

- reduction of the disproportionate number of youths and adults of color within the criminal justice and juvenile systems
- expanding alternatives to detention and incarceration, and development of an accessible, community-based network of resources that affords preventive services, mental health assessments, and early treatment for both juvenile and adult offenders; services must adhere to standards of care and be evaluated based on best practices models
- comprehensive criminal justice reforms such as the bipartisan Sentencing Reform and Corrections Act of 2016 (Legal Action Center, n.d.)
- expanding safe alternatives to solitary confinement to all federal, state, and local correctional facilities; ending the use of solitary confinement for juveniles, except for extreme situations that have life-threatening implications national law enforcement use of force standards and comprehensive disaggregated data collection on the use of force incidents by every authority
- comprehensive immigration reform to reduce the number of deportations of undocumented residents and allow for the 11.5 million undocumented immigrants to receive civil liberties protections afforded to all Americans
- laws, statutes, and policies that curtail Islamophobia and all forms of discrimination and profiling of religious minorities.
- NASW opposes the following:
- the use of mandatory sentencing requirements, particularly for first-time offenders

- the use of the death penalty as a method of punishment; any legislation and prosecutorial discretion that permit children to be charged and punished under adult standards
- life-without-parole sentences for juvenile offenders
- racial profiling under any circumstances
- laws that discriminate against transgender individuals, such as denial of access to gender-specific restrooms
- all laws and policies that restrict the right for LGBT individuals to marry.

Access to Justice, Equal Protection, and Due Process

NASW supports the following:

- the principle of habeas corpus, which safeguards people from unlawful imprisonment
- restoration of full funding for comprehensive civil and criminal legal aid services
- the notion that courts matter and advocating for the appointment of judges to the federal District Courts, the federal Circuit Courts of Appeals, and the Supreme Court who are committed to the maintenance of civil liberties and equal justice as guaranteed by the Constitution of the United States of America
- the appointment of federal and state judges who reflect the demographic diversity of the people of the United States, particularly women, people of color, LGBT people, and older adults
- the unimpeded application of individuals’ civil rights through the courts in such areas as sexual harassment, employment discrimination, and housing bias.
- NASW opposes the following:
- threats to freedom of the press and due process
- mandatory drug and HIV testing of employees, prospective employees, and criminal defendants for actions with no direct relation either to drug

abuse or HIV status

- any executive or legislative initiatives that would restrict the rights of individuals to file class action suits, either against the government or corporations.

Protection of Voting Rights

NASW strongly supports federal and state legislation and policies to make voting easier rather than more restricted. Therefore, NASW supports the following:

- passage of the Voting Rights Advancement Act of 2015 (H.R. 2867), which seeks to restore voting protections that were lost when the Supreme Court ruled that Section 5 of the Voting Rights Act of 1965 was unconstitutional
- passage of the Civil Rights Voting Restoration Act of 2015 (S. 457), which seeks to restore the right to vote for individuals who lose their right to vote following criminal convictions
- continued national advocacy, surveillance, and taking legal actions to prevent and overturn all efforts to suppress the vote of any segment of American society
- active advocacy for and strong encouragement of national and state governments to make voting easier rather than placing unnecessary barriers to voting.

Right to Privacy and Effects on Social Services

NASW strongly supports the preservation of the constitutional right to privacy and entitlement to services, especially in health and human services settings, and strongly condemns efforts by state legislatures, Congress, the executive branch of the federal government, or the courts to restrict access to information about abortion, contraception, or family planning, or to restrict access to any of these services.

NASW specifically opposes the following:

- the current ban on Medicaid funding for abortion and government efforts to erode and, ultimately, overturn the right of women to seek an abortion established in *Roe v. Wade* (1973) because such actions constitute an unjustifiable invasion of privacy
- violation of the confidentiality of welfare case records of individuals who seek assistance because of drug or alcohol abuse or HIV-related illness
- use of electronic information for purposes other than enhancement of services delivery to consumers.

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Community Development

ISSUE STATEMENT

Community-based social work practice dates to the 19th century, with the settlement house movement and efforts of social work pioneers such as Jane Addams. Programs at the Hull House—including an employment bureau; lunchroom; children's clubs; and classes in music, languages, painting, and mathematics— became models for other American settlement houses. An expert practical reformer, Jane Addams not only worked at a settlement house in Chicago, she lobbied Illinois lawmakers for legislation to benefit the poor while serving as neighborhood sanitation officer. She also challenged powerful and often corrupt ward bosses (Karger & Stoesz, 2018). Addams's efforts resonate with and inform social work– based community development. Social work rejects patronizing and disparaging ideas about people, groups, and communities and embraces deeply held values of respect for all people and communities with whom we work. Jane Addams epitomized these values.

Social work clients can be individuals, groups, or neighborhoods. Social work is grounded in the principle of viewing people in the context of their environment. Hence, micro and macro social work practices are intricately interconnected, and the profession must educate and practice in this fashion (Netting, Kettner, McMurtry, & Thomas, 2017).

Communities

Communities experience different types of challenges—economic, environmental, social, physical, and cultural. Social workers can play a significant role in the community development process.

Segregation by income and by race and ethnicity is still a terrible reality in our nation. Thus, by default, neighborhood is very important to low-income people, who are often denied choice in where they live. Social work needs to continue to engage in advocacy to expand housing choice. Social workers assist people in these neighborhoods to organize residents around issues such as blight, school quality, health, and economic development. Social workers help resident leaders to discover assets and strengths that are always present, but that may be invisible and not connected.

Today's communities are not only geographic in nature but also include identity and issue-based communities such as professional associations; communities with similar ethnic, racial, or religious backgrounds; online communities; social networks; and so on. The concept of community is far-reaching and reflects the many ways that human beings are linked and relate to each other, either through geographic proximity or some other affiliations (for example, similar socioeconomic status, faith). "The non-place-based communities have taken on more significance because we have the capacity to transcend geography" (Netting et al., 2017, p. 141).

There is a general concern across communities that the sense of "communitiness" has been lost and social workers must make efforts to regain, revitalize, and reinforce communities (Netting et al., 2017). Global challenges during the second decade of the 21st century include unprecedented linkages between economic markets; large-scale environmental threats; natural disasters; civil unrest leading to mass migration, wars, and terrorism; modifications to demographics in a physical community; lack of physical communities to adjust to influx of new and different populations; imbalance between skills of residents in low-income neighborhoods and needs of employers offering good-paying jobs; poor public transportation systems affecting access and labor pool mobility; and local violence. All these challenges negatively affect communities and their residents (Holzer, 2017). Nationally, "economic opportunities in the United States have become increasingly concentrated in communities that are inaccessible to many Americans . . . [and] good jobs, schools, and housing are, in many places, out of reach, especially for low-income families" (Lambe, Singleton, & Wachter, 2017, p. 129).

Technology

Increasingly, technology is providing new tools for those engaged in community practice. For instance, the ability to use geographic information system mapping at neighborhood level can show relationships in a way that static, singular data sets cannot. The ability to create an app to enable people in a neighborhood to report crime or blight may promote more participation from people who might be too fearful to do so. The use of technology like drones, driverless cars, and new types of robots presents new opportunities and threats that can strengthen or undermine communities. Less expensive tools like security cameras that allow for continual monitoring can open not only new ways of preventing crime, but also new potential threats to privacy. Large-scale availability of photo, video, and audio functions in cell phones provides new resources to hold police and others accountable for actions that violate the law. In addition, the use of Telehealth in social work practice presents opportunities as well as challenge. The *Code of Ethics of the National Association of Social Workers* addresses these challenges, while maintaining best practices (National Association of Social Workers [NASW], 2017). These challenges affect the social well-being and fabric of communities and quality of life.

Local Economic Development

Communities are being hollowed out by big corporations that divert money from local businesses and impoverished local communities. The following programs help reverse that trend.

New York City and community organizations are partnering with community residents to organize worker-owned cooperative businesses that are democratically run and that create living-wage jobs (Mayor’s Office of Contract Services, 2017).

The Democracy Collaborative helps organize hospitals and colleges (“anchor institutions”) to direct some of their spending to economically develop local communities and that benefit underserved populations (visit https://democracycollaborative.org/sector/anchor-institutions).

Organizing Trends

Whereas the U.S. health care system has been in a state of upheaval for decades, and the turmoil continues, placing vulnerable populations at risk, there has been an increase of community organizing in the past year around issues concerning immigration, women's issues, and gun violence. Organizing around health care as a social justice issue remains a priority for social workers. Federally funded community health centers begun in the 1960s continue to ensure that millions of low-income and marginalized populations have access to comprehensive prevention and primary care. Social workers have been integrally involved in providing services and developing programs to strengthen and expand them, although adequate funding needs to be ensured (visit https://www.nachc.org/wp-content/uploads/2017/11/Americas_Health_Centers_Nov_2017.pdf).

The bubble in the mature adult population will increase demand for social workers and for innovative approaches to care for those aging in place. In addition, the opioid epidemic is increasing demand for preventive, treatment, and recovery options and services for individuals and families within schools, corporations, municipals agencies, and health institutions.

The Robert Wood Johnson Foundation's Culture of Health is an example of how social workers can engage communities for social change relative to health care. The Culture of Health is an initiative with a focus on healthy communities with an emphasis on equity and overcoming disparities (Smedley, Stith, & Nelson, 2002).

Practices and Strategies

Community organizing, planning, and development are related practices and strategies that include grassroots organizing, social and economic development, program development, political social action, advocacy, coalition building, capacity building, and initiating or participating in social movements (Nandan, Mandayam, Collard, & Tchouta, 2016). The role of community practice is as relevant today as it was during the settlement house movement at the turn of the 19th century.

In 2012, a study by Professor Jack Rothman commissioned by the Association of Community Organization & Social Administration found an imbalance between macro and micro curricula and a diminishment of support and resources for macro practice in social work education. As a result, the Special Commission to Advance Macro Practice in Social Work was created in 2013 with the agenda of increasing macro specializations to 20 percent of social work MSW programs nationally that have specializations, and rebalancing micro and macro curricula in advanced generalist and BSW programs (Rothman & Mizrahi, 2014).

Current-Day Practice

Twenty-first-century social work practice has been marked by a return to the prominence of community development and attention given to macro social work practice (Kirst-Ashman & Hull, 2018). Spurred in part by the challenges outlined by Robert Putnam in the 1990s related to the state of community in the modern society, 21st-century community development approaches have regained prominence as a critical field of practice (Netting et al., 2017). It is incumbent on all social workers to stay current with emerging knowledge and strategies that affect clients and communities (NASW, 2017), but it is equally important for social workers to engage beneficiaries and community members in cocreating change (Nandan et al., 2016) and hence create empowering environments for community residents. In other words, transforming communities and engaging the individuals most vulnerable and oppressed within communities are both ethical and very important roles for social workers in community practice (Dentato, Craig, & Smith, 2010).

More specifically, community development social work relates to the profession’s ethical responsibility to the broader society (NASW, 2017). The NASW *Code of Ethics* outlines responsibilities related to improving social welfare and promoting public participation and engagement in social and political action. In addition, community practice is supported by the Council on Social Work Education (2017a, 2017b) as a core competency of both undergraduate and graduate social work education.

Although the roles of social workers in community development vary, they involve doing with, not for, community members. Some of the key roles that social work assumes are those of facilitator, enabler, mediator, broker, coordinator, and mobilizer (Kirst-Ashman & Hull, 2018). Each role supports the linkages in the community and the process of building the capacity of the community to achieve its goals. The methods used by social workers to achieve these goals include facilitating and participating in the community's work to identify its core values, belief systems, rights, assets, resources, strengths, needs, and goals. Social workers engage with the community to create community-building strategies to meet goals by collecting and analyzing data, studying alternatives, facilitating the community's selection of a course of action, facilitating and helping to implement this action, training and developing staff and community leadership, identifying and developing funding sources, and establishing ongoing evaluations and feedback mechanisms (Kirst-Ashman & Hull, 2018; Shulman, 2012).

In response to the increasing complexity of community life and challenges, social work has seen the rise of newer practice models— many of which are rooted in empowerment practice (Kirst-Ashman & Hull, 2018; Shulman, 2012). Among these are consensus organizing (Ohmer & DeMasi, 2009), capacity development (Cnaan & Rothman, 2008), applications of the strengths perspective (Saleebey, 2012), community resiliency (Kulig, Edge, & Joyce, 2008), community empowerment (Miley, O'Melia, & DuBois, 2013), asset building in communities (Han, Grinstein-Weiss, & Sherraden, 2009), microenterprise and microcredit (Yunus, 2007), community capacity (Huebner, Mancini, Bowen, & Orthner, 2009), and social entrepreneurship and intrapreneurship (Nandan, London, & Blum, 2014).

Notwithstanding that the international practices on sustainable development augments the community development social work literature (Cox & Pawar, 2013), asset-based community development provides a conceptual framework that recognizes that every community has strengths, and that finding those strengths is fundamental work. Until a community knows a lot about its assets, and until the assets are connected, community development will be driven from the outside and may be mired in negative stereotypes. Empowered people can direct their assets to improve social conditions. Hence, there is a mutual and circular relationship between people and communities. Strong communities in turn play a protective and pivotal role in human development and affect individuals' ability to thrive —core values of community development (Kirst-Ashman & Hull, 2018; Rubin & Rubin, 2008; Shulman, 2012).

Community development is a critical component of social work practice. Social workers can be involved in community development to help strengthen communities and in turn assist individuals and families. There are several effective strategies and best practice initiatives in place that have had positive implications on social workers' ability to affect systemic change.

Examples of Policy and Community Strategies in Place

- A charrette is an example of a highly collaborative planning tool created by planners for envisioning a community space. Through community engagement, social workers can help with cocreating built and relational communities.
- Organizations such as NeighborWorks America and Habitat for Humanity provide quality opportunities to learn outside formal educational institutions and access to capital and technical support.
- Regional and national community organizing networks such as the Industrial Areas Foundation and the InterValley Project enable leadership development.
- Intermediary organizations such as the Corporation for Supportive Housing, Local Initiatives Support Corporation, and Enterprise Community Partners provide vital resources that can help local organizations meet critical needs.
- The 2014 Workforce Innovation and Opportunity Act requires states to expand partnerships and career pathways for different populations, including Integrated Basic Education and Skills Training programs, National Fund for Workforce Solutions, and career and technical education in schools (Holzer, 2017).
- Why We Work Here is an initiative that focuses on inclusive problem solving in communities where power and leadership are shared (Hafner & Ramaccia, 2018).
- People United for Sustainable Housing (PUSH) is a member-driven organization that combines community development and organizing in

Buffalo, New York. PUSH is attempting to build a self-supporting ecosystem in a specific neighborhood of Buffalo—addressing affordable rent, energy efficient retrofits, urban gardens, storm water management systems, and so on (Hafner & Ramaccia, 2018).

- Globally, many countries (such as Canada, Australia, and Bhutan) and cities (such as Pittsburg, Rochester, and San Francisco) use "community well-being" indicators to guide policy work and community development initiatives (Castillo, 2017).
- Annually, the United Nations calculates the human development index using the economic, health, and education criteria to assess quality of life (Castillo, 2017).

POLICY STATEMENT

NASW supports

- ensuring transparency of decision making in the community development process
- worker cooperatives, and policies that promote worker cooperatives, which are owned by its workers and democratically run
- social workers understanding the implications of community, culture, and the influence that stakeholders have in communities
- beneficial and effective community development that includes the investment of time and resources
- community development efforts involving social workers partnering with members of affected communities examining and challenging existing power structures and enhancing relationships, which builds capacity to address gaps in services for disenfranchised populations
- building connections through collaboration with community stakeholders, such as universities, local businesses, and private sector organizations, especially as corporate social responsibility initiatives relate to community development
- exploring educational opportunities within a community to meet demand for talent

- both micro and macro professionals in developing partnerships with local community colleges and universities to generate a steady stream of trained and competent social workers
- social work educational programs that incorporate interprofessional and interdisciplinary approaches to community practice into all micro courses, regardless of specializations and concentrations in MSW programs, with an emphasis on social action, grassroots organizing, and social planning
- community development efforts that engage residents in designing and cocreating a shared community that addresses basic needs
- community development efforts that focus on promoting social justice; eliminating structural inequalities; and assuring access to affordable housing and safe neighborhoods, a healthy environment, and reliable transportation
- a strengths-based perspective, asset building, empowerment, and resilience in all community development efforts
- sustainable models of community development that protect and promote people and planet well-being while ensuring financial sustainability.

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Confidentiality and Information Utilization

ISSUE STATEMENT

Overview

The confidential nature of communications between social workers and their clients has been a cardinal principle of social work since its emergence as a profession. The social worker's central role as the recipient and custodian of personal information places a heavy burden on individual practitioners to maintain current knowledge of legal and ethical requirements and to weigh consequences, balance equities, and assume responsibility for actions taken. To ensure confidentiality, social workers must understand their ethical and legal obligations as well as any exceptions to these obligations. There are generally several sources of confidentiality obligations—including the National Association of Social Workers' (NASW, 2017) *Code of Ethics*, state licensure requirements, state privacy protections (see George Washington University, 2018), and federal privacy protections such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104-191).

Social workers are guided by the NASW (2017) *Code of Ethics*. The code, which may contain more stringent requirements than some states codes, sets forth the ethical principles that reflect the profession's core values and establishes standards that guide social work practice and the professional conduct of social workers. In relevant part, the code provides guidance on informed consent, privacy and confidentiality, use of technology, and access and maintenance of records.

In every social work practice area, the building and maintaining of the relationship between the client and the social worker is essential for effective social work interventions. An important element of this social work relationship is the building and maintaining of trust—which, in turn, relies on client confidentiality. Social workers are duty-bound to protect all client information, as guided by the client, to the extent permitted by law (NASW *Code of Ethics*, standard 1.07). Clients may believe that they have absolute confidentiality. However, it is important that clients understand that their confidentiality protection may need to yield to exceptions in the law, and it is the responsibility of the social worker to explain the limits of confidentiality of the professional relationship. Common examples of exceptions include the duty to make disclosures related to clients who may become violent and to report clients' abuse or neglect of children, elders, or vulnerable adults.

Social workers have access to the client's personal information from a variety of sources, and the information contained in the client record may include health information, education records, behavioral health information, psychological tests, court information, clinical notes, and child abuse and neglect reports. It is important for social workers to identify and understand the specific confidentiality laws in their jurisdiction that govern their practice area. For example, social workers in practice with minors should be familiar with the laws in their state regarding the rights of minors.

Working with Couples, Families, and Minors

It is also important that the social worker clearly explains, at the beginning of treatment, to all individuals involved who is the primary client and to whom the confidentiality provisions apply. This is especially important when working with couples, minors, guardians, and families. For example, issues pertaining to confidentiality can arise when social workers provide services to a couple and only one client is requesting that information be shared with a third party. Generally, whenever confidential information has been requested by a third party (subject to certain exceptions such as requests by agencies investigating child abuse or neglect), the social worker should make efforts to communicate directly, if possible, with the client or former client, about the request so that the client's consent (or desire to withhold consent) to release the information is informed (NASW *Code of Ethics*, standards 1.07[b], [d], and [e]). For example, issues pertaining to confidentiality can arise when social workers deliver services to minors while also interacting with their parents (NASW Legal Defense Fund [LDF], 2010). Generally, parents have a legal right, as their child’s personal representative, to access their child’s records, but there are several exceptions to this rule. One exception is when the social worker reasonably believes, in the exercise of professional judgment, that the minor child is subject to abuse or neglect by the parent or that parental access to the records is reasonably likely to cause substantial harm to the client or another person. In the latter case, notice and an opportunity for the parent to request a review of that decision must be provided. Another exception is if the jurisdiction has a “mature minor” rule. In those situations, the social worker may need to obtain consent from the minor to release information, such as when the minor is authorized under state law to independently consent to outpatient mental health treatment. Thus, it is important that social workers are aware of their state’s laws governing the rights of minors.

Types of Disclosures

There are three general types of disclosures that social workers may encounter in their practice setting: (1) disclosures permitted with client authorization, (2) disclosures permitted without client authorization, and (3) mandated disclosures without client authorization. With all three types of disclosures, the social worker should make efforts to disclose only the minimum amount of relevant information to respond to the request.

1. Disclosures with authorization occur when a client has exercised informed consent and provided written authorization for the release of their information, such as the request for psychotherapy notes.
2. Disclosures permitted without authorization allow for client information to be shared without the client’s specific written authorization. Common examples include information shared for the purposes of administrative supervision; health insurance audits; and treatment, payment, and health care operations—provided only the minimum amount of relevant information is released (NASW LDF, 2011b).

3. Disclosures mandated without authorization typically include actions necessary to protect vulnerable individuals, individuals at risk of imminent harm, or others in need of protection. Common examples include disclosures necessitated under state statute or judicial precedent, by the clinician's duty to warn of a threat posed by the client of imminent harm to third parties (National Conference of State Legislatures, 2015), and the reporting of child abuse and neglect or maltreatment of the elderly and vulnerable adults.

In instances when the social worker is not covered by HIPAA, state law and the NASW (2017) *Code of Ethics* require client consent before confidential information is disclosed to a third party, unless there is an applicable exception.

HIPAA

Most social workers must comply with HIPAA, which establishes a set of federal standards for maintaining the confidentiality of protected health information (PHI) in any form (verbal, written, or electronic) and identifies specific rights guaranteed to clients regarding their health information. Violations of these standards may subject social workers to federal civil monetary penalties, sanctioning from state licensing boards, and other penalties. Note that the following discussion regarding HIPAA is largely based on guidance published by the U.S. Department of Health and Human Services (2018a, 2018b), which enforces the law. Social workers should familiarize themselves with this guidance. It also draws on the HIPAA guidance materials specific to social work practice developed by NASW (NASW, n.d.) and a variety of NASW's LDF analyses, which are referenced later.

HIPAA defines *PHI* as individually identifiable health information that is transmitted or maintained in any form or medium and relates to "the past, present or future physical or mental health or condition of an individual; the provision of health care to the individual; or the past, present or future payment for the provision of health care to the individual" (45 C.F.R. § 160.103). Under HIPAA, individual social workers, organizations, and agencies that meet the definition of a "covered entity" and their business associates are required to comply with the law. A health care provider, such as a social worker, is a covered entity if the provider electronically transmits health information in connection with billing and payment for services or insurance coverage, among other transactions. A business associate is a person who assists in the performance of an activity that involves the use or disclosure of PHI, but who is not a member of the covered entity's workforce.

Assuming a social worker is a covered entity who engages a business associate to help carry out health care activities (such as claims processing, accounting, and billing services), the social worker must have a written business associate contract or other arrangement with the business associate that establishes specifically what the business associate has been engaged to do and requires the business associate to comply with HIPAA. To the extent that state law provides greater protections for the privacy of their clients, social workers must comply with such state law standards (rather than HIPAA standards). Social workers, of course, are also subject to standards on confidentiality contained in applicable codes of ethics.

HIPAA Notice of Privacy Practices

HIPAA contains privacy provisions, known as the Privacy Rule, which set out specific patient–client rights and providers' responsibilities to maintain records according to federal standards. To comply with the HIPAA Privacy Rule, social workers need to, among other things, develop written privacy policies, use specific forms for authorizations to release client records, and provide a notice of privacy practices (NPP) to all clients. The use of an NPP is required to provide clients notice of, among other issues, how the social worker may use and disclose certain health information about the client (that is, with authorization, without authorization, or mandated without authorization) and the individual's rights with respect to the information, including how the client may complain to the social worker. The NPP should also reflect any state laws that are more stringent than the Privacy Rule with respect to the use of disclosure of PHI.

HIPAA Electronic Security and Breach Issues

Social workers should also be familiar with the security provisions of the regulations known as the Security Rule (SR) (NASW LDF, 2017). The HIPAA SR sets out the basic requirements for securing clients' electronic PHI. The SR requires health care providers and business associates to conduct specific risk analyses related to unauthorized disclosures of PHI and to implement appropriate technical, physical, and administrative safeguards. The SR also outlines the steps a covered entity must take to protect electronic PHI from unintended disclosure through breaches of security, such as lost USB flash drives, stolen laptops, confidential patient information e-mailed to the wrong person, computer viruses, and hackers.

Last, social workers should be aware of the HIPAA breach notification requirements, applicable to both paper and electronic records, which require covered entities to provide notification following a breach of PHI (NASW LDF, 2014). A *breach* is defined as "an unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information" (42 U.S.C. § 17921[1][A]).

Family Educational Rights and Privacy Act and Substance Abuse

In some treatment settings, specialized privacy standards govern and HIPAA does not apply. These settings include schools (at the elementary, secondary, and college levels), where social workers' confidentiality obligations are governed by the Family Educational Rights and Privacy Act (NASW LDF, 2016; U.S. Department of Education, 2018), and federally assisted substance abuse treatment programs, where social workers must comply with specific federal statutes and regulations (42 CFR Part 2) applicable to those programs (George Washington University, 2013; NASW LDF, 2011a).

Privileged Communications

Social workers should be aware that in *Jaffee v. Redmond* (1996), the U.S. Supreme Court recognized a social worker–client privilege in the federal court system that protects the confidentiality of psychotherapy records, rejecting an approach that would have permitted federal judges to review and weigh the value of potential evidence excluded under the privilege (NASW LDF, 2005). The decision recognizes that the confidentiality protection is necessary to encourage open communications between the client and psychotherapist to promote mental health treatment. Although all state courts recognize some type of psychotherapist– patient privilege, some state courts permit judges to weigh the value of allowing or barring the introduction of psychotherapy evidence before deciding on its admissibility. The privilege regarding psychotherapy notes—and the protection of other PHI—is the right of the client; however, absent client consent (or some legal exception), social workers have a duty to claim the privilege on behalf of their clients to protect the information from release in legal proceedings, for instance, in response to a subpoena for testimony or records (social workers frequently are served with subpoenas in child custody or visitation disputes, among other matters) (NASW LDF, 2009).

Given the heightened sensitivity regarding psychotherapy notes, the HIPAA Privacy Rule requires the client to sign a separate authorization form before separately maintained psychotherapy notes may be released to a third party (NASW LDF, 2006). This is to help ensure that clients are clearly aware that such a specific request has been made, and clinicians can provide clients an opportunity to consider whether they wish to sign a separate authorization for release of psychotherapy notes.

Technology

As stated in the “Technology and Social Work” policy statement, the evolution and proliferation of technology have expanded the ways in which social workers provide services to clients and engage in a host of other professional activities. Clinical services can now be provided using live online chat in real time, video conferencing, telephone counseling, virtual support groups, digital social networking sites, e-mail, and text messaging (Reamer, 2015). In addition to addressing challenges such as establishing therapeutic relationships, and making appropriate assessments, the use of technology requires social workers to adapt their approach to protecting the confidentiality of health information and ensuring informed consent of clients. For instance, some video conferencing platforms may not be sufficiently secure; social workers must ensure that any platform used meets the HIPAA SR standards. Social workers should use applicable safeguards (such as encryption, firewalls, and passwords) when using electronic communications such as e-mail, online posts, online chat sessions, mobile communication, and text messages (NASW *Code of Ethics*, standard 1.07[m]). Social workers should become familiar with the *Standards for Technology in Social Work Practice*, published in 2017 jointly by NASW, the Association of Social Work Boards (ASWB), the Council on Social Work Education (CSWE), and the Clinical Social Work Association (CSWA). The standards offer guidance on, among other issues, how to use technology to design and deliver services and gather, manage, store, and access information about clients.

Social workers and other practitioners often rely on computer and information technology experts, including employees, contractors, and remote service providers. Thus, policies need to address how confidentiality will be ensured by all these parties, including the use of business associate agreements (Barsky, 2017). In addition, social workers must ensure that clients understand the technology being used to manage their data or over which services are being delivered, such as online counseling, and obtain their consent for the use of these services (NASW *Code of Ethics*, standard 1.03[e] and [f]). Furthermore, the code specifies that social workers should, when using technology to communicate, verify the identity and location of clients (standard 1.03[f]). Social workers bear a responsibility to understand the technologies used to optimize the potential value of technology to serve clients effectively and efficiently while safeguarding against exposure of confidential information.

POLICY STATEMENT

NASW supports the following:

- legislation, regulations, and policies that require compliance with the NASW (2017) *Code of Ethics* regarding confidentiality of information concerning individuals, families, groups, organizations, and communities

- social workers maintaining current knowledge of, and being compliant with, legal and ethical requirements regarding the protection of confidential client information
- transparency regarding information that is collected about clients, its use, the circumstances under which the information will be disclosed, and its retention period
- a right of access to one's PHI
- an individual's right to submit a correction of or an amendment to one's PHI
- competency in the use of technology; the maintenance of competency through relevant continuing education, consultation, supervision, and training in the technological tools and skills required for competent and ethical practice; and staying current with emerging technology to protect confidentiality and comply with legal and best practice standards, including the NASW, ASWB, CSWE, and CSWA (2017) *Standards for Technology in Social Work Practice*
- policies and practices that promote respect for confidential information exchanged by colleagues in the course of their professional relationships when collaboration is appropriate
- advocacy for the protection of confidential information in client systems in policy practice and when administering programs
- social workers seeking legal guidance as necessary to protect confidentiality when the NASW (2017) *Code of Ethics* and federal or state law may be unclear on the issue presented.

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Crime Victim Assistance

ISSUE STATEMENT

The social work profession has long been concerned with issues surrounding crime and violence. Social workers' efforts historically have targeted crime prevention and rehabilitation of offenders, but, more recently, the profession has expanded its focus to include the consequences of crime for victims, their families, and their communities.

The number of people affected by crime each year is significant. Over the past decade, the rate for violent and property crimes has averaged 3.5 percent of the population each year (3,500 individuals per every 100,000) (U.S. Department of Justice, Federal Bureau of Investigation, 2017). The number of crime victims rises when one considers that fewer than half (42 percent) of all violent victimizations committed in 2016 were reported to police (Bureau of Justice Statistics [BJS], 2017).

Federal statistics document a wide variety of crimes—including homicide, assault, sexual violence, intimate partner violence, workplace violence, hate crimes, stalking, and terrorism— and their impact on victims, including post-traumatic stress disorder (PTSD), depression, substance abuse, and other mental health and physical disorders (BJS, 2017). In recent years, there has been increased attention paid to crimes against disabled and elderly victims and to cyber crime, identity theft, and human trafficking (BJS, 2017).

Research shows that the shock waves from victimization touch not only the victim, but also the victim's immediate family and relatives, neighbors, and the friends and acquaintances with whom the victim interacts. Studies indicate not only that the mental well-being of the victim decreases, but also that the violent crime rate causes a decrease in the mental well-being of nonvictims (Comaglia, Feldman, & Leigh, 2014).

Children exposed to violence, crime, and abuse are more likely to abuse drugs and alcohol; suffer from depression, anxiety, and PTSD; fail or have difficulties at school; and become delinquent and engage in criminal behavior (Finkelhor, Turner, Shattuck, Hamby, & Kracke, 2015). If not treated, these negative effects can follow a crime victim across the life span. In their quest to transform themselves from crime victims to crime survivors, individuals may need a variety of social and mental health services, along with advocacy.

Victims' reactions to crimes vary by individual characteristics such as preexisting physical and mental health, racial and ethnic background, age, gender, sexual orientation, immigration status, and disability; the type of crime committed; the crime scene; and the perpetrator and his or her relationship to the victim. The effects of victimization strike particularly hard at vulnerable individuals, including those living in poverty, those with a disability, people with mental health issues, and those who are socially isolated. In addition, once an individual has been victimized, the likelihood that he or she will be revictimized significantly increases. For example, research shows that more than half of all sexual assault victims report experiencing sexual victimization more than once (Shin et al., 2017).

As described in the Adverse Childhood Experiences (ACEs) study, almost two-thirds of individuals reported at least one type of childhood maltreatment or household dysfunction, with more than one in five reporting three or more ACEs (Centers for Disease Control and Prevention, 2013), and many have found that the prevalence of ACEs is even higher among poor, disadvantaged, clinical, and criminal populations (Levenson, 2017). As the number of ACEs increases, risk for many chronic health, mental health, and high-risk behaviors increases too.

Social work intervention with victims as early as possible following a victimization is important to not only prevent further victimization, but also increase client physical and mental well-being in the long term. In 2016, one in 10 received victim services after victimization, and that rate reached 26 percent for victims of intimate partner violence (Morgan & Kena, 2017). Considering that most crime victims do not receive services, reducing barriers to service access including lack of service availability, lack of service awareness, or lack of qualification for the services is an important focus of social work intervention. In addition, it is imperative that culturally competent (including bilingual) professionals and service providers are available to crime victims.

Social workers who practice extensively with victims are at risk for negative impacts related to their work including secondary traumatic stress (STS), compassion fatigue, and vicarious trauma. Over time, listening to the stories of traumatized clients can cause a cognitive shift, affecting a provider's worldview and sense of self. For social workers suffering from STS, both individual- and organizational-level interventions have been used to prevent and reduce symptoms (Bercier & Maynard, 2015). Creating proactive strategies in both personal and work environments may enhance the resiliency of the workforce and minimize the likelihood of these problems occurring.

Social work addresses issues of crime and violence that span the micro, mezzo, and macro levels of practice (Knox, 2013). At the micro level, specialized forensic, clinical, and family and child welfare practitioners regularly work with individuals, families, and groups of both victims and offenders in correction, justice, and mental health settings. Social workers often function as case managers and victim advocates to link victims of crime with specialized services to facilitate a return to previous levels of functioning. These are the most common and publicly recognized roles of social work. Mezzo practice finds social workers engaged in community organizing, program development, organizational management, and advocating for local institutional and cultural change beneficial to victims of crime and other oppressed populations. Social work leaders engaged in these tasks play a vital role in ensuring that values such as social justice and respect for diversity are part of planned change in crime victim services. At the macro level, social workers empower clients and other professions to take action by lobbying for change in public policy and laws at the state and national levels. Social workers may hold public office, write social policies and legislation pertaining to crime victims, or lobby legislators regarding victim-related legislation (Ritter & Vakalahi, 2015).

POLICY STATEMENT

NASW supports

- universal screening of clients of all ages to determine whether they have been or are currently being victimized, to provide the best services and support culturally competent practice when working with victims of crime
- policy advocacy at the local, state, and national levels to promote assistance for victims of crime and to facilitate their safety and recovery from criminal victimization
- advocacy for individual victims of crime to help them overcome obstacles, barriers, and loopholes that may impede or prevent them from obtaining needed services
- increased funding to assist crime victims, particularly services for underserved populations and oppressed groups that may be more vulnerable targets of crime
- curriculum development in schools of social work and continuing education to identify victims of crime, to understand the biopsychosocial effects of victimization, and to acquire knowledge of services available to crime victims along with the development of field placements in victim services agencies so that students can gain experience in this area research on the effects of crime on victims, including psychological and financial consequences, and the effects on secondary victims such as family, friends, communities, and service providers; research on the effectiveness of services, interventions, and treatment modalities to help victims heal from their trauma
- research-informed practice and practice-informed research within the profession of social work and the field of crime victim services
- self-determination of victims of crime in all situations, acknowledging the right of victims to define the harm done to them and the services that would be most helpful to them, regardless of the goals of the service program
- opportunities for victims to share the impact of the crimes they suffered in the courts and in the community
- restorative justice through victim–offender mediation, only if initiated by the victim, with routine use of this process in intimate partner violence cases strongly discouraged

- agency policies and procedures, supervisory strategies, and training programs that are sensitive to the risk of secondary trauma for social workers and other advocates who work with victims of crime
- efforts to gain recognition for all domestic partners by providing access to compensation and other assistance programs for all such partners who are crime victims.

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Cultural and Linguistic Competence in the Social Work Profession

ISSUE STATEMENT

Elements of cultural competence have received wide and far-ranging attention in social work literature, and the way it has been traditionally conceptualized is expanding. Cultural competence has been seen as containing three basic elements: (1) cultural awareness, (2) cultural-specific knowledge, and (3) skills (Abrams & Gibson, 2007). Cultural competence implies a heightened consciousness and analytical grasp of racism, sexism, ethnocentrism, class conflict, and cross-cultural and intracultural diversity. Furthermore, cultural competence contributes to efforts to address racial and ethnic disparities in health and mental health status and the disproportionate confinement in restrictive settings in the child welfare, juvenile justice, and criminal justice systems.

U.S. society is constantly undergoing major demographic changes that heighten the diversity issues confronting social workers. The 2010 census reported that the largest single ethnic minority group is the Hispanic population, who comprise nearly 17 percent of the U.S. population (U.S. Census Bureau, 2011). Other population projections for 2050 have changed, and the U.S. growth has lowered because of a reduction in immigration and births—Asian and African American immigrants are expected to continue to increase, and Hispanics will have the greatest immigration through 2060 (U.S. Census Bureau, 2012).

Immigration to the United States by peoples from Asia, Eastern Europe, Russia, Africa, and Latin America can be expected to intensify the diversity social workers will witness in their practice settings. This demographic trend influences the need for social workers to enhance culturally competent practice approaches thatinclude indigenous groups and those from different cultures.

One dimension of cultural competence is the capacity to communicate. In the United States, there has been an increase in the number of people for whom English is not the primary language. The 2010 census documented more than 380 language groups spoken in this country. More significantly, there has been a 30 percent increase in the number of foreign-born, limited English proficient (LEP) residents in the United States, which occurred between 2000 and 2009 (Migration Policy Institutes, Data Hub, 2013). As the country becomes more linguistically diverse, linguistic competence within the social work profession becomes more critical for effective service delivery. *Linguistic competence* is

> the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing. (Goode & Jones, 2009, p. 1)

Individual practitioners and organizations are challenged to develop the capacity to use the verbal, written, and multimedia communications in a manner that supports effective practice.

Culture is not just an attribute of racial and ethnic groups. Cultural differences are often influenced by belief systems founded in religions. The values, beliefs, and practices of particular faith groups can be the primary source of cultural identity and create a specific worldview that affects every component of a person’s life. In addition, people who identify with a sexual orientation different from that of the dominant society also represent distinct cultural groups. Gay, lesbian, bisexual, *omni-sexual* (people having or open to many forms of sexual expression), transgender, queer, and questioning women, men, and youths have established their own cultural identity and demand fair treatment and inclusion in all aspects of U.S. life. Social workers of all sexual orientations must be prepared to bridge the cross-cultural experiences of people of different sexual orientations.

People with disabilities also have established a cultural identity that demands more than empathy and accommodation. They wish to be recognized as bicultural people with the right to seek inclusion in both mainstream and their own cultures.

Professional interest in cultural competence among social workers is predated by a rich and varied history on the subject and many decades of discourse regarding the profession’s response or lack of response to the service needs of diverse clients. The settlement house movement in the early history of the profession is an example of efforts to serve immigrants, many of whom were culturally different from the dominant population at the time. In retrospect, the practice was designed to facilitate acculturation of immigrants into the dominant society. The civil rights movement of the 1960s marked the beginning of a shift in focus from promotion of advocacy against the barriers to acculturation to greater affirmation of differences and recognition of the need to offer services attuned to a client’s view of his or her life circumstances shaped by his or her cultural worldview.

The concept of cultural competence has moved through a progression of ideas and theoretical constructs favoring cultural pluralism, cultural sensitivity, multiculturalism, and a transcultural orientation to social work practice (Mendoza-Denton & Page-Gould, 2008). A brief review of the social work literature in the past few years reveals a range of content areas present in cultural competence, including racial identity formation; the interrelationship among race, gender, class, and ethnicity; racial, ethnic, and socioeconomic health disparities; work with poor families; work with poor African American or Puerto Rican families; sexual identity and sexual orientation; gay adolescents; acculturation and immigration; spirituality and religious diversity; biculturalism and multiculturalism; cross-racial practice considerations; work with people with disabilities; outreach to American Indian and Asian American clients; empowerment; interracial marriage; racially mixed clients; biracial children; mental health services for Chinese, Cuban, Indochinese, and West Indian clients; sociocultural models of practice; and training of culturally sensitive practitioners.

Diverse groups have differential experiences in U.S. society. The differential treatment is a function of the dynamic interaction with the dominant culture of U.S. society, which in turn contributes to the values, beliefs, and practices adopted by the group. It is important for social workers to acquire advanced skills and abilities to advocate for clients against the underlying devaluation of cultural experiences based on difference and oppression. This mandate is addressed to social workers of all cultures, not just those who are members of historically and currently underserved, underrepresented, and oppressed groups. All social workers need to master culturally competent knowledge and skills because the pluralistic society is a social reality (Gould, 1995).

Cultural competence requires awareness. The quest for authentic cultural competence is a process of becoming more attuned to how clients experience their uniqueness, deal with their differences and similarities, and cope with a sociopolitical environment that is often unconcerned with the welfare of their people, however diverse their needs may be. Culturally competent social work practice starts with the driving assumption of individual uniqueness connected to humanness, and the individual experience of culture through which reality is seen and meaning is interpreted (Congress & Kung, 2013). Social workers' self-awareness of their own cultures is as fundamental to culturally competent practice as the informed assumptions about clients' cultural background and experiences. Just as the advocacy agenda is applicable to social workers of dominant groups, the development of cross-cultural skills is requisite for all social workers, including those from historically oppressed, underserved, and underrepresented populations. This expectation is important because of intragroup variability and because any given individual is a member of multiple cultures.

Although the discussion of culture often isolates people by virtue of race, ethnicity, religion, nationality, gender, class, sexual orientation, physical ability, and other attributes, in reality people represent intersections of these various cultural groups. Cultural competence requires the capacity to recognize the interaction of these multiple identities at the individual, family, group, neighborhood, and community levels and discern the salient cultural issues within any given helping relationship. Cultural competence requires a heightened consciousness of how clients experience their uniqueness and deal with their differences and similarities within a larger social context (NASW, 2001, 2007).

The complexities associated with cultural diversity in the United States affect all aspects of professional social work practice, requiring social workers to deliver culturally competent services to a broad range of clients. Cultural and linguistic competence requires knowledge, skills, and attitudes that promote and support respectful and effective cross-cultural communication and practice. To that end, efforts are required at the micro-, mezzo-, and macro-practice levels to affect direct practice and supervision, program administration, and social policy to achieve meaningful outcomes as defined by consumers, families, and communities.

Social workers using a person-in-environment framework for assessment rely on important cultural factors that have meaning for clients and reflect the culture of the world around them. Although in U.S. social work cultural diversity historically has been associated primarily with race and ethnicity, progress has been made to develop culturally competent skills, knowledge, and values that are transferable when working with people of a different gender, social class, religion or spiritual belief, sexual orientation, age, or with a disability. This kind of sophisticated cultural competence does not come naturally to any social worker and requires a high level of professionalism. This policy statement speaks to the importance of a clear definition, support for, and encouragement of advanced-level social work practice skills and knowledge that promotes cultural competence among all social workers so that they can respond effectively, competently, and sensitively to the diversity among the people they serve, the agencies where they work, and the communities in which they live.

Cultural competence is a vital link with the theoretical and practice knowledge base that defines social work expertise. Increasing cultural competence within the profession requires efforts to recruit and retain as diverse a group of social workers as possible, many of whom bring some “indigenous” cultural competence to the profession. In addition, cultural competence requires efforts to increase avenues for the acquisition of culturally competent skills by all social workers. Indigenous cultural competence is a result of absorbing positive and negative cultural memories through lifelong experiences, which can be an advantage as well as an obstacle when the workers confront the subjective qualities of sharing the same cultural experiences as their clients.

Cultural competence is not, necessarily, synonymous with cultural identity or consciousness. For example, a Latino social worker is not inherently culturally competent when working with Latino clients; that is, it is not the social worker’s ethnicity that makes him or her effective when dealing with clients of similar heritage. Rather, it is the combination of the worker’s cultural history that is mediated through his or her social work training that makes for effective social work practice. This training emphasizes focus on the client context of socioeconomic status, race, gender, sexual orientation, religion, age, and abilities—all of which may vary among clients who share an ethnic heritage. When social workers have little contact with people who are culturally different, it can be helpful to acquire additional knowledge and awareness to increase one’s capacity for cultural competence through cognitive methods that lead to affective insight. The profession is committed to enhancing culturally competent social work practice by addressing the needs of both indigenous workers and those from different cultures struggling to acquire competence.

Cultural competence builds on the profession’s stance on self-determination and individual dignity and worth, adding inclusion, tolerance, and respect for diversity in all its forms. Social workers know the importance of developing practices that are sensitive to different races, nationalities, language proficiencies, and immigration or migration experiences. Social workers are keenly aware of the deleterious effects of racism, sexism, ageism, anti-Semitism, homophobia, and xenophobia on clients’ lives and how social advocacy and action can serve to empower diverse clients and communities. This policy statement reinforces this awareness but moves the discussion toward the development of clearer guidelines, goals, and objectives for the future of social work practice in which cultural diversity will increase in complexity.

POLICY STATEMENT

NASW seeks to promote cultural and linguistic competence in all areas of social work practice, research, and education. Social workers must honor the ethical responsibility to be culturally competent practitioners as the NASW *Code of Ethics* (NASW, 2008) instructs. This policy statement adopts the definition of cultural competence proffered by Cross, Bazron, Dennis, and Isaacs (1989) as “a set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals and enables the system, agency, or professionals to work effectively in cross-cultural situations” (p. 13). The word “culture” is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. The word “competence” is used because it implies having the capacity to function effectively. A culturally competent system of care acknowledges and incorporates, at all levels, the importance of culture, the assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services (Cross et al., 1989; NASW, 2001) to improve quality of life for all people. To this end, the U.S. Department of Health and Human Services, Health Resources and Services Administration (n.d.) has constructed a definition of *cultural competence* that is “a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enable effective work in cross-cultural situations.”

NASW promotes and supports the implementation of cultural and linguistic competence at three intersecting levels: the individual, institutional, and societal. Cultural competence requires social workers to examine their own cultural backgrounds and identities while seeking out the necessary knowledge, skills, and values that can enhance the delivery of services to people with varying cultural experiences associated with their race, ethnicity, gender, class, sexual orientation, religion, age, or disability. Culturally competent practice is a critical component of professional social work expertise in all practice settings that include, but are not limited to, direct practice, community organizing, supervision, consultation, administration, advocacy, social and political action, policy development and implementation, education, and research and evaluation. Culturally competent practice is required in all geographic communities, whether urban, suburban, rural, or frontier.

Culturally competent social work practice cannot occur within a vacuum. It requires an institutional and professional infrastructure that supports the efforts of individual practitioners to conduct themselves in a culturally competent manner. In addition, social workers should be respectful of cultural diversity among colleagues in the workplace setting, creating an atmosphere of open acceptance and inclusion. This means that the organization must have policies, procedures, and financial allocations that support and reward the growth and development of the staff. Furthermore, organizational philosophy, policies, and procedures can serve to ensure that suitable structures and practices are designed, funded, staffed, implemented, and evaluated to achieve the most effective and acceptable services for culturally and linguistically diverse populations. Through partnerships with consumers, families, and cultural communities, social work institutions can successfully improve access to services.

It is the position of NASW that social policy be developed at the local, state, and national levels to promote cultural and linguistic competence. Such policies should assert the expectation of cultural and linguistic competence, institute the structures and financing to facilitate cultural and linguistic competence, and demand accountability of institutions and practitioners for cultural and linguistic competence. These policies address human resources and program factors that promote the recruitment and retention of a culturally diverse workforce, require specific educational preparation and continued professional development in cultural and linguistic competence of the workforce, and establish strategies to monitor and evaluate service outcomes for people of diverse cultures. These social policies are needed not only to address the requirements of cultural and linguistic competence, but also to help advance the work against the continued expressions of racism, prejudice, and discrimination in this country.

NASW supports access to services and care for diverse populations and policies that encourage inclusion of culturally and linguistically competent care. The development of partnerships in diverse communities where there is grassroots organizing and capacity building will increase access to services. The Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) (commonly referred to as the Affordable Care Act) provisions address ways to increase access to health care for diverse groups, including people with LEP (U.S. Department of Health & Human Services, n.d).

NASW recognizes that the expertise required for the development of acceptable and effective interventions for diverse populations resides within that population. It is the position of NASW that collaboration with consumers, families, and cultural communities is a precondition for creation of culturally and linguistically competent services, reasonable accommodations, interventions, programs, and policies.

It is the position of NASW that practitioners and their host organizations ensure that services are offered in the language preferred by the consumers and families receiving services. In addition, NASW supports actions given to improving linguistic competence and a diverse workforce in the social work profession. Linguistic competence requires the growth in capacity to use the preferred language of the consumer and also to develop the skills to use effective strategies for interpretation and translation. Several strategies that organizations can pursue include modifications in staffing and operations, such as the inclusion of bilingual and bicultural staff; foreign language interpretation services; use of cultural brokers; provision of materials in alternative formats such as audiotape, Braille, enlarged print; and print materials in easy-to-read, low-literacy, picture, and symbol formats (Goode & Jones, 2009).

NASW recognizes that a policy statement alone cannot fully define the values, knowledge, and skills required for culturally and linguistically competent practice. Cultural competence is an important ingredient of professional competence, as important as any other component that forms the basis of the theoretical and clinical knowledge that defines social work expertise. This policy statement supports and encourages promulgation and adherence to the *Indicators for the Achievement of the NASW Standards for Cultural Competence in Social Work Practice* (NASW, 2007).

NASW supports the advancement of practice models that have relevance for the range of needs and services represented by diverse client populations and promotes the application of practices for which there is evidence of effectiveness for the relevant cultural group and the development of a knowledge base that emanates for the practice within and on behalf of cultural communities. As advocates for the providers and consumers of social work services, social workers need to promote cultural competence by supporting the evaluation of delivery of services and practice models that are offered as cultural competence. In monitoring cultural competence among social workers, the establishment of mechanisms for obtaining direct feedback from clients is essential.

The social work profession is encouraged to take proactive measures to ensure cultural competence as an integral part of initial and continuing social work education and practice and to increase research and scholarship among its professionals. The social work profession emphasizes cultural competence as an integral part of organizational practice and social policy.

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Deprofessionalization and Reclassification

ISSUE STATEMENT

Every day, professional social workers empower and assist individuals, families, and communities with their specialized knowledge, training, and experience in a variety of settings across the nation. Social workers have historically and consistently moved society forward by promoting social justice, which is a precursor to progress and inclusivity. The social work profession is a major contributor to effective social services and an advocate for positive and progressive social welfare policies and programs across the United States.

NASW and the Council on Social Work Education (CSWE) both define *professional social workers* as “individuals who have graduated from an educational program accredited by CSWE with at least a bachelor’s degree in social work” NASW, 2007, p. 6). More than 840,000 social workers provide a wide range of social services across the life span at the micro, macro, and mezzo levels (Whitaker, Weismiller, & Clark, 2006). Unfortunately, social work positions have increasingly become subject to deprofessionalization and reclassification, as administrators, policymakers, and institutions fail to recognize or value the profession.

Dressel, Water, Sweat, Clayton, and Chandler-Clayton (2015) defined *deprofessionalization* as “the reduction of education or training requirements necessary for employment” (p. 115) and noted that this issue has been present since the development of the federal public relief in the 1930s. They also defined *reclassification* as

> a further attempt to deprofessionalize and deskill social welfare work by reducing educational requirements for public social service jobs,

> combining work tasks to eliminate functions mandating higher levels of education, and breaking jobs into smaller tasks that can be organized in assembly-line fashion. (p. 117)

Healy and Meagher (2004) saw the causes of deprofessionalization as “fragmentation and routinization of social work roles and tasks, a decline in professional categories of social work employment, and underemployment of social workers in paraprofessional positions” (p. 244).

At times, under various deprofessionalization and reclassification schemes, public and private agencies have created generic job classifications, such as “clinical case manager,” “case management specialist,” and “social services worker,” that eliminated the title of “social worker.” The combined effect of the deprofessionalization and reclassification movement has been civil service systems that struggle to retain or attract qualified social workers for key positions and instead resort to hiring individuals for social work positions who have not received a social work education.

The value of a social work education from an accredited program cannot be overstated. Schools of social work educate and train students in best practices to competently work with underserved and vulnerable populations. Social workers are trained to view and address problems within the social context and work toward addressing not only the individual, but the person’s environment and beyond. Social change and social justice are cornerstones of the profession, and these values are embedded in all social work programs. A rigorous education program combining social work courses and training, coupled with the core value of social justice, promotes a level of excellence from those who graduate with social work degrees. However, students interested in social policy, social research, or social services administration frequently choose other professional degrees, and MSWs often enroll in doctoral programs to further specialize. Degrees such as the MBA and MPA may be favored over social work degrees, even when social workers have educational qualifications in administration as well as relevant experience (Donaldson, Hill, Ferguson, Fogel, & Erickson, 2014). As a result, non–social workers often occupy decision-making and supervisory positions and formulate policies that affect the status of social workers and social work practice.

Social work education provides the practice knowledge and skills necessary to succeed in a wide array of work settings. An NASW study concluded that graduate social work education is the best predictor of optimal performance (NASW, 2007). Yet, in states where social workers do not have title protection, paraprofessionals, counselors, or human services personnel often are considered to be trained social workers and are at times, sanctioned to function under the title “social worker.” As such, these non–social work credentialed personnel are held responsible for providing social services, despite lacking the social work knowledge base, skills, and values necessary to perform social work tasks (Dressel et al., 2015).

Since 1981, NASW has enhanced its capabilities to address deprofessionalization and reclassification. First, NASW has intensified legislative capabilities and lobbying activities at the state and federal levels, resulting in the achievement of landmark legislative goals with the inclusion of social workers as payees under Part B and other sections of Medicare and the establishment of standards for social services staffing in nursing facilities. Since NASW, in collaboration with other professional organizations such as the Association of Social Work Boards (ASWB), designated social work licensing a high-priority action, all states have established some form of licensing regulation.

There are currently 51 distinct license titles for social workers and 204 regulated licenses (C. Sanner, member services specialist, ASWB, personal communication, October 21, 2016). In addition, NASW has blocked legislation in some states that would have required social workers to obtain other professional licenses and certifications to practice in areas traditionally within their scope, such as family therapy. Unfortunately, there is no reciprocity between states for social worker licenses, thus inhibiting or delaying social workers from receiving their license when moving to another state.

On March 15, 2011, the historic Congressional Social Work Caucus was formed with the Honorable Edolphus Towns as its first chair. Congressman Towns (D-NY) and Senator Barbara Mikulski (D-MD) first introduced the Dorothy I. Height and Whitney M. Young, Jr., Social Work Reinvestment Act, which brought much needed attention to addressing the future of the profession and to workplace improvements and research in social work interventions, among other issues pertinent to the profession.

In another effort to protect and promote the profession, in 2001 NASW established the NASW Foundation, which has the following six goals: (1) to identify, develop, and respond to social work policy and practice issues; (2) to assist with rapid response to social crisis; (3) to support practice-based research, so that practice and research are directly linked; (4) to raise the visibility of social work and enhance public esteem for the profession; (5) to support the development of cutting-edge continuing education that addresses critical issues; and (6) to promote the appropriate application of new technology to the practice of social work. As part of the foundation's work, in 2004 NASW launched Help Starts Here, a public education campaign geared toward changing the public's perceptions of social work and to improve the profession.

POLICY STATEMENT

Professional social workers possess specialized knowledge necessary for an effective social services delivery system. Social work education provides a unique combination of knowledge, values, skills, and professional ethics that cannot be obtained through other degree programs or by on-the-job training.

Therefore, NASW supports the following:

- a client's right to expect and to receive high standards of social work services provided by professionally trained social workers
- service delivery that adheres to the NASW (2015) *Code of Ethics* and social work licensing and certification regulations set forth by each state
- multilevel licensure for social workers in all states
- title protection for social workers in all states
- promotion opportunities that recognize the education and expertise of social workers in all areas, including policy, administration, leadership and supervision, direct service, and advanced clinical positions
- collaboration with professional organizations, including unions, to emphasize the importance of professional social work degrees in hiring and promotion practices

- organizational and public policies that promote the hiring of CSWE program degreed social work practitioners
- the promotion and understanding of social work as a distinct profession with highly qualified professionals
- the identification of tangible social work skills gained through social work education, such as biopsychosocial assessment, treatment planning, discharge planning, administrative and budget management skills, leadership and supervisory skills, policy development, and advocacy, which are essential to the social services delivery system
- the education of social workers in accredited programs with courses designed and taught by social work educators that will promote advocacy for social justice and the culture, knowledge, values, and ethics of the profession
- research and outcome studies that demonstrate the effectiveness and benefits to clients of hiring trained social workers.

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Disasters

ISSUE STATEMENT

According to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, as amended by the Disaster Mitigation Act of 2000 (P.L. 106-390),

> major disaster means any natural catastrophe (including any hurricane, tornado, storm, high water, wind driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought), or, regardless of cause, any fire, flood, or explosion, in any part of the United States, which in the determination of the President causes damage of sufficient severity and magnitude to warrant major disaster assistance under this Act to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby. (Title I, §§ 102, 5122)

The steadily changing global, political, and environmental climate has led to an increase in terrorism, random acts of violence, and catastrophic occurrences of nature, seemingly increasing the frequency of disasters and the need for effective responses. The social work definition of *disaster* is

> an extraordinary event, either natural or human-made, concentrated in time and space, that often results in damage to property and harm to human life or health and that is disruptive of the ability of some social institutions to continue fulfilling their essential functions. (Barker, 2014, p. 120)

A local emergency is declared when the governance of a city or county deems conditions to pose an extreme threat to the safety of people and property within that jurisdiction. When the disaster conditions threaten the safety of people and property within a state, the governor may proclaim a state of emergency, making mutual aid assistance mandatory from other cities, counties, and state authorities. Incidents such as rape or other violent crimes, serious house fires, or a tragic accident that involve individuals may affect that individual, their family system, and certain members of the community. However, these incidents are not “declared” disasters, even though they may create upheaval in communities, and there may not be financial or other resources available to address them.

A major disaster is declared when the event is clearly more than what state and local governments can handle alone. An emergency declaration is more limited in scope and without the long-term federal recovery programs of a major disaster declaration (Federal Emergency Management Agency [FEMA], 2014). Individual or family assistance may be available to those whose property has been damaged or destroyed as a result of a federally declared disaster, and whose losses are not covered by insurance (FEMA, 2014). Assistance may include low-interest loans, individual and family grants, temporary or permanent housing, assistance with basic needs, and crisis counseling. Other disaster aid programs include disaster-related unemployment assistance, case coordination, legal aid and assistance with income tax, and social security and veterans’ benefits (FEMA, 2014).

Federal laws, in particular the Disaster Relief Act of 1970 (P.L. 91-606), the Disaster Relief Act Amendments of 1980 (P.L. 96-568), and the Robert T. Stafford Disaster Relief and Emergency Assistance Act (P.L. 93-288), address disaster-related concerns. Following the terrorist attacks on September 11, 2001, the Homeland Security Act of 2002 (P.L. 107-296) and the Homeland Security Presidential Directive Five issued in 2003, titled “Management of Domestic Incidents,” authorized changes in the U.S. government’s approach to disasters. This approach is outlined in the National Response Plan (NRP), “which specifies that extensive training is necessary for those operating in the system” (Gillespie, 2008, p. 62). The NRP, now called the National Response Framework, is a complex, formal preparedness and response plan intended to provide a comprehensive policy framework for coordinating federal, state, and local governments, as well as nongovernmental organizations and private sector resources (U.S. Department of Homeland Security, 2013).

In addition to FEMA, other federal, state, and local government agencies assist with disaster planning and response, including the Substance Abuse and Mental Health Services Administration (SAMHSA) Disaster Technical Assistance Center, which prepares states, territories, tribes, and local entities to deliver an effective mental health and substance abuse response to disasters (SAMHSA, n.d.); the Small Business Administration (SBA), which provides low-interest disaster loans to homeowners, renters, and businesses (SBA, n.d.); the U.S. Department of Agriculture, Farm Service Agency (n.d.), which provides assistance for natural disaster losses; and the Internal Revenue Service (n.d.), which advises individuals and businesses on tax law provisions, including business continuity planning, insurance coverage, and record keeping in the event of a disaster. In addition, several volunteer agencies assume defined roles and responsibilities in disaster situations, including the American Red Cross and numerous other national and state charitable and religiously affiliated organizations and agencies.

In a community affected by disaster, in addition to considering the overall needs of people directly affected, several special populations can be identified that would require special attention. Among these groups of disaster survivors and victims are subpopulations historically of concern to social work, including older adults, people with low incomes, people with preexisting mental illness, children, immigrants, refugees, people with disabilities, and people who are isolated, institutionalized, or otherwise at social or physical risk. These populations are among the most vulnerable disaster survivors and require special attention during preparedness, immediate relief, and recovery phases. People who have a history of trauma are also a group at risk. Virtually no one experiences or responds to disasters in the same way, but no one escapes unscathed. Rescue workers and military personnel, witnesses to the event, first responders, people who are physically injured, mental health professionals, and the skilled workers on the scene all constitute at-risk populations. The specific makeup of the at-risk population groups will be determined by the nature and location of the disaster.

Access to numerous media sources, especially television and the Internet, has broadened the scope and awareness of disasters. On one hand, covering a disaster is a public service, commanding the attention of the world to the needs of the people affected. However, the coverage can also deepen the wounds and intensify the anxiety of people affected because of the constant repetition of the stories, the misinformation that breaking news is often fraught with, and the response of people and government as a result of the media coverage. It can also affect those following the media coverage through experience of vicarious trauma.

Social workers are critical components of the overall disaster response team. “Along with emergency management agencies, police and fire departments, and other organizations, social services agencies are important participants in the interorganizational efforts to respond to disasters” (Robards, Gillespie, & Murty, 2000, p. 41). Inherent in social work policy is the recognition of individual and systems considerations.

Disaster social work is concerned with the intervention in the social and physical environments of individuals and groups as a means of preventing serious long-term emotional, spiritual, and mental health problems after a disaster (Rogge, 2003). “With community connections and knowledge of local values and norms, social workers can be involved with disaster mitigation, including mobilizing communities to support land-use planning and management, lobbying for stronger building codes and standards, expanding the use of disaster insurance, creating improved disaster warning systems, and working toward safer infrastructure to reduce vulnerability” (Gillespie, 2008, p. 63).

“Social workers also facilitate access to those in need, linking vulnerable populations to services and creating connections across service systems to improve distribution of resources” (Gillespie, 2008, p. 63). They provide traumatic stress services, including psychological debriefing, to help victims understand typical stress response and teach useful coping mechanisms (Miller, 2003). Interventions at the community level have been developed to prevent long-term damage to vulnerable populations (Zakour, n.d.). Effective interventions must be tailored to phases of recovery. Crisis intervention occurs during and immediately after a disaster to help people cope with stress reactions. Typically, the goal of this intervention is to help survivors return to their precrisis level of well-being and ability to function and to regain control over their lives (Rosenfeld, Caye, Lahad, & Gurwitch, 2010). Clinical social workers also provide *psychological first aid*, which is defined as “the practice of recognizing and responding to people who need help because they are experiencing stress reactions, resulting from disaster situations” (Engfehr, 2014, p. 1).

Postdisaster intervention is also critical and can be characterized by “mental and physical suffering that continues and sometimes escalates long after the disaster is over” (Rosenfeld et al., 2010, p. 298). The goals of postdisaster intervention include ameliorating mental pain and social anguish (Rosenfeld et al., 2010).

There is a range of reactions to stress. Exposure to severe psychological trauma, including disasters, can result in psychological and physical health problems (Adams & Boscarino, 2009). Posttraumatic stress disorder (PTSD) is a serious potentially debilitating condition that can occur in people who have experienced or witnessed a natural disaster, serious accident, terrorist incident, or other life-threatening event (Anxiety and Depression Association of America, n.d.). Approximately 3.5 percent of the U.S. adult population is currently classified as having PTSD, and 36.6 percent of those cases are classified as severe (National Institute of Mental Health, n.d.). Studies indicate that almost 90 percent of adults have experienced at least one lifetime traumatic event, yet only 15 percent of those exposed developed PTSD (Breslau, Kendler, Su, Gaxiola-Aguilar, & Kessler, 2005). Intervention models must be based on resilience and strengths rather than pathology and deficits.

Because of the chaos that ensues after a disaster, a well-ordered and coordinated mass response system is needed for effective disaster management. NASW has adopted a disaster policy at the national level for four primary reasons:

1. Disasters are large-scale catastrophes that affect whole communities or multiple communities in geophysical, social, and psychological ways.
2. The trauma and deprivation resulting from disasters often are magnified for those with few resources and reduced opportunities to rebuild homes and replace losses. As such, vulnerable populations are likely to be among those especially affected by disasters.
3. Social workers are well suited to interpret the disaster context, to advocate for effective services, and to provide leadership in essential collaborations among institutions and organizations. Furthermore, compatible with social work epistemology, disaster assistance must be

construed holistically, encompassing the physical, developmental, psychological, emotional, social, cultural, and spiritual needs of individuals and systems.

4. Social workers continue to respond quickly and effectively to need in the immediate aftermath of disasters. The importance of the potential contribution and role of social work warrants more than spontaneous responses on a disaster-by-disaster basis. Effective disaster leadership and a proactive presence on the part of the profession require preparation, direction, training, and practice.

The broad range of social work practice allows social workers to provide services in a variety of settings, and social workers from all fields of practice must have knowledge and understanding about disasters and the course of recovery. Due to the increasing number and scope of disasters worldwide, multidiscipli-nary partnerships, training, research, and coordination of response efforts are needed.

NASW entered into the first of a succession of professional agreements with the American Red Cross in 1990 to facilitate social work participation in the planning, training, and provision of mental health services to disaster victims (NASW & American Red Cross, 1990). Furthermore, the NASW Foundation created a Social Work Disaster Assistance Fund to provide financial assistance to social workers affected by disasters. Donations go directly to social workers and social welfare organizations that can provide assistance to those who have suffered loss and are in need of financial or other assistance due to a disaster (NASW Foundation, n.d.).

POLICY STATEMENT

NASW supports participation in and advocates for programs and policies that serve individuals and communities in preparation for, during, and in the wake of disaster. NASW supports

- prevention or mitigation of the adverse consequences of disaster and effective preparation for disaster by individuals, families, social networks, neighborhoods, schools, organizations, and communities, especially where vulnerable populations are concentrated;

- enhancement of the efficiency, effectiveness, orchestration, and responsiveness of disaster relief and recovery efforts to prevent exacerbation of problems related to the disaster;
- policies and procedures that provide access to disaster relief services and resources to all (including relationship rights for gay, lesbian, bisexual, and transgender people and undocumented immigrants);
- provision of behavioral health, care coordination, and social services to survivors in a context of normalization and empowerment, with sensitivity to the phases of disaster recovery and with understanding of the unique cultural characteristics of the affected community and its populations;
- attention to the long-term recovery phase of disasters, including the provision of mental health services and support;
- attention to the special training needs, stress management techniques, and support needs of first responders and other disaster workers;
- education of social workers and social work students in the specialized knowledge and methods of trauma response;
- continued research on the impact of disasters, effective interventions, and disaster management strategies;
- development of a cadre of well-trained, culturally competent disaster professionals committed to effective interdisciplinary and interorganizational collaboration in disaster planning and disaster response;
- provision of accurate and effective public information on the normal phases of disaster reaction, functional coping methods, and strategies for accessing and successfully using the disaster assistance systems.

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Early Childhood Care and Services

ISSUE STATEMENT

The first several years of a child's life, most significantly the prenatal phase through the first three years, play a critical role in the success of the child as he or she develops. Healthful development includes having good-quality parent–child relationships that positively affect physical health and development, psychological well-being, and social functioning. The fields involved in early childhood care are diverse yet committed to the core value that every child requires special attention from prenatal through eight years old to develop optimally. The growing awareness of the critical nature of experiences during these years and their impact on brain development and attachment requires the social work profession to be involved in setting policies that ensure the well-being of young children and their families.

A young child's relationship with his or her parent or caregiver affects the child's cognitive, language, social, and emotional development (National Women's Law Center [NWLC], 2013a). This parent–child relationship benefits when it is nurtured and enhanced by a caring, competent, professional relationship between the child care provider and the parent or care-giver. Parental or caregiver involvement and family-centered care are crucial factors in effective early childhood programs. Supporting parents and caregivers in their role as the primary educators and caregivers for their children is a crucial key to children's long-term outcomes.

Parents, caregivers, and relatives continue to provide vast amounts of early child care, and many can benefit from evidence-based home visitation programs that promote healthy child development and positive parent–child relationships. However, reliance on child care outside the home has increased due to economic necessity. High-quality early childhood programs provide important educational and nurturing experiences to young children. Many studies have concluded that children who attend early childhood programs, such as preschool, pre-K, and kindergarten, experience numerous benefits that last a lifetime. Numerous studies have shown that children enrolled in high-quality early education programs go on to perform better on cognitive tests in elementary and secondary school; are more likely to graduate from high school, go to college, be employed, and be in good health; and are less likely to become involved with criminal activity or turn to public assistance (NWLC, 2013b). Many families experience difficulty finding quality and affordable child care. Often, spaces in early child care programs are limited and expensive, putting an enormous strain on families, especially those who are financially challenged. Only 50 percent of three- and four-year-olds (not yet in kindergarten) are enrolled in public or private preschool programs. Low- and moderate-income children are less likely than higher-income children to be enrolled. Early Head Start, which was established to serve the nation’s youngest children, reaches fewer than 4 percent of eligible infants and toddlers (NWLC, 2013b). The federal Early Head Start program, which was established as part of the 1994 reauthorization of Head Start and began with 68 programs in 1995, offers comprehensive supports for vulnerable infants, toddlers, and their families through center-based, home-based, and combination program options. Yet, fewer than 4 percent of eligible infants and toddlers are able to participate in this high-quality early learning program due to a lack of adequate funding (NWLC, 2013a). This inadequacy leaves many families without the services they need.

Young children are directly affected by their family’s economic security. Experiencing poverty has a profound negative effect on a child’s healthy development and school success (National Center for Children in Poverty [NCCP], 2013). More than 16 million children in the United States—22 percent of all children—live in families with incomes below the federal poverty level (NCCP, 2013). These families struggle to meet the basic needs of their young children and strain to gain access to quality early child care programs. Increased family support programs and policies to address poverty are critical to improving the long-term outcomes for these children.

Many parental and caregiver factors, including personality characteristics and psychological well-being, history of maltreatment, substance abuse, attitudes and knowledge, age, and family structure are correlated with child maltreatment (Administration for Children and

Families, 2014). Poverty is also strongly linked to child maltreatment—particularly neglect— as parents and caregivers are unable to provide for their children's basic needs, emotional well-being, and adequate supervision (NCCP, 2013). In addition, even without factoring in poverty, the rate of child maltreatment is the highest for young children, with the most at-risk population being infants under one year of age (NCCP, 2013). All areas of development are closely intertwined in the early years, thus physical harm can damage emotional, social, cognitive, and language development (Zero to Three, 2014). Child maltreatment in the early years of life directly affects brain development and leads to serious, long-term negative consequences.

Early childhood care and service programs require professionals with specialized training and knowledge. Early childhood care and services should be designed to incorporate the principles of infant mental health, which focus on the optimal development of infants and toddlers within the context of secure and stable relationships with primary caregivers, delivered within a culturally competent framework. Infants and toddlers need early care, and education providers who have specialized knowledge of the development of infants and toddlers, provide a consistent relationship with the children's parents and caregivers, respond to their individual needs, and enhance the parents' and caregivers' ability to nurture the child's growth and development (NWLC, 2013a).

Social work is a critical component in advocating for and delivering early childhood care and services. An essential component for effective service provision is collaboration with other professions, such as nursing and teaching, through a multidisciplinary approach. Social workers bring a unique understanding of coordinated care, integrated health, and collaboration and are remarkably trained in identifying and addressing the emotional and developmental needs of young children, especially those who have been exposed to environmental stressors, including divorce, parental stress, neglect, abuse, social isolation, violence, substance abuse, mental illness of primary care-givers, and so forth.

POLICY STATEMENT

Early childhood care and services include a broad range of services for families of young children, prenatal through eight years old.

NASW supports effective early childhood programs and services that

- are evidence-based
- are offered in diverse settings such as families' homes, public and private schools, family day care homes, group child care centers, school–university campuses, parent and care-giver workplaces, and so forth
- are designed to include children from diverse backgrounds
- are integrated and include perinatal services, family support services, health and mental health services, educational services, day care (full- and part-time), respite care, culturally sensitive parent and caregiver training, and before- and after-school care
- include comprehensive prevention, intervention, and support services that are provided for infants and young children, including those with special needs, and their families are based in the belief that parents and caregivers should be supported in actively participating in the development and implementation of services and programs affecting their children
- use the services of appropriately trained and culturally competent early childhood providers who receive ongoing training to ensure continuous learning and professional development.

NASW also supports

- national, state, and local policies that use the principles of child development, infant mental health, and early childhood education to meet the physical, social, emotional, and educational needs of young children and their families
- equal access to high-quality, culturally and developmentally appropriate, affordable early childhood services and programs
- programs and services that reflect the needs of a variety of family structures and are based on evidence-informed principles of child development
- parents and caregivers as the first and primary educator and caregiver for young children, and the belief that all children benefit from a sustained primary relationship that is nurturing, supportive, and protective

- advocating for accessible early childhood programs and services for all infants and young children, including children with special needs and their families, at all income levels
- programs and services that conduct regular, periodic developmental screenings of children in care, provide parent–caregiver education components, and address factors that place children at risk, including health and nutrition, environmental stressors, psychosocial issues, and economic factors
- flexible and sufficient family leave policies, such as maternity leave, paternity leave, and family sick leave, that support families in providing adequate care for their children
- policies and programs to address children experiencing poverty, violence, malnutrition, or other risk factors.

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Economic Justice

ISSUE STATEMENT

As the social work profession moves into in the 21st century, iteration of critical economic policy priorities is essential. These priorities include promoting just policies that build a universal system of support, promote financial security, and provide an adequate safety net for those in need.

Poverty in America

Based on 2015 data from the U.S. Census Bureau (2016), 13.5 percent of Americans are living in poverty. This translates to over 45 million individuals. Over 19.7 percent of this country's children less than 18 years of age lived in poverty in 2015. Income disparities (U.S. Census Bureau, 2016) by race and ethnicity continue to persist. According to the U.S. Census Bureau (2016), 9.1 percent of white Americans lived in poverty compared with 24.1 percent of black Americans, 11.4 percent of Asian Americans, and 21.4 percent of Hispanic Americans.

Minimum Wage and Living Wage

The minimum wage (U.S. Department of Labor, n.d.) varies from state to state. Currently, the federal minimum wage is $7.25 an hour (Minimum-Wage.org, n.d.). The fundamental idea of establishing a minimum wage is to set an earnings threshold under which our society is not willing to let families slip. However, universally minimum wages fall short in determining the basic expenses of families and whether those expenses far exceed the minimum wage, especially in considering the geographical variations in living expenses. Thus, it is often true that many working adults receive public assistance, such as food stamps, or work at several minimum wage jobs to afford to feed, clothe, house, and pay for medical care for themselves and their families.

Therefore establishing a living wage (Minimum-Wage.org, n.d.), which is a more realistic approximation of the annual income needed to meet a family's basic needs that would more reasonably enable the working poor to achieve financial independence while maintaining housing and food security, is an essential step to realistically begin to address economic injustices. However, the primary issue is to first set a national minimum wage rate well above $7.25 per hour. Getting broad acceptance of a living wage is the next hurdle.

Inequality in Wealth Distribution

In the United States, wealth is very much controlled by a relatively small number of people (Domhoff, 2013). As of 2010, the top 1 percent of households (the upper class) owned 35.4 percent of all privately held wealth, and the next 19 percent (managers, professionals, and small business owners) held 53.5 percent of America's wealth. Therefore, only 20 percent of the people owned over 89 percent of the wealth. This means that the remaining 80 percent of all Americans owned 11 percent of the country's wealth (Domhoff, 2013).

Food Insecurity

Succinctly speaking, *food security* (U.S. Department of Agriculture, Economic Research Service, n.d.) is the capacity by all people to always have access to enough food for an active, healthy life. The most recent statistics indicate that 42.2 million Americans live in food insecure households (Feeding America.org, n.d.), including more than 13 million children.

Inequities in Access to Affordable Housing

As stated by the National Coalition for the Homeless (n.d.), “Housing represents the fundamental base-solution to the problem of homelessness. The lack of affordable housing and the limited scale of housing assistance programs contribute to the current housing crisis and to homelessness. This deficit of affordable housing has led to high rent burdens, overcrowding, and substandard housing, which has not only forced many people to become homeless but has also put a growing number of people at risk of becoming homeless” (para. 1).

According to the How Housing Matters Survey conducted by the MacArthur Foundation (2016), one-third of adults (34 percent) report that they know someone who has or have themselves been evicted, foreclosed on, or lost their housing in the past five years. Three in 10 adults (31 percent) spend more than 30 percent of their monthly household income on their rent or mortgage payment. In addition, over half of the U.S. public (53 percent) reported that they have made sacrifices over the past three years to be able to cover their rent or mortgage including getting an additional job, ceasing to save for retirement, taking on credit card debt, cutting back on healthy food, and delaying health care. The same study found that African Americans and Hispanic Americans are affected at higher rates by the lack of affordable housing. Rental housing is increasingly becoming unaffordable and low-income people who live in urban areas (many of whom pay more than 30 percent of their income to cover housing costs) are enduring the most unequal access to affordable housing.

Health Disparities in the Context of Economic Injustice

When we discuss the issue of health disparities, we often think of race and ethnicity as the primary determinant of unequal access to quality health care. However, experts have suggested that, although race can play a role in health disparities based on biological determinants (Kawachi, Daniels, & Robinson, 2005) of certain health conditions, race is a proxy for class and socioeconomics (Kawachi et al., 2005). Therefore, the issue of health disparities can and should be discussed in the context of economic justice.

Education Disparities in the Context of Economic Injustice

Most social workers would agree that the pathway out of poverty is education. Yet, paradoxically, economic injustice makes that pathway very hard to follow. Low-income children are significantly less likely to succeed in school than their more affluent counterparts. Parents' educational attainment and household poverty status are associated with the quality of children's educational experiences and their academic performance (National Center for Education Statistics [NCES], n.d.), whether they are in public school, in private school, or being homeschooled. For example, research suggests that living in poverty during early childhood is related to lower levels of academic performance—beginning in kindergarten and extending through elementary and high school—and lower rates of high school completion (NCES, n.d.).

Effects of Welfare Reform

In 2016, Temporary Assistance for Needy Families (TANF), the signature program associated with welfare reform, turned 20 years old. Congress created TANF through the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (U.S. Department of Health and Human Services, 1996) as part of a federal effort to "end welfare as we know it" (Center on Budget and Policy Priorities [CBPP], 2015). From its inception, TANF was supposed to help low-income families move off of cash assistance to self-sufficiency through employment. According to CBPP (2015), employment rates improved significantly among single mothers in TANF's early years. However, that level of employment started declining more than a decade ago. The share of never-married mothers with a high school education or less who were employed jumped from 51 percent in 1992 to a high of 76 percent in 2000, but by 2013 it had fallen back to 63 percent, about the same level as in 1996. Although the sharp improvement in employment among single mothers in the 1990s is often attributed to welfare reform, research has shown that other factors—especially a very strong labor market (with unemployment as low as 4 percent) and the Earned Income Tax Credit (EITC)—were far more important.

Work Requirement of Supplemental Nutrition Assistance Program (SNAP)

In 2016, at least 500,000 (and perhaps 1 million) of the nation's poorest people will lose SNAP benefits due to the reinstatement, in many areas, of a three-month limit on SNAP benefits for unemployed adults ages 18 to 49 years who are not disabled or raising minor children. These individuals will lose their food assistance benefits after three months regardless of how hard they are looking for work. Twenty-two states require or are choosing to reimpose this work requirement (CBPP, 2016).

Impact of Economic Crisis of 2008

The impact of the economic crash of 2008 cannot be understated. Households in the United States lost an average of $5,800 (Pew Charitable Trust, 2010) in income due to reduced economic growth during the acute stage of the financial crisis from September 2008 through the end of 2009. Costs to the federal government due to its interventions to ease the financial crisis amounted to $2,050, on average, for each American household. Also, the combined peak loss from declining stock and home values totaled nearly $100,000, on average per U.S. household, during the July 2008 to March 2009 period.

In addition, the economic crisis of 2008 disproportionately sapped the wealth of black and Hispanic Americans because of foreclosures, often due to predatory mortgage lending (Kraly, 2002). During the first three years of the foreclosure crisis (Gruenstein Bocian, Li, & Ernst, 2010), from January 2007 through the end of 2009, it is estimated that 2.5 million fore-closures were completed. A profile of those who lose their homes reveals the following:

- Most families who lost homes were non-Hispanic and white, but African American and Latino families were disproportionately affected relative to their share of mortgage originations.

- Among recent borrowers, nearly 8 percent of both African American and Latino Americans have lost their homes to foreclosures, compared with 4.5 percent of white Americans (Gruenstein Bocian et al., 2010).

The racial and ethnic disparities in these estimated foreclosure rates hold even after controlling for differences in income patterns between demographic groups.

Racial and Gender Disparities in Employment Rates

White unemployment rate is at 4.3 percent as compared with 8.6 percent for black and 5.7 percent for Hispanic unemployment rates. Although the overall unemployment rate for women (Department of Numbers, n.d.) is lower than that for men, when we factor in race, the picture changes. For example, in 2014 African American women (Hamm, 2015) had the highest unemployment rate among women (10.5 percent) compared with white women (5.2 percent).

Debt and Poor Credit Rating

It is well known that communities of color have not had equal access to credit, dampening their ability to build assets. One of the culprits in the racial and ethnic disparities in access to consumer credit and paying higher interest rates was the deregulation of the lending industry during the 1980s. Credit card companies targeted consumers of color with card offers, but at terms and conditions that were often economically detrimental (Dēmos, n.d.). For example, in 2008, low- to middle-income Hispanic families had an average of $10,002 in credit card debt, whereas white families had an average of $9,775 and African American families had an average of $7,390 in credit card debt. However, the estimated annual percentage rate paid on the credit card was an average of 17 percent for African Americans, 16 percent for Hispanic Americans, and 14 percent for white Americans (Dēmos, n.d.). Also, according to 2008 data, 39 percent of Hispanic and African Americans had used their credit cards to pay for basic living expenses such as rent, mortgage, groceries, utilities, or insurance because they did not have enough available cash; this is compared with 35 percent of white Americans (Dēmos, n.d.).

The racial and ethnic disparities in levels of indebtedness are significant. Hispanic Americans dedicate 56 percent of their monthly income to pay monthly debt, whereas African Americans dedicate 53 percent and white Americans dedicate 47 percent. In addition, in 2008 a higher percentage of African Americans reported being closer to bankruptcy, being called by bill collectors, or having their cars repossessed as compared with white Americans. In the same year, 37 percent of Hispanic Americans, 34 percent of African American, and 18 percent of white Americans had a settlement agreement with a credit card company (Dēmos, n.d.).

POLICY STATEMENT

NASW has been a champion of economic justice and equity since its inception. The social work profession was founded on the notion that those living in poverty are often politically marginalized and in need of advocates to help mitigate their plight. NASW believes that America must fully use and develop available, productive, and creative human resources and capacities. We reject any suggestions that the United States cannot achieve economic reforms that lead to economic justice and end economic disparities based on race, ethnicity, and gender. Therefore, NASW supports the following:

- the commitment of social workers to continue to be vocal, strong, and proactive advocates for economic justice from a social justice and ethical point of view.
- policies and legislation that maintain the social safety net related to food security. This position includes ensuring that SNAP is fully funded.
- the immediate establishment of a national minimum wage of $15 per hour. We further support a national policy of establishing a living wage based on geographical cost of living variations.
- the end to predatory mortgage lending that has historically depleted wealth from low- and moderate-income Americans through foreclosures.

We also support serious criminal penalties for predatory mortgage lenders.

- legislation, policies, and programs that significantly address the paucity of affordable housing (especially rental housing) in the United States. We support increased rental subsidies for low- and moderate-income families and individuals.
- policies, programs, and legislation that recognize the direct link of low education attainment to generational poverty. We support increased preschool education for low-income children, expansion of after-school programs, and increased psychosocial support for at-risk families.
- advocacy and legislative support for longterm authorization of EITC, which has proven to be one of the most important income safety-net programs.
- advocacy for the full adherence to and enforce of the Credit Card Bill of Rights of 2009, so that consumers no longer fall victim to predatory credit card practices.
- creation of a Consumer Financial Protection Bureau, to provide needed regulation and oversight of the credit card industry.
- a review of the current TANF program to determine how it can be reformed to meet the realistic income and employment needs of indigent heads of households and their families. We support an end to linking employment attainment to receiving financial assistance, especially in the face of the inadequacy of the current minimum wage in achieving self-sufficiency.
- elimination of the work requirement for childless single adults to receive SNAP benefits.
- national legislation and policies that end or greatly regulate payday loan businesses that have preyed on low-income, mostly people of color with extremely exorbitant interest rate.
- national policies, legislation, and programs that address disparities in the unemployment rate based on race and gender.
- a policy of full employment at all levels for all those able to work, with a range of alternative work patterns and strategies to address conditions if the economy is unable to sustain full employment.

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Education of Children and Adolescents

ISSUE STATEMENT

In the United States, the provision of a free, appropriate, equitable, and quality public education continues to be a challenge for federal, state, and local governments. An array of federal legislation has been enacted to help the U.S. Department of Education support its mission of "student achievement and preparation for global competiveness" (U.S. Department of Education, 2012, para. 10).

Elementary and Secondary Education

The original Elementary and Secondary Education Act of 1965 (P.L. 89-10) set standards for students, teachers, and, most important, formulas for block grants to states. The legislation instituted large-scale resources for educationally deprived students.

The passage of the Education for All Handicapped Children Act of 1975 (P.L. 94-142) guaranteed all children a free and appropriate public education, the right to due process, and individualization of instruction according to need. Subsequent reenactments broadened the coverage to include the educational needs of children ages three to 21 years, additional conditions that qualify people with disabilities for coverage, and greater encouragement for the implementation of local programs for children from birth to three years. It remains essential that accommodation of students with severe disabilities continues to be available when their individualized education plan identifies the need. This approach was mandated and reinforced with passage of the Individuals with Disabilities Education Act

(IDEA) Amendments of 1997 (P.L. 105-17), which amended IDEA (1990, P.L. 101-476).

The Individuals with Disabilities Education Improvement Act of 2004 (P.L. 108-446), a revision of IDEA, calls on educational institutions to demonstrate improved outcomes for all students.

The No Child Left Behind Act of 2001 (P.L. 107-110) “laid emphasis on the idea of accountability, adding timelines and sanctions for not achieving goals” (Jonson-Reid, 2008, p. 109).

Population Specific

Specific legislation that mandates continuous services to transient or homeless students was established in 1987 by the Stewart B. McKinney Homeless Assistance Act (P.L. 100-77), which was amended and later became known as the McKinney-Vento Act.

Public education is a vital socializing force that, with the family, promotes the total development of the child intellectually, socially, and physically. To nurture the full potential of children and youths, our nation’s public schools are an excellent forum to ensure equal opportunity and preparation. NASW believes that schools must pursue excellence and provide for the physical and emotional safety and growth, in addition to the education, of children. Schools must identify students with disabilities and disadvantages early and provide support to such students in accordance with federal legislation. Educational environments promote transitional learning in the areas of work, community living, and civic responsibility.

Students with excessive truancy and who are at risk of dropping out must receive outreach services. Potential dropouts and pushouts represent another significant high-risk group in the educational system. In too many cases, discipline involves suspensions or expulsions that deny access to school or placement in supervised atmospheres. Exclusion from school increases the risk of negative behaviors, such as crime and misuse of alcohol and other drugs. Furthermore, students from racial and ethnic minority groups experience a disproportionately high incidence of suspensions and expulsions. “Studies show that students of color receive harsher punishments for engaging in the same conduct as white students”

(Issurdatt, 2013). In addition, children and youths who have been incarcerated must not lose their right to an equal education.

POLICY STATEMENT

Education is a continuous maturation process that promotes the intellectual, physical, and social development of students in their environments. It is the position of NASW that the educational system has a responsibility to provide all students with free, appropriate, and high-quality education. Through quality education, students should be able to attain full vocational and career skills and concomitant behaviors conducive to success and lifelong learning. In addition, students need educational opportunities that foster increased self-awareness and self-actualization; empathy for others; understanding and acceptance of differences in race, culture, ethnicity, and sexual orientation; and understanding of the personal realities of individuals with disabilities and how to help them to participate more fully in normal daily activities. NASW supports the following components as essential to operationalizing free, appropriate, equitable, and high-quality education:

- **Safe, Positive, and Secure Schools.** Positive school climate and the prevention of school violence continue to be central in ensuring the safety of children, adolescents, and young adults in school buildings and on school campuses. School connectedness is associated with increased school safety and a reduction in violence (Issurdatt, 2010). Policies and programs to improve school climate and prevention of school violence need to ensure safe and secure physical facilities and sustain school connectedness. In addition, it is imperative for these policies and programs to address bullying behaviors and be based on evidence-based, effective interventions (Issurdatt, 2010).
- **Nondiscriminatory Education.** The right to equal educational opportunity requires a non-segregated, nonsexist environment. Educational institutions should create pluralistic environments; they should provide for, and facilitate interaction among, students and faculty of diverse racial, cultural, religious, spiritual, and ethnic backgrounds. An integrated environment promotes understanding, knowledge, and

acceptance of diversity in family composition (for example, sexual orientation and same-sex families). To ensure nondiscriminatory education for all students, a policy prohibiting the use of discriminatory or stereotyping labels and practices should be established. Bilingual education programs promote greater understanding of the educational process of those experiencing language and cultural barriers.

- **Nontraditional Education.** Millions of youths are underserved or not served at all by the public educational system. Any reform in public education must include alternative routes to becoming educated and finding successful roles as adults. These alternatives, however, must not isolate "undesirable" students from the mainstream, but, rather, offer them sufficient support to meet their unique behavioral and situational needs. The widespread availability of computers, and the Internet in particular, has had a revolutionary impact in the classroom, and more significantly, on educational formats for learning at home.
- **Least-restrictive Environment.** Every student has the right to a free, appropriate public education in the least-restrictive environment. NASW supports the least-restrictive environment concept as it is determined individually for each student. NASW supports the regular education environment as the first placement consideration and strongly supports placement of students in the setting that best meets the student's needs, with the appropriate continuum of services, staffing, and assistive devices, and replacement in a more restrictive setting if so determined by student need.
- **Alternative Testing and Performance.** All students do not learn in the same fashion. Divergent learners may test poorly on standardized tests. This does not mean that a student is not learning; rather, the particular testing used may not adequately tap the student's knowledge. Alternative testing method options need to fit the student's learning style. Therefore, alternate ways to measure academic growth is essential, especially among the learning disabled population of students and other educationally disadvantaged students in U.S. public schools.
- **Family, School, and Community Linkages.** Effective communication among school personnel, families, and communities is vital to reach the goals set for each student. Coordination of services is critical to the efficient and effective use of resources and the attainment of goals.

Strengthening the relationship among the families, schools, and communities is a fundamental principle of any educational policy. NASW encourages linking the school to community resources as sound public policy and encourages further policy development focused on bringing schools, families, and communities together for mutual support and problem solving as well as for cultural and celebratory events.

- **Early Childhood Education.** It is the policy of NASW that early childhood education should continue to be expanded and made available to all children through federal and state support (see also NASW policy statement on Early Childhood Care and Services). Such programs promote total learning for all children through emphasis on early stimulation of children in the home, recognition and use of parenting skills, provisions for adequate nutrition and medical care, and the introduction of important social skills needed for later school success. In addition, significant research supports the position that early intervention for children with disabilities of all types benefits their later ability to succeed educationally.
- **Career and Vocational Education.** NASW affirms that the primary function of education is to prepare students for life tasks, specifically the world of work. Preparation should include instilling the attitudes and behaviors that ensure successful entry into the labor market. American children must be prepared to compete in a global society that offers opportunities for all nations to share the resources of the world. It is the policy of NASW that transitional experiences and entry structures should be available throughout the educational ladder. To accomplish this, schools, postsecondary educational institutions, communities, and businesses should continue to form linkages that provide opportunities for entry into the labor market. Career and vocational programs should have the same economic and academic investment from school facilities and administrations as college preparatory programs. High schools should assist all students who are preparing for postsecondary education, and all students should be graduating with a high school diploma.
- **Comprehensive Health and Mental Health Education.** It is the policy of NASW that educating students about their health and physical needs and about optimal health practices, including sexual conduct and HIV/AIDS education, is a necessary and appropriate function of public

schools. Such programs should be developed by multidisciplinary teams that include, but are not restricted to, social workers, health care providers, educators, and parents. The programs should be evidence-based and use best practices. They should be offered in early childhood programs or kindergarten and should continue throughout students' formal public education. Such programs should be age and developmentally appropriate and provide information that enables students to make responsible choices about their bodies, behavior, relationships, and emotions.

- **Sex Education.** To make responsible choices, students need access to basic facts about human physiology and psychology, including information on reproduction, family planning, pregnancy prevention, responsible parenting, HIV/AIDS and sexually transmitted diseases, substance use, healthy eating, exercise, stress management, anger management, and general lifestyle decisions. A comprehensive life education program should involve parents and should promote open communication among parents, students, and schools. With increasing attention to children suffering physical and sexual abuse, it is imperative that students are protected from violence and abuse.
- **Discipline.** It is the policy of NASW that disciplinary practices in elementary and secondary schools, including detention, suspension, and expulsion, must reflect the desire to shape students' behavior toward productive participation in schools and society. Many such policies are clearly punitive in intent and thus do not reflect the school's concern for retaining and successfully graduating students involved in their disciplinary system. The focus of school discipline should be to help students accept responsibility for their own behavior, rather than punishment. The use of corporal punishment in schools should be abolished in the remaining states that still approve of such practices.
- **School Truancy and Dropout Prevention.** NASW supports comprehensive and individualized services to enhance each student's opportunity to successfully complete school and to have the opportunities of a full and productive adult life (NASW, 2009).
- **Social Workers in Elementary and Secondary Schools.** School social workers are one of the few resources in elementary and secondary schools for addressing personal and social problems that inhibit students'

ability to learn. Unfortunately, the distribution of social workers is uneven and inequitable; school social workers tend to be clustered in greater proportions in industrial states and in school districts with greater resources. NASW encourages legislation and funding at the federal and state levels to substantially increase the number of social workers available in schools to serve both students with identified disabilities and students in the general school population. NASW recommends that pupil services teams in every state include school social workers on the elementary and secondary levels who graduated from a Council on Social Work Education–accredited program. School social workers seek to ensure equitable education opportunities; ensure that students are mentally, physically, and emotionally present in the classroom; and promote respect and dignity for all students (NASW, 2012). These components enable students to acquire the academic skills and the ability to function in and contribute to a multicultural society.

- **Specialized Instruction Support Personnel.** The policy of NASW is that the model of collaboration used by multidisciplinary teams, including school social workers, psychologists, pupil services personnel, teachers, administrators, and families, in the identification and evaluation of students for appropriate services is optimal for the delivery of services to all students.
- **Evaluation and Research.** Evaluation of school social work services is critical in documenting effectiveness. Federal, state, and local education agencies as well as school social workers should conduct research related to the effectiveness of social work services in the schools. Research that examines both the shortterm and the long-term effectiveness of innovative prevention programs must be supported.
- **Full Funding for Education.** All legally mandated educational programs must be funded at a level that ensures their effective implementation. Programs must not be weakened by changing or eliminating key rules and regulations because of politically shortsighted initiatives or economic recession. The rights of students and families should not be eliminated or reduced to foster a more controlling, and in some cases, more oppressive environment. Full funding for education should include safe and fully functioning educational facilities in addition to appropriate programming.

- **Accessibility of Vocational and Higher Education.** NASW supports the availability of an adequate array of low-cost loans, scholarships, and fellowships that will ensure that high-quality vocation and higher education opportunities are available to individuals in need of such support. In addition, loan forgiveness programs should be available to attract individuals to high-need occupations, including social work.

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Electoral Politics

ISSUE STATEMENT

Social workers have always participated vigorously in political processes. The social work profession grew out of the political activism of its founders, from Jane Addams and Jeanette Rankin in the early 1900s to Frances Perkins, Harry Hopkins, and Molly Dewson in the New Deal era to current political office holders. Social workers now hold many prominent political offices, and, in recent decades, have moved toward greater participation in political activity (Myers & Granstaff, 2013).

In most representative democracies around the world, the electoral political system is the determining vehicle for expressing human values and for the provision of resources. As experts in the areas of human needs and services delivery, social workers' role in the political process is axiomatic. Since the early part of the 20th century, social workers have participated in national, state, and local political party campaigns and elections. Social workers have also lobbied the legislative and executive branches of government, advancing policy recommendations and implementing new programs. They are in a unique position to participate in electoral politics, to advocate for candidates, laws, and policies that promote NASW's agenda. As a profession, social workers must become informed about, and involved in, all levels of electoral politics.

Beginning with Theodore Roosevelt's Progressive Party in 1912, social workers have been active in presidential campaigns, including those of Franklin Roosevelt, Lyndon Johnson, Bill Clinton, and Barack Obama. NASW has been active in federal and state elections since 1976. Social workers show a growing willingness to enter the political arena in all capacities—as voters, party officials, political professionals, candidates, and officeholders.

Few studies over the years have attempted to reinforce the perception that social workers are active in campaigns and elections and that they vote at much higher rates than the general public. One conducted in 1984 replicated a 1968 survey designed to assess the level of activism by social workers (Reeser & Epstein, 1990). Among measures of electoral participation, this study found increases in specific behaviors, such as giving money to campaigns, volunteering for candidates, and encouraging political activity among clients. Reeser and Epstein's historical comparison between social workers' political behavior in the original survey and their own demonstrated fundamental increases in the profession's political activism profile.

More recently in 2000, another study examined social workers' political participation and civic engagement (Rome & Hoechstetter, 2010). Of the 1,269 valid responses received, 74 percent of social workers reported that they always vote on election day, which exceeds the turnout rate of the general public. In the same study, social workers reported actively campaigning for candidates and encouraging others to vote. The authors concluded that these high participation levels should be recognized, but the profession should continue to increase its emphasis on policy practice.

Throughout its history, NASW has promoted the broad concept of electoral political action in various ways. Political activity is outlined as an ethical responsibility in the *Code of Ethics* (NASW, 2008), and successive delegate assemblies have encouraged social worker involvement. On the practice level, valuable program initiatives have included the following:

- operating federal and state political action committees (PACs)
- organizing national, regional, and chapter training programs
- establishing a check-off system on annual membership renewal forms to enhance voluntary candidate contributions
- mobilizing association support for political candidates whose stances on issues advance NASW's professional and program agenda
- encouraging social workers to seek public office
- promoting voter registration.

Furthermore, by supporting practitioners who spent decades securing legal and commercial recognition of the profession through licensing and vendorship campaigns in state legislatures, NASW steadily built elements of electoral political activity into its program.

Social workers frequently approach electoral politics with great caution because of its potential for divisiveness. The major cause for division occurs around the concepts of partisan-ship and political parties. Some members of the profession believe that NASW should be non-partisan in engaging in electoral politics, or they believe that NASW should take positions only on issues, not candidates. Other members think that NASW should be aligned with only one of the major parties, and still others favor a bipartisan or multipartisan approach.

There are two practical difficulties with NASW adopting a nonpartisan approach to candidates or taking positions on issues instead of candidates. For most political offices in this country, partisanship is unavoidable. Only a few offices, such as those on school boards and some municipal and judicial positions, are contested on a nonpartisan basis. Virtually all other elective offices involve partisan contests. If an individual or group wants to be able to influence electoral outcomes, it has to make partisan choices. Campaigns and elections in the U.S. political system are, by and large, about choices among candidates, not issues. Social workers must be involved in the election of candidates who support NASW values and issues to advance the profession.

Some social work educators and practitioners, however, have been more equivocal and cautious in their approach to electoral politics (Salcido & Seck, 1992; Weismiller & Dempsey, 1993). Educators’ ambivalence is reflected in social work education programs with a dearth of either electoral political field placements or specific curriculum material about campaigns, elections, political parties, or other important electoral institutions and processes (Wolk, Weismiller, Dempsey, & Pray, 1994). Although educators appear committed to teaching the importance of political involvement, professors may not set the best examples. Still, educators have ample opportunity to foster students’ interest in politics and encourage engagement.

Electoral Political Institutions and Processes

Electoral politics are the formal and informal systems by which citizens and groups in a democracy contest for the power to run government (Plano & Greenberg, 2001). Primary electoral political institutions include political parties, interest groups and coalitions, candidate campaign organizations, PACs, the campaign industry (that is, businesses that provide management, polling, fundraising, and communication services to candidates), and the media. Electoral political processes encompass candidate nominations, party conventions, primaries, caucuses, campaigns, elections (including primary, general, and special), voter registration, voting (including absentee and special voting programs), ballot measures, and transitions.

Some aspects of electoral politics, including political parties, PACs, transitions, and political education, require special attention by NASW. Participation in these processes often amplifies the political influence of a group.

Political parties are voluntary groups of voters with shared ideology, who organize to try to win elections, control government, and influence public policy. Political party activity increases organizational electoral power. A person who holds firmly to a party or its cause is a *partisan,* hence the term “partisan politics.” Partisan politics are about working with, or within, major political parties to achieve desired public policy goals. Whatever partisan choices an individual or organization makes, it is still possible, and often necessary, to have civil and constructive relationships with partisans of other political parties.

Confusion often occurs about the terms “bipartisan” and “nonpartisan.” *Bipartisan* means relating to, or involving, members of two parties. Republicans and Democrats presenting a united front in the face of a serious foreign threat to the country is a bipartisan action. *Non-partisan* usually refers to elections in which candidates have no party designations and political parties are prohibited from entering candidates.

Federal election law refers to a corporate political committee as a separate, segregated fund (SSF), although it is more commonly called a PAC. As the name implies, money contributed to an SSF is held in a separate bank account from the general corporate treasury. These accounts hold money voluntarily contributed by association members, and can be used legally for candidate contributions (Plano & Greenberg, 2001). NASW maintains such an account, called Political Action for Candidate Election

(PACE), in accordance with federal election law. Authority to make decisions about candidate endorsements and disbursements from the PACE fund has been delegated by the NASW National Board of Directors to the National PACE Board of Trustees. *Transition* refers to the time between election to an office and the assumption of the office. Successful candidates use transition time to prepare to hold office. This presents an opportunity for organizations and campaign activists to shape the development of a new administration.

NASW Involvement in Electoral Politics

Current tax and campaign election laws permit corporations such as NASW to use dues-generated funds to support all electoral activity of their members, except for direct contributions to candidates. Although these laws make much activity legally permissible, the availability of funds limits what is organizationally feasible. NASW has numerous demands on its resources and must balance many needs in its program planning and budgeting process.

National Level. Elections provide a vehicle for accomplishing diverse association agendas. For three decades, NASW has focused on electing progressive candidates to public offices. Since 1984, NASW and PACE have made it a priority to support the candidacies of women and people of color seeking election to federal offices whose agendas are aligned with those of the association on the most significant issues. The composition of Congress shows some increased diversity, and social workers can be proud of the role NASW has played in that change.

Elections can also be used to gain power for the profession. The 1993 Delegate Assembly made support of social worker candidates for public offices a priority. Since 1991, the association has published several brochures identifying social workers serving in elected office, and, specifically, social workers serving in Congress. Currently, NASW maintains a database of social workers serving in elected office, which can be accessed on the association’s Web site.

State Level. NASW electoral activity in states originated primarily from chapter legislative initiatives on professional issues such as licensing and vendorship. Acquiring the means to support or oppose legislators spurred the creation of chapter PACs. Once they were in the electoral arena, chapters quickly realized the value of trying to influence the outcome of statewide office races, particularly the governor's office, and capitalized on opportunities to do so.

Ballot measures are also an electoral tool that chapters are using to spread their sphere of influence. NASW's interest in state ballot measures is mounting. These measures include the *initiative,* a mechanism by which citizens can propose legislation or constitutional amendments; the *referendum,* a mechanism by which voters can veto a bill passed by their legislature; and the *recall,* a procedure enabling voters to remove an elected official from office before his or her term has expired (Plano & Greenberg, 2001).

Issues Raised by Electoral Political Participation

Candidate Endorsements. A candidate endorsement is a public statement of support and commitment to provide resources and mobilize members to promote, work, and vote for the candidate. NASW has authorized PACE to make such endorsements on behalf of the association. Endorsement decisions are based on established process and criteria, including thorough research on the potential endorsees and their opponents and deliberations between NASW, PACE, and chapters (NASW, 2010).

Candidate Contributions. Through PACE, NASW provides financial support to endorsed candidates. Current federal law and state laws require that money given to candidates by corporations such as NASW come only from monies voluntarily contributed by members and disbursed by PACs. NASW may also make other campaign support available to candidates, such as recruiting volunteers; sending information to members; publicizing a candidate's record on policy issues; and using an endorsement by NASW, photo opportunities, letters of support, and assistance with position papers and issue development.

Fairness. The social work professional value of fairness requires that the association maintain procedures for candidate endorsements that are open and evenhanded. To maintain credibility with candidates and its own members, NASW and PACE follow a clearly defined endorsement process, with criteria that are applied fairly to all candidates who wish to go through the process.

NASW can promote inclusion of members in its political activities by respecting the diversity of political positions they hold. PACE is committed to endorsing political candidates only on the basis of their support for NASW policy positions, not on the basis of political party affiliation. It is PACE's responsibility during its endorsement deliberations to give fair consideration to all candidates (NASW, 2010).

Communication with Power versus Exercise of Power. Having readily available communication with a public official is often confused with having power to influence that official. Power derives from parlaying that communication into effective advocacy. Social workers frequently view a friendly political relationship as a successful relationship, regardless of whether it advances the agenda of the profession or of that professional. The goal of NASW is to build political relationships with elected leaders that will result in favorable action on its policy priorities (NASW, 2010).

Money and Politics

For many years, money has had a troubling and corrosive influence on America's political process. A new and even more harmful element was introduced with the ruling handed down by the U.S. Supreme Court in *Citizens United v. Federal Election Commission* (2010).

This ruling has multiple consequences. For one, both corporations and unions may make unlimited expenditures and electioneering communications. Such policies tend to favor wealthy individuals and corporations at the expense of low- to moderate-income citizens. For another, the *Citizens United* case has given rise to the concept of a "super PAC." Super PACs may engage in unlimited political spending, as long as they do not coordinate with candidates or campaigns. Unlike traditional PACs, there is no limit to the amount of money they can raise, and they do not have to disclose the names of individual donors.

This fallout from the *Citizens United* case is troubling to NASW. As an organization, we support full and complete transparency in the process of recording political and campaign contributions, be they from individuals, corporations, unions, or any other entity. We also support policies that seek to limit the influence of money in the political process and reduce the cost of elections, so that undisclosed sources cannot enjoy such limitless and undue influence.

Voter Suppression

The United States suffers from a long and shameful history of voter suppression. In the 1950s such acts were overt, in the form of fraud, violence, poll taxes, literacy tests, and frequent re-registration requirements. The Voting Rights Act of 1965 effectively outlawed many of these practices; Whitney M. Young, Jr., one of the country's key civil rights leaders who fought for and eventually won passage of the Voters Rights Act of 1965, also served as NASW president from 1969 to 1971.

However, new and more subtle forms of voter suppression have arisen in recent years. Photo identification laws, the purging of voter rolls, misinformation about voting procedures, gerrymandering, and a lack of sufficient polling places are all forms of voter suppression that have occurred throughout the United States in the 21st century. NASW opposes such actions in the strongest terms.

We also encourage early voting, to ensure that everyone has fair and adequate opportunity to communicate their electoral preferences, as well as the expansion of early voting as a concept throughout the United States. Those states that fail to offer this option limit and diminish the enfranchisement of its voters.

Given its history as a frontline leader in the fight for civil rights, NASW has a strong and unyielding commitment to the continued protection of one of America's most fundamental rights. NASW continues to honor its proud history of supporting fair and equal balloting access for everyone of eligible voting age in the United States.

POLICY STATEMENT

- NASW reaffirms that participation in electoral politics is consistent with fundamental social work values, such as self-determination, empowerment, democratic decision making, equal opportunity, inclusion, and the promotion of social justice.
- NASW's ability to achieve public policy goals and other political objectives depends on participation in the full spectrum of legitimate electoral activities; these activities should be thoroughly integrated into other association programs.
- NASW's primary organizational strength lies in the involvement and mobilization of its members in all aspects of electoral politics, with particular emphasis on campaigns and elections, electoral coalitions, fundraising, and the seeking of public office.
- NASW reaffirms that members seeking or serving in appointive and elective public offices are rendering community service consistent with the profession's *Code of Ethics.*
- NASW encourages its members to participate in all facets of electoral political activity and recognizes the right of individual members to make their own choices about electoral participation and candidate support.
- NASW seeks to work collaboratively with the Council on Social Work Education and social work education programs to develop appropriate curriculum material on, and field placements in, electoral politics, and to expand opportunities for political social work practice.
- NASW cautions that members' vigorous participation in electoral politics and advocacy for NASW positions are bounded by avoidance of conflicts of interest that would take unfair advantage of any professional relationship or exploitation of others to further their personal, religious, political, or business interests (NASW, 2008).

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Employee Assistance

BACKGROUND

One of social work's primary missions is to support individuals, families, and communities as they strive to achieve and sustain basic needs. For many families, continuous and full employment of one or more members is vital to providing for these needs, including food, clothing, and shelter. Social workers in the workplace support employees in meeting those needs, for themselves and for their families (Akabas & Kurzman, 2005). Employee assistance (EA) is a multidisciplinary field with a strong value placed on collaborative work relationships with other professionals and paraprofessionals within the workplace (Employee Assistance Professionals Association [EAPA], 2009). Through employee assistance programs (EAPs), social workers provide organizational consultation and frontline social support, mental health care, and wellness services for the many working adults in the Unites States and their family members, especially in large companies and institutions (Akabas, 2008).

Established in the United States during the 1940s, EAPs were originally referred to as occupational alcohol programs (OAPs) and focused on identification of and early intervention for alcohol problems among employees. The federal Comprehensive Alcohol Abuse and Alcoholism Treatment and Rehabilitation Act of 1970 (P.L. 91-616) mandated that OAPs be made freely available to all federal employees. In addition, this legislation established the National Institute on Alcohol Abuse and Alcoholism (NIAAA), whose mission included the promotion of EAPs throughout the nation. To accomplish this daunting task, NIAAA funded two occupational program consultants in each state who worked collaboratively with labor representatives to educate private industry about the need for alcohol programs. Together, the consultants and labor organizations formed the Association of Labor–Management

Administrators and Consultants on Alcoholism (ALMACA), a nonprofit organization and the precursor of the present-day EAPA.

During the 1980s, OAPs expanded their scope of services, covering a wider array of personal and work-related problems and were renamed EAPs. Passage of the Drug-Free Workplace Act of 1988, as amended by HR 1107 (2011), and its subsequent amendments spurred further growth of EAPs.

Throughout the 1990s, EAPs partnered with larger managed behavioral care (MBC) companies to provide continuous and seamless behavioral health care. EAPs continued their focus on initial assessment to identify underlying personal problems that might negatively affect the workplace and to assist employees in accessing appropriate care within their benefit plan or the community. Within the MBC environment, EA professionals often advocated on behalf of employee clients for effective and timely services. EAPs gained acceptance among public and private workplaces and succeeded in offering “broad brush” services (Akabas, 2008) to employees, family members, and managers. Currently, EAPs offer diverse services related to trauma and crisis intervention; assessment and grief therapy; work– life balance; elder and child care; legal and adoption referrals; workplace and interpersonal violence; and support during organizational changes, such as mergers and downsizing.

Compared with other fields of practice, EA is relatively new, yet it already has standards and practice guidelines developed by social workers and other EA professionals (Council on Accreditation, 2008; EAPA, 2010b). Social workers make up a significant percentage of professionals providing a broad range of workplace and EA services (Jacobson & Hosford-Lamb, 2008; Zastrow, 2008, 2009). The social work field is well-positioned to offer or expand undergraduate and graduate education that will result in increasing numbers of formally trained EA professionals able to fill a wide range of EA positions, including program managers, clinical roles requiring licensure, management consultants, work– life specialists, account managers, researchers, and policy experts (Kurzman, 2008; Pompe & Sharar, 2008).

Social workers excel in EA practice, in part because of their professional training in systems theory and their application of the person-in-environment, or person-in-work-environment, perspective within an ecological framework (Zastrow, 2009). Social workers in EAPs serve employees and family members on a micro practice level; train managers, organizational leaders, and other employees on a mezzo practice level; and promote integration of community, society, and legislative policy on a macro practice level (Jacobson & Hosford-Lamb, 2008). Viewed from a public health perspective (Federal Occupational Health, Leadership Today, 2007), EA professionals have a unique opportunity to apply primary prevention and early intervention services that frequently eliminate the need for additional and often costly health care. EA professionals attend to the needs of the working poor and other potentially vulnerable adults and family members by providing outreach, education, and early intervention to working populations including, but not limited to, racial, ethnic, and religious groups or minorities; older adults; people with disabilities; and employees of all genders and sexual orientations.

The EAPA defines *EA* as the “work organization’s resource that utilizes specific core technologies to enhance employee and workplace effectiveness through prevention, identification and resolution of personal and productivity issues” (2010c). This definition originates from research conducted by Roman and Blum (1985, 1988), resulting in EAP (EAPA, 2010a) core technology, the unique characteristics common to all EAPs, which were recently confirmed as still relevant to the field through survey research (Bennett & Attridge, 2008). The certified employee assistance professional credential is recognized internationally as the knowledge standard for individuals who provide EA services.

Although EAPs address a diverse array of personnel problems through outreach, education, and early identification of and intervention for employees in need, they have demonstrated success in helping businesses reduce costs associated with employee personal, mental health, and substance abuse concerns (Christie & Harlow, 2007; Greenwood, DeWeese, & Inscoe, 2005; Hargrave & Hiatt, 2005; Hargrave, Hiatt, Alexander, & Shaffer, 2008; Wang, Simon, & Kessler, 2008). With the economic downturn starting in 2008, EAPs have expanded their roles to help businesses with organizational development goals, employee termination, supervisory consultations, and management and leadership training.

ISSUE STATEMENT

Two of the most prevalent and costly problems addressed by EAPs are alcohol abuse and depression (National Institute of Mental Health, 2008); employers rank mental illness as the health issue they believe has the most effect on their indirect health costs, ahead of high blood pressure, heart disease, asthma and allergies, diabetes, cancer, smoking, substance abuse, and back problems (Employer Benefit News, 2007). Depression alone is estimated to cost businesses over $44 billion per year and is predicted by the World Health Organization (WHO) to become the second leading source of disability globally by 2020 (Marlowe, 2002; WHO, 2009). In addition to medical-related indirect costs, there are many work-related indirect costs associated with mental illness and substance abuse, such as absenteeism and turnover (Bernstein, 2011).

The Society for Human Resource Management (SHRM) (2009) reported that over 75 percent of U.S. businesses provided EA services; similar results were reported by Mercer (2008) for large U.S. employers. Availability of EA services appears to be somewhat dependent on the size of the workplace, with larger employers being more likely to offer EA services (SHRM, 2009). According to the U.S. Department of Labor, Bureau of Labor Statistics (2008), more than 75 percent of people employed by state and local government have access to EA services. Conversely, EAPs are not available to most people in the workforce, including those who work for small businesses or are self-employed. In addition, women and ethnic or racial minorities are not as attracted to the EAP model as are white men, possibly due to issues involved in supervisory referrals for such services (Akabas, 2008).

Future trends in EA include the adoption of evidence-based screening protocols, such as alcohol screening and brief intervention with referral to treatment, which have been shown in initial tests to reduce at-risk drinking behavior and have a positive return on investment (Substance Abuse and Mental Health Services Administration, 2008). In today’s economic environment, services such as management consultation and organizational programs are increasingly considered more important to both employers and EAPs as they may be the best types of services that reach the most troubled employees and, when handled appropriately, provide the best return on investment. EAPs are becoming more decentralized by offering services at multiple locations, using contracted providers, distance counseling, and triage. With the expanding use of technology, online evidence-based self-assessment tools, online wellness information, Webinars, and blogs for employees may reach many more workers and offer effective resources for problem solving (Jacobson & Attridge, 2010; Jacobson & Hosford-Lamb, 2008). Additional activities for EAPs include supporting the global and diverse workplace; providing services from a health promotion, wellness, or work– life balance paradigm; and integrating technology into traditional EA service-delivery systems (Jacobson & Attridge, 2010). EA professionals have made significant strides to eliminate stigma and other barriers to health and mental health care within the workplace through benefit plan consultation and design, education through workshops and health fairs, and case-finding initiatives such as depression and substance abuse screening. EAPs also provide services in a manner that ethically balances dual relationships and sometimes opposing goals of various clients and stakeholders (Mizrahi & Davis, 2008). Services to managers and supervisors include, but are not limited to, consultation and organizational services regarding troubled employees, policy development, and crisis intervention. By influencing workplace policies, benefit plan design, and service selection, EAPs translate social work ideals into business terms and develop them into tangible policies and programs that can improve productivity, workplace safety, and overall employee and organizational health and wellness.

POLICY STATEMENT

NASW supports and advocates for the following:

- the accessibility and availability of EAP services to all employees in all types and sizes of work settings.
- the application of *both* the NASW (2008) *Code of Ethics* and EA professional standards and ethics when social workers are providing EA services.
- the inclusion of EA in social work higher education curriculums and research as well as professional continuing education, including content

related to business management and financial knowledge and skills.

- legislation and public policy designed to improve the employment and well-being of working adults, their families, and communities. Some examples are mental health parity legislation; health care reform; workplace safety provisions; labor relations; and legislation designed to improve federal, state, and global workplaces.
- expansion of specialized certifications or credentials for social workers as EA professionals.

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End-of-Life Decision Making and Care

ISSUE STATEMENT

Advances in health care have enabled people to live longer, even in the face of life-limiting conditions, than would have been possible only a short time ago. Such advances have the potential not only to increase survival time, but also to enhance quality of life. At the same time, the growing availability of life-sustaining treatments presents complex challenges for end-of-life care. Too often, however, individuals and families do not have the opportunity to consider, before a health care crisis occurs, either the physiological or psychosocial consequences of prolonging life. This approach to end-of-life decision making is fueled, in part, by widespread reluctance to discuss either the limitations of curative and life-sustaining treatments or the realities and uncertainties of the dying process. At the same time, deep-seated social inequities pose barriers to individuals' and families' options for, and informed decision making regarding, care at the end of life. Rectifying such inequities and supporting clients' end-of-life decision making constitute key roles for social workers, who provide services in palliative and hospice care programs, throughout the health care continuum, and across service delivery systems (Csikai, 2008; NASW, 2004).

Individuals and families contemplating end-of-life care face a broad range of decisions, each made within a specific cultural, legal, medical, psychosocial, and spiritual context. Such decisions can include where a person plans to spend the final months, weeks, or days before death; services and supports, such as assistive devices and assistance with personal care, to facilitate participation in needed and desired activities; goals and desired strategies for alleviation of pain and other symptoms; and technological interventions, such as cardiopulmonary resuscitation, mechanical ventilation, and artificial nutrition and hydration, she or he wishes to forgo or receive.

Many people do not communicate their end-of-life care preferences to either their loved ones or health care professionals. Unfortunately, this tendency leaves many family members (both legally recognized family and family of choice) ill prepared to determine the care their loved ones might have wanted. Advance care planning—which includes discussion of end-of-life care choices and documentation of those choices in advance directives, such as a living will, and appointment of a health care agent—is a key strategy to maximize client self-determination in end-of-life decision making (Morgan, 2012; National Hospice and Palliative Care Organization, n.d.; Waldrop & Meeker, 2012). Initiatives such as National Healthcare Decisions Day, which NASW has supported since its 2008 inception, educate consumers, health professionals, policymakers, and the media about the importance of advance care planning. National Healthcare Decisions Day encourages all adults with decision-making capacity to consider and discuss their end-of-life care preferences at numerous junctures throughout the life span, not just when an individual is diagnosed with a life-limiting illness or experiences an acute, life-threatening event (Black, 2010; National Healthcare Decisions Day, 2012).

A growing number of states have endorsed programs based on the National Physician Orders for Life-Sustaining Treatment (POLST) Paradigm, which offers individuals another option to direct their end-of-life care. POLST, which is known by different names across states, refers to an individualized, portable set of medical orders to guide treatment of people living with serious or life-limiting illnesses (POLST, 2012). These orders are not intended to replace advance directives; rather, POLST can be a valuable component of the advance care planning process (Bomba, Morrissey, & Leven, 2011; Pile & Pole, 2013).

The U.S. judicial, legal, and regulatory record regarding end-of-life decision making is complex. During the latter part of the 20th century and the beginning of the 21st century, the cases of Karen Ann Quinlan, Nancy Cruzan, and Terri Schiavo drew national attention to the issue of withdrawing life-sustaining treatment for individuals in a persistent vegetative state. The Patient Self-Determination Act (1990) has mandated that Medicare- and Medicaid-funded health care institutions inquire and provide information about advance directives, and all 50 states and the District of Columbia now have statutes regarding advance directives. Yet, 20 years later, an attempt by the Centers for Medicare & Medicaid Services to include advance care planning as a reimbursable service within the newly created Medicare annual wellness visit—a provision for which NASW had advocated—met with such political opposition that the decision was rescinded within days of implementation (National Hospice and Palliative Care Organization, 2011; Pear, 2011).

In recent years, some states have enacted right-to-know laws, such as California's Right to Know End-of-Life Options Act (2009) and New York's Palliative Care Information Act (2010), to ensure that individuals and families receive information about the full range of care options legally available within a given state. Such options may include, but are not limited to, electing or forgoing artificial nutrition and hydration, cardiopulmonary resuscitation, curative or disease-modifying treatments, and palliative and hospice care. At the same time, legislation addressing conscience clauses (also known as provider refusal laws) has been considered or passed in a number of states. Such legislation, which allows health care practitioners to refuse participation for reasons of conscience, may jeopardize individuals' ability to access end-of-life care options. In consideration of conscience clauses, NASW cautions that social workers neither discriminate against nor abandon clients in need of professional services (Morgan, 2010, 2011).

The issue of physician aid in dying (PAD) has prompted, perhaps, the greatest controversy regarding end-of-life decision making. PAD "refers to a practice in which a physician provides a competent, terminally ill patient with a prescription for a lethal dose of medication, upon the patient's request, which the patient intends to use to end his or her own life" (Starks, Dudzinski, & White, 2009). Though the first PAD state bill was introduced in Florida in 1967 (Compassion & Choices, 2013b), it was almost 30 years before Oregon became the first state to legalize PAD with the Death with Dignity Act (1994, amended 1999). The same year Oregon implemented the law, the U.S. Supreme Court ruled (*Vacco v. Quill*, 1997; *Washington v. Glucksberg*, 1997) that mentally competent people with terminal illness do not have a constitutional right to PAD—while upholding the right to pain management, including sedation (Altilio, 2011). These rulings did not prevent states from legalizing PAD, however. Since that time, several other states have legalized PAD, and initiatives to both legalize and criminalize

PAD are underway in a number of other states (Compassion & Choices; 2013a; Death with Dignity National Center, 2013).

In 2001, U.S. Attorney General John Ashcroft filed suit against Oregon to overturn the Death with Dignity Act and stop its proliferation to other states (*Oregon v. Ashcroft*, 2004). Three years later, a federal appeals court ruled against the attorney general and upheld the Oregon statute. The case proceeded to the Supreme Court, which upheld the Death with Dignity Act in 2006 (*Gonzales v. Oregon*, 2006). NASW, in collaboration with other organizations representing mental health professionals, filed two “friend of the court” briefs (Reiss, Yale, & Fisherman, 2005; Yale, 2002) in response to these court challenges. In both briefs, NASW and other members of the Coalition of Mental Health Professionals submitted expert information supporting three positions:

> ▪ Adequate diagnostic tools and protocols are available to assess the mental capacity of a person with terminal illness who desires to hasten death. . . .
>
> ▪ A terminally ill patient can be capable of making a reasoned decision to hasten death. [The Coalition discouraged use of the term *suicide* in this context. NASW no longer uses the term *physician-assisted suicide*.] . . .
>
> ▪ Involvement of mental health professionals in situations involving end-of-life decision-making, including serving in the role outlined in the ODWDA [Oregon Death with Dignity Act], is considered to be appropriate. (Reiss et al., 2005, pp. 8, 14, 22; Yale, 2002, pp. 8, 17, 24)

At the same time, the Coalition of Mental Health Professionals did “not take a position . . . on either the general issue of ‘physician-assisted suicide’ or the more particular issue of the legitimacy of prescribing controlled substances under the ODWDA” (Yale, 2002, p. 3). Rather, the coalition clarified that provision of mental health “services to individuals considering hastening death does not indicate support for hastening of death itself” (Reiss et al., 2005, p. 3; Yale, 2002, p. 3).

Within the social work profession, a variety of opinions exist regarding the legalization of PAD. Mindful of this diversity, and recognizing that decisions governing PAD occur at the state level, NASW has not adopted a national position either in support of or in opposition to legalization of PAD. In states in which PAD is legal, however, NASW affirms both the right of individuals to choose this option and the responsibility of health care systems and practitioners to honor clients' choices. In states in which PAD is either legal or under consideration, NASW also affirms the social work role in creating and implementing state policies and procedures that reflect the ethical values and principles of social work, such as preventing abuse of individuals in vulnerable situations. Furthermore, NASW upholds the social work role in clients' end-of-life decision-making processes and encourages further study, both within and beyond the profession, of the many complex issues associated with PAD.

U.S. policy and health care practice concerning end-of-life decision making center on the bioethical principle of respect for individual autonomy (O'Donnell, 2011). This principle dovetails with social workers' promotion of self-determination, inherent in the profession's ethical mandate to respect the dignity and worth of every person (NASW, 2008). At the same time, social workers realize that autonomy is not valued equally by all; some people, especially within certain ethnic, racial, and religious communities, prioritize family decision making or defer to the will of a divine power (Borgmeyer, 2011; Bressi Nath, Hirschman, Lewis, & Strumpf, 2008; Bullock, 2011a, 2011b; del Río, 2010; McCormick, 2011; Wittenberg-Lyles, Villagran, & Hajek, 2008). Meanings attributed to concepts such as *suffering* (Morrissey, 2011) and *good death* (Ko, Cho, Perez, Yeo, & Palomino, 2013) also vary widely. Moreover, social inequities and stigma related to age, class, disability, gender identity, geography, health conditions (such as HIV/AIDS), immigration status, inadequate health coverage, language, sexual orientation, and other cultural factors differentially affect individuals' and families' access to high-quality end-of-life care, thereby diminishing their ability to provide informed consent or refusal when faced with treatment decisions.

Thus, "a one-size-fits-all approach to medical decision making does not work in a multi-cultural and pluralistic society" (del Río, 2010, p. 145). Consequently, support for clients' end-of-life decision making entails not only respect for each individual's right to direct her or his end-of-life care, but also cultural and linguistic competence to ensure maximum participation (NASW, 2007) and advocacy to eliminate health disparities and related injustices (Mackelprang & Mackelprang, 2005). Balancing these tenets in an environment of cost containment (Jennings & Morrissey, 2011) and in relation to other professions, whose standards and ethics may differ from those of social work (Erlbaum-Zur, 2005), presents challenges for social workers. These challenges notwithstanding, the social work profession remains committed to maximizing knowledge of, and access to, end-of-life care that is congruent with the unique values and goals of each individual, family, and community.

POLICY STATEMENT

NASW promotes respect for dignity, quality of life, and self-determination, as defined by each person approaching the end of life. Accordingly, NASW supports legislation, policies, practices, programs, regulations, and research that promote the following principles and goals related to clients' end-of-life decision making and care:

- consumer education and health care practitioner communication about the full range of options for end-of-life care and the potential benefits and risks associated with each option
- clients' ability to exercise the full range of legally available options as the end of life approaches
- equitable access to affordable, comprehensive, person- and family-centered services, including palliative and hospice care, to maximize physical, psychological, social, and spiritual quality of life
- sustainable public and private reimbursement for advance care planning and hospice and palliative care, including (but not limited to) the Medicare hospice benefit, services available to Medicaid beneficiaries, and federal and state health insurance marketplace (exchange) plans
- preservation of economic support programs and expansion of residential care and home- and community-based services, including support for family caregivers, to enable people to live and die in their setting of choice
- tools and training to facilitate culturally and linguistically appropriate care
- multidimensional approaches to prevent and alleviate pain and other symptoms common at the end of life

- engagement in a process of advance care planning—including, but not limited to, completion of advance directives—with respect for each person's decision-making capacity, values, and choices
- health care practitioners' honoring of advance directives, with consideration of each individual's values and unique medical context
- support for the role and responsibilities of health care agents and surrogates
- expansion of state programs based on, and education of health care practitioners regarding, the National POLST Paradigm
- continuity of care across service settings, with particular attention to client transitions between health care practitioners and settings
- prevention of client abandonment during transitions of care and in situations in which health care practitioners' values conflict with clients' choices
- health care practitioner self-awareness of personal values about dying and death
- support for health care practitioners in coping with professional grief reactions common in end-of-life care
- respect for, and integration within interdisciplinary teams of, the multifaceted social work role in end-of-life decision making and care (including social work presence, if requested by individuals or families, at the end of life), in accordance with the NASW *Code of Ethics*, NASW standards of practice, and state licensure laws and regulations
- expansion of social work curriculums and research addressing end-of-life care
- widespread access to professional development opportunities (including mentoring, supervision, consultation, continuing education, and postgraduate training programs) specific to end-of-life care
- continued study and education, both within and beyond the social work profession, to enhance understanding of the complex issues associated with PAD.

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Environmental Policy

ISSUE STATEMENT

Global climate change is affecting our daily lives in countless ways. The environmental crisis cuts across political, economic, cultural, and social boundaries. All forms of social work practice are affected by environmental degradation (Hoff & McNutt, 1994). Until recently, much of social work's professional attention to the environment emphasized its social, cultural, and economic components, oftentimes to the exclusion of the natural or physical environment. However, "the natural and built environments have a direct impact on people's potential to develop and achieve their potential," and they are critical components of the social work person-in-environment perspective (International Federation of Social Workers, 2012, para. 9). Hoff and Rogge (1996) have argued compellingly for the need to develop and implement social work responses to the environmental crisis, particularly the pervasive "environmental injustice."

Environmental justice is a concept that has gained currency in the public arena and has particular relevance for the social work perspective (Rogge, 2008). *Environmental justice* is defined as "fair treatment and meaningful involvement of all people regardless of race, ethnicity, income, national origin, or educational level with respect to the development, implementation, and enforcement of environmental laws, regulations, and policies" (Rogge, 2008, p. 136). No population should bear a disproportionate burden of the negative human health or environmental effects. Environmental justice is a fundamental principle embedded in the idea of sustainable development and is consistent with the principles of social work. Attending simultaneously to the "three Es" of equity, economy, and environment is important to manage world resources for current and future generations (Rogge, 2000). For social workers, more fully integrating environmental, social, and economic justice means applying familiar skills and methods while learning new areas of substantive expertise.

While the social work profession has been gaining understanding of the importance of the natural environment and how it affects vulnerable populations, the environmental crisis has worsened (United Nations, 2015). In the 21st century, increasingly sophisticated methods are producing a rigorously examined, disturbing body of scientific documentation with regard to human exposure to and harmful health effects associated with industrial, commercial, agricultural, and household chemical use (Beyond Pesticides, n.d.; Centers for Disease Control and Prevention, 2015; Poppell, 2003). Climate change created by global warming stems from the size of our individual and collective carbon and ecological footprints, which are much greater for those of us in the developed world (Hoff, 2002; Natural Resources Defense Council, 2007). Thus, it can be argued that the more economically developed world carries a greater responsibility for addressing the crisis that has resulted through government policy and private sector practices. Techniques, such as integrated pest management, are being identified as best practices in reducing and balancing human health risks from pests and pesticides (U.S. Environmental Protection Agency [EPA], n.d.). The precautionary principle, as an alternative to traditional risk assessment methods, is used increasingly to apply research knowledge while protecting the most vulnerable citizens (Myers & Raffensperger, 2005). Social workers have a special concern for and responsibility to vulnerable populations who suffer as a result of dangerous environmental conditions.

Neighborhoods, communities, and countries with high levels of poverty are at greater risk of environmental pollution and its effects (Morello-Frosch & Jesdale, 2006). Social workers are key stakeholders in climate adaptation planning that accounts for vulnerable communities by preparing to assist those with little resources to withstand catastrophic climate events, including older adults and children affected by severe floods, intense heat, and prolonged drought. People of color, people living in poverty, and rural communities in the United States and internationally are disproportionately exposed to the dangers associated with environmental degradation (Rogge & Combs-Orme, 2003), whether it is the location of a toxic waste dump or dangerous chemical manufacturing plants (for example, the Dow Chemical plant in Bhopal, India). Social workers have fought against *environmental racism*, “the practice of operating hazardous businesses or storing toxic waste products in or near areas inhabited primarily by racial and ethnic minority groups" (Barker, 2003, p. 145). Poor communities often are affected disproportionately, such as when landfills located in inner-city areas are filled with refuse transported from wealthier suburban communities. Bell and York (2010) and Pellow (2004) have posited that rural communities also are disproportionately vulnerable because of additional factors such as "low levels of voting, home ownership, access to wealth, and disposable income that leave them unable to stand up to polluting facilities and their political supporters who have power and resources" (Young, Teixiera, & Hartnett, 2015, p. 3).

Populations across the globe are being affected by the rise in average global sea levels, which have increased several inches over the past century. When sea levels rise, storm surges from severe storms travel farther inland damaging buildings, cropland, and drinking water supplies (National Geographic Society, 2013a). Such changes will produce millions of climate refugees, and displaced people will require psychosocial support and resources facilitated by social workers (Kemp & Palinkas, 2015). For example, a sea level rise of 4.5 feet in 150 years would displace 17 million people in Bangladesh (GRID Arendal & United Nations Environment Programme [UNEP], n.d.). Three of the world's four cities with the greatest exposure to insurance losses from climate change in 2050 are Miami, New York, and New Orleans. When insurers can no longer provide affordable coverage, development in these areas will decline (National Geographic Society, 2013b).

The inextricable links among poverty, environmental degradation, and risk to human well-being cannot be denied. Often, residents feel that they have no power to resist having dangerous sources of contamination in their communities, or they are told that these features will bring desperately needed economic development (Bullard, Mohai, Saha, & Wright, 2007). Children are a particularly vulnerable group: Developing cells are more susceptible to damage, and toxins concentrate more rapidly in smaller bodies. Pesticides may concentrate in sources of nutrition, including breastmilk. Hand-to-mouth activity of children increases the likelihood of ingesting toxins. Pesticides and other toxins concentrate in or near the ground, where children play, particularly in developing countries (Healthy Schools Network, 2015; UNEP, UNICEF, & World Health Organization, 2002). Health disparities exist in polluted inner-city neighborhoods, where children of color suffer from high rates of asthma and lead exposure, and in croplands, where poor migrant workers may expose their families to agriculture pesticides from their work clothes, for example in low-income Louisiana along the industrial “Cancer Alley” stretch of the Mississippi River. Although most research examining the effects of toxic exposure on children occurs in industrialized countries, children’s risk, exposure, and harm are global phenomena.

Another link between poverty and risk to childhood growth and development is the lack of sustainable, healthy food resources that do not interfere with growth and security. Global food production must shift to prioritize plant-based diets and de-emphasize meat. According to the U.S. Department of Agriculture (USDA) (2010), agriculture dominated by livestock production accounts for 30 percent of greenhouse gas emissions. Animal-based foods, and beef production in particular, require significantly more land and emit more greenhouse gases than plant-based protein sources (World Resources Institute, 2016). Current farming and production of processed food items that are most affordable often have a base of corn that has been grown and harvested using genetically modified organism (GMO) seeds (Stanton, 2014). There is little research showing a link between GMO crops and adverse health, but we do know that the inclusion of processed corn (for example, as high fructose corn syrup) in the majority of accessible, processed foods contributes directly to childhood obesity, which can lead to prehypertension, hypertension, and type II diabetes (Gökler, Bugrul, Metintas, & Kalyoncu, 2015; Yang & Chen, 2016). Lower consumption of fruits and vegetables, along with increased access to sugary foods and drinks, fast foods, and processed foods are major contributions to childhood obesity in both rural and urban areas (Gökler et al., 2015). GMO crops, while helpful to the farming industry, can significantly increase the risk of lowered diversity in crop selection and spread disease and cross-contamination of organic crops (Yang & Chen, 2016).

An additional threat to the health and welfare of children is water contamination. The economic and health effects of chemical or pesticide contamination on major water sources is a global issue that increases costs of health care, causes loss of natural and developed resources, and negatively affects agricultural and industrial production (Al Barghouthi & Marie, 2016). Nationally, water contamination continues to be a problem with chemical spills that have affected several states (including Michigan, West Virginia, and Texas), with many of these areas continuing to respond to the disaster of losing a major water source. Recovery of improved health, usable sustainable resources, and economic success often takes years, and vulnerable populations, particularly those living in low socioeconomic or rural communities, have the most difficulty responding to the disaster of water contamination. According to Pyles (2007), "access to safe affordable housing, clean environments, living-wage jobs and other aspects of social development are critical after a disaster for those most vulnerable to long-term effects" (p. 322).

Since industrialization, human activity has increased greenhouse gas emissions, contributing to global climate change. Today, modern cities of the developed countries are the greatest hope for solving climate change through efficiency and energy innovation, but substantial action must be taken immediately. Fifty percent of the world's population live in urban centers and produce 70 percent of the world's greenhouse gases (World Bank, 2016). To address climate change by reducing burning fossil fuels, American cities should set a near-term goal for cutting greenhouse gases with a plan to be carbon neutral by 2050; generate power with only clean or renewable energy; create electric public transit systems that serve all communities; institute deep energy efficiency measures for homes and all other buildings; require new land use policies that prioritize pedestrian-based and bicycle-friendly communities; incentivize district (shared source) heating and cooling using natural sources such as geothermal technology, nearby rivers, bio gas, and waste and sewer heat, among many available options; provide investment and leadership to undeveloped and developing countries' cities for using green energy; and substantially reduce the need for generating greenhouse gases while increasing the gross domestic product and standards of living. Many scientists at the 21st Conference of the Parties (COP 21) international climate conference in Paris recommended requiring net zero carbon emissions by 2050 (Goldenberg, 2015; Intergovernmental Panel on Climate Change, 2013). The final historic COP 21 agreement called for binding commitments from each country toward this goal, and by the next annual meeting in November 2016 in Marrakesh, 111 countries had made their commitments. The international community as well as many U.S. cities, states, and businesses are beginning to advance sustainable practices and lead by example.

Social work, with its focus on political advocacy, can be an important force in addressing environmental issues. Social workers can engage in strategizing to organize and confront environmental injustice through grassroots organizing, political action, and collaboration with communities, including indigenous leaders. For example, in 2016 community leaders and advocates at Standing Rock Sioux Reservation, North Dakota, joined together to oppose an oil pipeline through tribal land. After months of peaceful protests bringing attention to the project's serious environmental concerns that would disproportionately affect residents and destroy sacred sites, the U.S. Army Corps of Engineers halted the project to conduct further evaluation of its environmental impact and explore alternative routes. Although this decision was overturned by the incoming administration, this effort was an important demonstration of the effectiveness of nonviolent direct action as a change strategy.

Current attitudes, practices, and lifestyles in developed countries continue to be based on the misguided notion that there is an endless supply of fresh water and other natural resources. Facing the needs of the natural environment requires change in how society organizes and sets priorities about community capital and means of production. It requires that we alter our current lifestyles. Social workers and those we serve will benefit from the profession's increasing awareness of the reality of our current environmental situation; action in support of the environment should be included in all of the profession's public and private activities. The Grand Challenges for Social Work Initiative, launched in 2016 by the American Academy of Social Work and Social Welfare, highlights the response to environmental change as a critical social issue of our time and encourages the social work community to take a leadership role in advancing "evidence-informed, culturally-responsive interventions" (Kemp & Palinkas, 2015, p. 13).

Some social workers suggest that a paradigm shift is needed—away from a worldview focused on individualism, competition, perpetual economic growth, and reductionism with social workers in the role of experts, toward a holistic paradigm based on interdependence, partnership, cooperation, and respect for the earth and all beings, with social workers practicing in a partner role. Such a shift can help support a values-driven approach that can unite different groups (Mosher, 2010).

POLICY STATEMENT

NASW supports the following:

- policies that reduce environmental threats to vulnerable and disenfranchised populations—including people who are poor, people of color, women, and children—who are disproportionately at risk
- the reduction of risk from and exposure to pesticides and other chemicals for vulnerable age groups
- government regulation and private sector policy based on rigorous scientific knowledge and effective testing, regulation, and labeling of toxic industrial, commercial, agricultural, and pharmaceutical chemicals and products that contain them
- the elimination of fossil fuels, where feasible, to be replaced with clean energy, such as solar, wind, and water, with the goal of 100 percent renewable energy in the United States by 2050
- secure, sustainable, and affordable food systems that are free of industrial, commercial, agricultural, and pharmaceutical chemicals, antibiotics, hormones, and pesticides
- local, organic food production that provides healthy food to local markets and supports economic development
- secure, sufficient, accessible, and sustainable safe water supplies free of industrial, commercial, agricultural and pharmaceutical chemicals and pathogens in waste from confined animal feeding operations
- the protection of individuals who work in hazardous jobs by strict national and international environmental standards, including effective enforcement mechanisms
- interdisciplinary collaboration, research, policy practice, and community-based actions to promote environmental health and justice
- strategies that will reduce our individual and collective carbon and ecological footprints
- adequate funding of environmental agencies such as the EPA. State and local counterparts must have the necessary resources and authority to establish and enforce environmental protection in accordance with rigorous scientific standards and data

- the development and funding of international environmental governing agencies throughout the world, with enforcement by the appropriate offices within the United Nations
- the elimination of all forms of environmental racism and injustice
- social work education at all levels that incorporates discussions of the natural environment, global warming, habitat destruction, chemical contamination, environmental racism, environmental justice, and sustainability
- social work practice methods and techniques that address natural environment, disaster response, and trauma-informed care related to ecological and environmental crisis
- comprehensive training and development of social workers' skills in identifying difficult-to-detect workplace and environmental hazards to physical and mental health
- programs that enable social workers to study traditional environmental perspectives and theories held by indigenous peoples in the United States and other countries
- community organizing, coalition building, social and economic development planning, case advocacy, and political action such as indigenous leadership, citizen lobbying, nonviolent direct action, and using grassroots and technological organizational strategies
- the inclusion of the natural environment as a routine part of the assessment and treatment planning activities of social workers in all settings with all clients, especially those clients who are most likely to be affected by climate change as well as unsound and unsafe environmental practices
- social services agencies and organizations recognizing the need to protect the environment and acting accordingly.

In addition, NASW opposes the following:

- policies that allow toxic waste to be relocated or exported from wealthy industrialized
- areas and nations to less economically favored areas and nations
- government and corporate policies that further environmental injustice.

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Family Policy

ISSUE STATEMENT

Strengthening families and providing family support are priorities of the social work profession. *Family*, as defined in its broadest sense, includes two or more people who consider themselves “family” and who assume obligations and responsibilities that are generally considered essential to family life.

The family is the primary socializing agent, economic unit, and mental health resource of its members, young and old (Carr & Springer, 2010). Social workers work with families every day. They either provide services directly to a family, or, in individual cases, indirectly to the client’s family unit, working with the impact the family unit has had on their client.

Family policy strives to recognize and respect a variety of family compositions and their particular needs. The social work profession is called to advance social justice and effect social change for all families.

Stress of the Caregiving and Provider Roles

Profound changes in family structure have been brought about by the increase in longevity, which has resulted in many four- and five-generation families. According to the U.S. Census Bureau (2014), 2.7 million grandparents in the United States were raising their grandchildren. The percentage of children who lived with a grandparent in 2012 was 10 percent, rising from 7 percent in 1992.

Family caregiving has not been compensated in this society except for families receiving Temporary Assistance for Needy Families (which provides income below the federal poverty level, is severely restricted and time limited, forces a parent to obtain employment without providing adequate quality child care, and places additional hardship on the family), or through limited state resources that provide compensation to a family member who acts as an attendant for an adult.

The caregiving role can be financially precarious, emotionally stressful, and physically straining. As women increase their participation in the workforce, and increasingly all two-parent families (whether gay, lesbian, or heterosexual) have both parents working, prioritizing and balancing home and work responsibilities become more challenging, especially for parents also caring for elders (who are becoming ill at a younger age). Baby boomers are in poorer health than their parents' generation despite major improvements in medicine, according to new research. According to Jaslow (2013), baby boomers are more likely to have diabetes, high blood pressure, and high cholesterol than their parents.

Multigenerational living arrangements are becoming more popular and have become a topic of growing interest. *Multigenerational families* are family households consisting of three or more generations. According to the U.S. Census Bureau (2012), "in 2000 3.7 percent of U.S. households were multigenerational. By 2010, multigenerational households increased to 4.0 percent" (p. 1). Multigenerational families may be more likely to reside in areas where new immigrants live with their relatives, in areas where housing shortages or high costs force families to double up their living arrangements (for example, as a result of poor economy, young adults not able to find employment beyond college, ageism in workforce firings and layoffs, or older family members becoming ill).

Sources of family stress are wide-ranging. Lack of paid family and medical leave may create stress in the workplace and at home for U.S. families. Lack of comprehensive prenatal care is linked to low birthweight, developmental delays, and health problems. The lack of early childhood education or day care is linked to poor social development and poor performance in school. The lack of financial support and community resources for home-based care may leave a medically fragile child or adult unattended.

Family Violence

Family and domestic violence continue to grow in intensity and kind. On average, nearly 20 people per minute are physically abused by a family member in the United States. One in three women and one in four men have been victims of some form of physical violence by an intimate partner in their lifetime (National Coalition Against Domestic Violence [NCADV], 2015).

Elimination of family violence is not dependent merely on better services, punitive judicial actions, and other protective approaches. Family violence must be seen in the context of root causes of violence in our society, including poverty, racism, sexism, unmet needs, and insufficient supports for child and elder care. In addition, family aggression and violence have to be assessed in the context of increased rates of alcohol and other drug abuse in the United States.

The economic impact of domestic and family violence is quite high. Victims of family violence lose a total of 8.0 million days of paid work each year. The cost of family abuse exceeds $8.3 billion per year. In addition, between 21 percent and 60 percent of victims of intimate partner abuse consequently lose their jobs (NCADV, 2015).

Although historically social workers have overlooked institutional and sociocultural explanations for violence and have focused instead on interpersonal family concerns, social workers are encouraged to focus on the underlying dynamics that promote family aggression and violence.

Culturally Diverse Families

The meaning of cultural diversity is changing in the United States. The minority population is expected to rise to 56 percent of the total population in 2060, compared with 38 percent in 2014 (U.S. Census Bureau, 2015). When that happens, “no group will have a majority share of the total and the United States will become a ‘plurality’ [nation] of racial and ethnic groups” (U.S. Census Bureau, 2015, p. 9). Today, communities are rich with people and families from all racial and ethnic groups and, increasingly, with people from around the world. Many families are now multicultural in composition, and this blending will undoubtedly characterize families of the future. A record 14.6 percent of all new marriages in the United States in

2008 were between people of two different races or ethnicities, according to a social and demographics trends report by the Pew Research Center (2005), and the children of these couples reflect this country’s changing demographics. This “two or more races” population is projected to be the fastest-growing group over the next 46 years and is expected to triple in size. The growing diversity in race and ethnicity brings strength to our communities and potential understanding, but it will also challenge the skills of social workers. Many families with members who are relatively recent immigrants face the effects of discriminatory legislation and policies.

Families with Lesbian, Gay, Bisexual, and Transgender (LGBT) Members

LGBT families have made considerable gains over the past decade. Same-sex couples, including bisexual and transgender people in same-sex relationships, achieved judicial victory on June 26, 2015, with the U.S. Supreme Court’s final ruling that same-sex marriage is legal in all 50 states. Transgender people have gained more visibility and are experiencing an increase in advocacy for their rights. Regardless of these gains, LGBT families continue to face extensive discrimination throughout the stages of the family life cycle. There are 28 states that do not protect LGBT families from employment and housing discrimination, 29 states that can deny them access to public places, and 36 states in which they can be refused credit or financing from a bank (Movement Advancement Project, 2016b). A majority of the states restrict LGBT families from providing foster care, adopting children, or allowing the second parent to adopt (Family Equality Council, 2016). LGBT youths continue to experience bullying, homelessness, and suicide attempts, each at a higher percentage than that for straight youths (Trevor Project, 2016). Only five states have laws preventing licensed mental health providers from practicing conversion therapy on minors (Movement Advancement Project, 2016a). Last, the growing number of LGBT older adults often face harassment, hostility, and discrimination from staff and other older adults in long-term care facilities and when accessing community services for older adults (National Resource Center on LGBT Aging, 2016).

Fathers' Role in Families

Fathers' involvement in and influence on the health and development of their children have gained visibility in the past 10 years in the public policy arena. Focus has shifted away from "deadbeat dads" and what men are not doing for their families to a more supportive perspective on positive involvement, such as child well-being, especially with regard to issues of diet and nutrition, exercise, play, and parenting behaviors. Father involvement in the early childhood years is associated with positive child developmental and psychological outcomes over time, although most studies do not differentiate the benefits of having two parents from a specifically male presence as the second parent. Also, cultural and structural biases still play a role in the care of children, with the majority of mothers still involved with all aspects of caregiving (Yogman & Garfield, 2016).

Family- and System-Focused Services and Practice

Service and practice with families in the 21st century is no longer limited to the family. Instead, a myriad of system-focused models or interventions apply. Today, increases in substance abuse, school dropouts, homelessness, teenage pregnancies, suicide attempts, family violence, bullying (including workplace and cyber), trauma, and other stress-related health disorders are just some of the challenges that require interventions at the individual, family, and community levels (Germain & Gitterman, 2008). Family life cycle challenges of today are multifaceted and multilevel. Families experiencing more than one stressful event need multilevel assessment (Jordan & Franklin, 2003). Yet family interventions have often focused on one matter or issue, with one service provider or a host of service providers, resulting in fragmentation of services that yields symptom- and deficit-focused practice, instead of addressing the individual, family, and community issues as a whole (Colapinto, 1995).

A system-focused approach to practice works in the person-in-environment paradigm. It is a holistic and collaborative approach to addressing family disruptions through wraparound services and acknowledgment and recognition of ecological and social impacts on family dynamics, norms, and structure. It recognizes the uniqueness of modern families and modern family dysfunctions resulting from human ecosystem interactions and influence. As such, practice models and interventions must be encompassing, not fragmenting.

Economic and Social Services Infrastructure

Families juggle numerous economic responsibilities. Supports to families should encompass a comprehensive array of economic and social services to enhance family functioning. Gaps in social services and economic resources are often the root of multiple stressors including homelessness, family violence, substance abuse, and mental illness. Poverty can cause serious psychological distress (Weissman, Pratt, Miller, & Parker, 2015). Families living with incomes below the poverty line experience this distress more than those with incomes above the poverty line. Access to health insurance is also imperative.

Affordable child care, flexible work schedules, paid maternity and paternity leave, and other family supports are essential. Employers must be responsible in responding to the requirements of the families of their employees. Wages that allow families to live above the poverty line and benefits that include health care options, retirement plans, and paid family leaves will reduce family stressors. Inequitable pay for women is another serious problem for families, as so many women are the sole supporters of their families. According to the Institute for Women’s Policy Research (Hegewisch & DuMonthier, 2016), in 2015 women earned 80 percent of men’s median annual earnings. This pay gap is even greater for African American and Latina women. Furthermore, this statistic has not seen a significant increase since 2007. “If the pace of change in the annual earnings ratio continues at the same rate as it has since 1960, it will take another 45 years, until 2059, for men and women to reach parity” (Hegewisch & DuMonthier, 2016, p. 1). Employee policies, wages, and work roles are critical to the stability of families and to the development and protection of both children and adults. Therefore, the role of private-sector policies in promoting family support policies in the United States warrants attention.

Family Mental Health

The mental health of individuals has an impact on the overall health, mental health, and financial situations of the entire family. Families caring for children with developmental disabilities incur an additional cost of 5 percent to 12 percent above the average financial cost of parenting (Anderson, Dumont, Jacobs, & Azzaria, 2007). Furthermore, it was found that parents of children with disabilities have additional time demands, compared with those parenting children who do not have a diagnosed disability, of 31 to 60 hours for children under age nine and 15 to 30 hours for adolescents and adults. As time increased, families reported increasingly feeling burdened (Ramisch, Pavkov, Negash, & Wetchler, 2009).

The family also becomes stressed when one or both parents suffer from mental illness. Parents with mental illness report decreased rates of marriage and higher divorce rates, impaired parenting ability, increased rates of child abuse, and increased rates of loss of parental custody (Mental Health America of Wisconsin, n.d.). In addition, mental health disparities remain across the nation. Native Americans and Alaska Natives suffer some of the highest rates of mental illness, substance abuse, and violent victimization rates (American Psychiatric Association, 2010). Yet, in the face of these staggering numbers, the Indian Health Service, the government organization charged with providing health care for these populations, does not reimburse or pay for mental health or substance abuse services, leaving those families who do not have an additional form of insurance coverage without affordable access to these services (Substance Abuse and Mental Health Services Administration & National Indian Child Welfare Association, 2013). Mental health parity is imperative across the country, regardless of demographic, to support families.

POLICY STATEMENT

NASW supports the following:

- giving families a strong voice in all aspects of decision making that affect their lives

- providing families with support that is flexible and targeted to meet the unique, diverse needs of family members
- providing families available and accessible services within communities
- services to families that encompass a comprehensive infrastructure of economic and social entitlements, including health care; income supports; family allowance; and access to employment, education, dependent care, housing, and social services
- welfare policies that enable families to achieve self-sufficiency and that contain national standards that ensure education and training opportunities, including school-based options for parents to attain high-level skills, sufficient choices of high-quality day care for parents and other primary caregivers who are entering the workforce or undertaking training and educational programs, provision of transitional health and day care services, and adequate family income supports
- opposition to profit-oriented ownership of the essential safety net services for families, such as welfare supports, job assistance, and schools
- education of policymakers on the development of family policy legislation that includes cultural competency and the diversity of today's families
- assistance to grandparents raising grandchildren
- encouragement by the media of positive messages about families and sensitivity to the level of violence portrayed and its effect on families
- affirmation of cultural diversity and reduction of biases
- services to families that are delivered by adequately trained professionals, including training on working with culturally diverse families
- giving families the ability to function multiculturally
- full and equitable employment, including initiatives that promote permanent part-time jobs with adequate wages and benefits, including medical, flextime, and paid leave, for adults and youths
- early childhood and family life education addressing all aspects of caregiving, couple relationships, and problem solving throughout the life span

- affordable, accessible, and high-quality dependent care in a variety of settings to meet the needs of all families; increasing adult programs such as day care as well as state assistance to fund programs
- affordable, accessible, and high-quality housing available in all urban, suburban, and rural areas so that families may experience a high quality of life
- paid family and medical leave to provide time off from part-time and full-time work for the birth, adoption, or illness of a child or the illness of a spouse or partner or older or disabled relative
- comprehensive and available health, mental health, and family planning services, including strategies focused on prenatal and perinatal care for high-risk mothers
- comprehensive services that are designed to keep family units together and to preserve the quality of life, especially when families are faced with chronic and life-threatening illnesses
- gender-equitable income supports or credits for people whose family caregiving demands impede their continuous participation in the labor force
- supportive programs in the workplace that provide education, flexible working hours, day care facilities, counseling, and assistance to working family members
- a comprehensive range of supportive and protective services that meet the needs of family members who are abused or neglected and also include corrective intervention services for the perpetrator
- policies that assist the public in understanding family violence, encourage citizens' involvement, and use multidisciplinary teams to find a solution
- services that are sensitive to the unique needs of LGBT families such as second-parent adoption, teenage homelessness, and older adults needing retirement housing.

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Family Violence

ISSUE STATEMENT

Family violence “refers to a range of violence that can occur in families, including intimate partner violence (IPV), child abuse, and elder abuse” (Holditch Niolon et al., 2017, p. 7). Other forms of family violence include sibling violence, abuse related to disability, and abuse of family pets. Some family violence is gender based—that is, related to gender or gender norms (Ball Cooper, Levy Paluck, & Fletcher, 2013). Such gender-based violence primarily affects women and girls, but it also affects transgender individuals and boys and men who are gay or bisexual. Decreasing IPV and child abuse within military families is a targeted area of change for the U.S. Department of Defense (Military One Source, 2017).

Although risk factors for family violence vary, research indicates that children with adverse childhood experiences (ACEs) are at risk for serious, violent, and chronic offender development (Fox, Perez, Cass, Baglivio, & Epps, 2015). Family violence may contribute to the development of health problems and psychological distress (Centers for Disease Control and Prevention [CDC], 2016b, 2017b; Podnieks & Thomas, 2017). Moreover, children who are abused or who are exposed to IPV are more likely to abuse their own children or partners (CDC, 2017a, 2017b), although no such association has been reported between exposure (direct or indirect) to violence as a child and elder abuse.

Family violence occurs within all socioeconomic levels and racial and ethnic communities in the United States. Child abuse is more prevalent in areas with significant income inequality (Eckenrode, Smith, McCarthy, & Dineen, 2014); however, poverty is sometimes mistaken for neglect (Dale, 2014). Women of color who experience IPV are less likely to seek help from mental health professionals (Cheng & Lo, 2014), and both IPV and homicide resulting from IPV are more common among American Indian, Alaska Native, non-Hispanic black, and multiracial women (Petrosky et al., 2017; Smith et al., 2017). Across racial and ethnic groups and income levels, lack of social support is a primary risk factor for elder abuse and for negative outcomes following such abuse (Acierno et al., 2010; Acierno, Hernandez-Tejada, Anetzberger, Loew, & Muzzy, 2017).

Three perspectives are central to preventing and addressing family violence: the family-centered approach (Child Welfare Information Gateway [CWIG], 2018), the trauma-informed approach (Substance Abuse and Mental Health Services Administration, 2018), and the ecological framework (Violence Prevention Alliance, 2018). Considering these perspectives together and in the context of the Grand Challenges for Social Work (American Academy of Social Work and Social Welfare, 2018), it is clear that reducing family violence requires a two-pronged approach: (1) addressing the needs of families affected directly by violence and (2) advancing social changes that diminish structural inequality and decrease social marginalization.

Elder Abuse

Within a family context, *elder abuse* refers to an act inflicted by an intimate partner, adult child, or other relative that harms or creates a risk of harm to an older adult. Its forms include physical, sexual, emotional, and financial abuse and also neglect (Hall, Karch, & Crosby, 2016). Although the scope of elder abuse remains uncertain, the most recent nationally representative survey suggests that one in 10, or 5 million, community-dwelling older adults in the United States experience elder abuse each year (Acierno et al., 2010).

Title XX of the Social Security Act, created by the Social Services Amendments of 1974 (P.L. 93-647), enabled the development and spread of Adult Protective Services (APS), which remains the only program nationwide dedicated solely to responding to elder abuse. From 1972 onward, amendments to the Older Americans Act of 1965 (P.L. 89-73) have created the National Center on Elder Abuse, authorized funds for other elder abuse programs, and strengthened the role of the Aging Network in addressing elder abuse.

Federal action to prevent and address elder abuse has grown significantly during the past decade. Provisions of the landmark Elder Justice Act of 2009 (EJA) (S. 795), supported by NASW and enacted into law as an amendment to the Patient Protection and Affordable Care Act (ACA) (2010) (P.L. 111-148), included establishment of a federal Elder Justice Coordinating Council to coordinate and enhance federal activities addressing elder abuse, neglect, and exploitation. The *Elder Justice Roadmap*, a federally funded publication and strategic planning resource developed “by the field, for the field” (Connolly, Brandl, & Breckman, 2014, p. 2), includes numerous action recommendations to enhance education, policy, research, and services. Elder justice was one of four priorities at the 2015 White House Conference on Aging. Since that time, a National Adult Maltreatment Reporting System has been developed, as have Voluntary Consensus Guidelines for State APS Systems. The Elder Abuse Prevention and Prosecution Act (2017) (P.L. 115-70) established requirements for the U.S. Department of Justice to investigate and prosecute elder abuse and to enforce elder abuse laws. However, EJA implementation, APS activities, and other elder justice efforts have been hampered severely by governmental underfunding (Colello, 2017; Mosqueda, Hirst, & Sabatino, 2016–2017).

Recently the elder justice field has focused on identification and expansion of evidence-based interventions (Stahl, 2015), especially those implemented by multidisciplinary teams (Connolly et al., 2014). Social workers play an integral role in such teams and in APS (Rath-bone-McCuan, 2013). Enhancing public understanding of elder abuse as a social justice issue—one that can be addressed by strengthening social supports—is not only integral to eliminating elder abuse (FrameWorks Institute, 2017), but also consistent with the social work profession’s core values and person-in-environment perspective (NASW, 2017).

IPV

IPV (also known as domestic violence) refers to a constellation of abusive and violent acts (such as physical violence, sexual violence or coercion, threats, stalking, and emotional or verbal abuse) occurring in an intimate relationship in which one partner systematically exercises power and control (Stark, 2007). In the United States, 37.3 percent of women experience sexual violence, physical violence, or stalking by an intimate partner in their lifetimes (Smith et al., 2017). IPV leads to acute and chronic physical, reproductive, and mental health issues, costing the United States approximately $8.3 billion in 2003 alone (Max, Rice, Finkelstein, Bardwell, & Leadbetter, 2004)—a cost that has probably grown significantly since that time. Furthermore, more than 15 million children are exposed to IPV annually (Futures Without Violence, 2017), thereby increasing the likelihood of perpetuating violence across generations (CDC, 2017a, 2017b).

Most IPV survivors and intimate partner homicide victims are women (Smith et al., 2017; Stöckl et al., 2013), and the movement addressing IPV originated as part of the feminist movement and privileged white, cisgender, heterosexual identities. However, IPV occurs among people of every age, ethnicity, gender, race, sexual orientation, and socioeconomic stratum. IPV and associated negative outcomes, including the unintended consequences of policies intended to address IPV, exacerbate disparities for communities of color; individuals with disabilities; military service members and veterans; and lesbian, gay, bisexual, and transgender people (Alpert, 2015; Breiding & Armour, 2015; CDC, 2017b; Dichter, Wagner, & True, 2018; Richie, 2012).

Among heterosexual couples, IPV toward the female partner precedes intimate partner homicide in most cases in which either partner murders the other (Campbell, Glass, Sharps, Laughon, & Bloom, 2007). The most salient risk factors for male-initiated intimate partner homicide are controlling behavior, forced sex, nonfatal strangulation, access to firearms, and threats of harm (with or without a weapon) (Spencer & Stith, 2018). Used within an evidence-based practice framework, IPV risk assessment provides practitioners with information about the likelihood of recurrent IPV or of intimate partner homicide (Messing & Thaller, 2015).

The Violence Against Women Act (VAWA), last reauthorized in 2013 (P.L. 113-4), provides resources for IPV intervention, emphasizing legal remedies (Messing, Ward-Lasher, Thaller, & Bagwell-Gray, 2015). Although such remedies are essential, they may be of limited use to some survivors, such as immigrants, refugees, and women of color, who fear deportation, violence, or other consequences from criminal justice intervention (Ballard, Witham, & Mittal, 2016; Richie, 2012). Consequently, a multisystem, community-based approach, including advocacy, is essential to meet the multifaceted needs of people who have experienced IPV. However, such needs are often difficult to meet because social service providers are underfunded (National Network to End Domestic Violence, 2016).

Child Abuse and Neglect

Child abuse and neglect is defined in federal statute as “any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm” (CAPTA Reauthorization Act of 2010, Sec. 3). The number of children who received a Child Protective Services (CPS) investigation or alternative response increased 9 percent nationally from 2011 (3,081,000) to 2015 (3,358,000); of that group, more than 75.3 percent were neglected, 17.2 percent were physically abused, and 8.4 percent were sexually abused (Administration for Children and Families, 2016). However, these statistics are far lower than the actual child abuse and neglect rate; one national survey found that as many as one in four children experience some form of maltreatment (Finkelhor, Turner, Shattuck, & Hamby, 2013).

Child welfare agencies are under scrutiny to address racial inequity (Child Welfare League of America, 2013) because families of color are involved disproportionately in the public child welfare system (Kim, Wildeman, Jonson-Reid, & Drake, 2017). Some data suggest that this overrepresentation can be attributed to the intersection between race, poverty, and maltreatment (Kim et al., 2017). Other data indicate that, even when poverty is considered, racial and ethnic differences may influence decision making in public child welfare agencies (Johnson-Motoyama, Moore, Damman, & Rudlang-Perman, 2018).

Research such as the ACE Study (CDC, 2016a) has focused on the lifelong implications of child abuse and neglect, including generational trauma within families (CWIG, 2013). In fact, risk factors for child abuse and neglect include a personal history of child abuse and direct exposure, as a child, to community violence or to substance use disorders, mental health issues, or IPV within the family (CWIG, 2017).

The Child Abuse Prevention and Treatment Act (CAPTA), enacted in 1974 (P.L. 93-247) and last reauthorized in 2010 (P.L. 111-320), provides funding for assessment, investigation, prosecution, treatment, and prevention activities, including community-based prevention efforts. States use federal funds—for example, those granted under Title IV-E of the Social Security Act (Administration of Financial Assistance Programs, 1980; Requirements Applicable to Title IV-E, 2016)—to finance other child abuse prevention strategies, such as training programs for social work students interested in public child welfare careers (California Social Work Education Center, 2018; McGowan, 2013). The Adoption and Safe Families Act of 1997 (ASFA) (P.L. 105-89) focuses on other goals of public child welfare, including safety, permanency, and well-being.

POLiCY STATEMENT

NASW supports the following overarching principles:

- development and implementation of culturally competent services and systems that are accessible and responsive to people of every ability, age, class, ethnicity, family status, gender, gender identity or expression, immigration status, language, literacy level, military or veteran affiliation, national origin, political belief, race, religion, and sexual orientation
- elimination of all forms of structural inequity and oppression that create and maintain disparities in the occurrence of and response to family violence; person-centered, trauma-informed, strengths-based services, programs, and systems that remediate power disparities
- funding and support for research that enhances family violence prevention, assessment, and intervention, including harnessing big data (collection of digital data) in ways that preserve and promote the rights of people affected directly by family violence and people who observe it
- coordinated involvement of and collaboration among the public, private, and educational sectors on the federal, state, and local levels in

promoting healthy relationships and in primary, secondary, and tertiary prevention of family violence

- assessment by interdisciplinary teams to determine the presence of family violence and the risk of repeat, severe, or fatal violence, as well as to plan and implement appropriate interventions
- ethical use of media and technology to increase access to accurate information about family violence, improve service delivery, and enhance collaboration among service providers
- firearm restrictions for people with a history of violent behavior, universal background checks, homicide surveillance systems, and other measures to reduce injury and murder within families
- professional and workforce development— including, but not limited to, specialized education and training, financial support, credentialing, supervision, and mentoring—to increase the number of social workers qualified to provide evidence-based family violence services
- consistent integration of and reimbursement for services provided by professional social workers (individuals with a baccalaureate, master’s, or doctoral degree in social work) in teams and settings serving children, adults, and families; title protection for social workers.
- NASW also supports the following population-specific principles:
- full implementation of EJA and the Elder Abuse Prevention and Prosecution Act; sufficient funding for the ACA, APS, the Older Americans Act, the Social Services Block Grant, and other programs that identify and address elder abuse, neglect, and exploitation
- preservation, strengthening, and creation of programs that decrease social isolation, increase social engagement, enhance economic security, improve health, and provide long-term supports and services for older adults and family caregivers, thereby decreasing risk for elder abuse
- promotion of gender equality and eradication of toxic masculinity; implementation of interventions to reduce power, control, and violence within intimate relationships; provision of material resources that empower women and their children to live free of violence
- full funding and implementation of VAWA to reflect program, population, and community needs, particularly for marginalized

communities; reprioritization of funding in VAWA to empowerment-based social service prevention and intervention

- full funding and implementation of CAPTA and ASFA; sufficient funding for CPS, Medicaid, the Social Services Block Grant, Title IV-E, and other programs that address child maltreatment
- full funding for the ACA-authorized Maternal, Infant, and Early Childhood Home Visiting Program, which helps to prevent child abuse and neglect.

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Foster Care and Adoption

ISSUE STATEMENT

Approximately 400,000 children are in foster care on any given day in the United States (U.S. Department of Health and Human Services [HHS], 2018). Children and youths enter foster care because they have been abused, neglected, or abandoned by their parents or guardians. Foster care and adoption have served as society's approach to providing alternative care for children who cannot live with their families of origin. Around 70 percent of these children live with foster parents or kinship parents (that is, relatives) (HHS, 2018). Of children who leave foster care, most are reunified with parents or live permanently with other relatives, around 25 percent are adopted, and about 10 percent emancipate (that is, turn 18 without a permanent legal guardian) (HHS, 2018).

Foster care traditionally conjures images of children removed from abusive parents and placed with safe, caring strangers (that is, foster parents). However, this represents just one aspect of what is really a continuum of child welfare services. Families frequently receive services and supports from professionals in child welfare agencies without the children ever being removed from the home. A wide variety of services may be offered to children and families such as individual or family therapy, medical services, parent education, substance use disorder treatment, occupational support, job search support, assistance in obtaining material needs, and day care assistance.

The role of the biological family is important in terms of placement stability and permanency, and it is particularly important when considering child adjustment and well-being. When children cannot safely remain in their own home, child welfare agencies frequently look to other relatives. Called kinship caregivers, these are people to whom the child is related by blood or marriage. Some jurisdictions also include "fictive kin" or "kin of the heart" in their definition of kinship caregivers. These are people the child already knows well such as a close family friend, teacher, neighbor, or a friend's parents. Not all children in kinship care are also in foster care; some families make such arrangements on their own. Child welfare agencies may provide support to kinship caregivers without taking formal custody of the child.

Traditional foster care—when a child is placed in a resource family home—is used when children's safety cannot be maintained using in-home or kinship services. Some children may also be placed in group homes or residential treatment facilities. Because research has shown that a family setting is best for healthy child development (Dozier et al., 2014), children should only be placed in group care settings when acute care is needed. Unfortunately, many jurisdictions struggle to recruit and retain foster parents, which leads to children, often teenagers, being placed in group care settings as they are the only "beds" available (Annie E. Casey Foundation [AECF], 2015a).

Finally, placement through the foster care system may be necessary not only to protect children from maltreatment, but also to provide therapeutic and residential care for severely developmentally disabled or mentally ill children and youths whose parents are not able to care for their special needs despite an array of in-home and community-based supports.

While a child is in foster care, services are provided to both the child and the birth family to promote reunification. If reunification is not an option, child welfare professionals will work to find other permanent families through either guardianship or adoption. Caregivers who become permanent legal parents through guardianship or adoption sometimes receive financial support until the child turns 18 or, under certain conditions, 21. The final point on the child welfare continuum begins when youths turn 18 while in foster care, referred to as emancipation or aging out. The Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351) has enabled such youths to choose to remain in foster care up to age 21, allowing them to receive financial, educational, and other supports. Access to extended foster care varies by state, with some states ending support prior to age 21; as of 2017, four states did not offer any extended foster care services to youths beyond age 18 (Child Welfare Information Gateway, 2017).

Significant Federal Legislation 1970–2020

The course of child welfare in this country over the last 40-plus years can be charted through major federal legislation that shaped how states developed their own interventions and systems. The Child Abuse Prevention and Treatment Act of 1974 (P.L. 93-247) tied federal funds to minimum standards for defining physical abuse, neglect, and sexual abuse that states are required to use in their statutory definitions. These federal dollars can be used for prevention, assessment, investigation, prosecution, and treatment activities. The need to ensure that states respected tribal rights and customs in child welfare proceedings involving eligible Native American youths was the impetus behind the Indian Child Welfare Act (ICWA) of 1978 (P.L. 95-608).

As children's need for permanency became a coequal with the goal of ensuring safety, a variety of landmark legislation focused on this area. The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) mandated that child welfare departments make reasonable efforts to avoid unnecessary removal of children from their homes and to reunify those children with their families whenever possible. The Family Preservation Support Services Program Act of 1993 (P.L. 103-66) supported states by funding programs meant to establish preventive family support and family preservation services. Adoption was revisited in the Adoption and Safe Families Act of 1997 (P.L. 105-89) by requiring permanency planning for children and mandating that a child's safety is the highest degree of concern in a case.

The Foster Care Independence Act of 1999 (P.L. 106-169) targeted youths aging out of foster care with a focus on developing and maintaining independent living skills and helped move the focus to supporting life after foster care. The Promoting Safe and Stable Families program, which arose out of the Family Preservation Support Services Program Act of 1993, sought to reduce child removals, improve the services to children and their families, and encourage permanency in placements. It was reauthorized through additional federal dollars in the Promoting Safe and Stable Families Amendments of 2001 (P.L. 107-133) and the Child and Family Services Improvement Act of 2006 (P.L. 109-288).

The Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351) expanded the ability for Child Protective Services agencies to support youths in foster care by increasing adoption assistance through Title IV-E funds. Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act or the SUPPORT for Patients and Communities Act of 2018 (P.L. 115-271) was seen as a necessary response to the opioid epidemic in the United States and increased the workforce, expanded access to care, and expanded coverage for medication and treatment. The Family First Prevention Services Act of 2018 (P.L. 115-123) further broadened the application of Title IV-E funds to tertiary prevention and set guidelines for states to transform their congregate care facilities into Qualified Residential Treatment providers.

Best Practices in Foster Care Services

Emotional and Relational Permanence. Every young person needs ***relational permanence***—healthy social connections with others, including caring and supportive adults in their life as they grow into maturity. These are people whose involvement may range from providing a holiday meal, a place to do laundry, a listening ear, or a resource for emergency housing, should the need arise (Hook & Courtney, 2011). These adults may be relatives, including siblings; former foster caregivers; court-appointed special advocates; coaches; mentors; former caseworkers; and others committed to a long-term relationship. These relationships come from different parts of a youth’s life, from newly found kin to others with whom the child has developed a familial or mentor-like relationship. Relational permanence may also include repairing frayed bonds with mothers and fathers, to whom young people often turn at some point after exiting care (Lenz-Rashid, 2009).

Promoting Normalcy for Children and Youths in Foster Care. A significant challenge facing youths in foster care is access to the same experiences and privileges extended to those who are not in foster care such as learning to drive, having a job, being able to go on vacation with their foster family, or even hosting sleepovers with friends and participating in after-school activities, including sports. The long-term impact of being denied these experiences is the inability to develop into a successful adult

(AECF, 2015b). The Preventing Sex Trafficking and Strengthening Families Act (P.L. 113-183) requires states to allow caregivers to adopt a “reasonable and prudent parent standard” when making decisions about such activities to afford foster children the same experiences as their nonfostered peers (American Bar Association, 2016).

Foster families, including kinship care-givers, are valuable members of the team responsible for services and support for the child and their parents. The ideal relationship between foster and biological parents is one of shared parenting similar to that of separated custodial parents. Foster families at times become like an extended family, continuing their supportive relationship with parents and children after reunification. Foster or kin parents may become the adoptive parents of the child if reunification is not achieved (Juvenile Law Center, 2015).

Trauma-Informed Care. Children in the child welfare system have often experienced multiple traumas, both prior to placement and during out-of-home care. Trauma-informed care (TIC) is a way of understanding and responding to a child’s behaviors by recognizing the impact of their past experiences (Ko et al., 2008). It requires the adults around a youth, including caregivers and foster parents, to respond to the effects of trauma as it manifests in a child’s actions and emotions (Hanson & Lang, 2016). TIC can help a youth become more resilient by learning how to self-regulate their behaviors and emotions and build positive relationships (Greenwald, 2005). This care model may represent a cultural change in child welfare practice and is a way to ensure that all youths feel safe and connected while in care.

Advocacy

Youth Voice. Engaging youths as partners can help them feel heard and empowered. Youths should participate in decision making and also be encouraged to shape the system and the direction of their lives. Giving youths a voice allows them to develop the relational and decision-making skills needed to transition successfully to adulthood (AECF, 2014). The peer-to-peer leadership model of most youth-led organizations helps young people build their social support network and inspires other young people to be more engaged. When youths are given leadership within public or private organizations, they are prepared to work together with program developers, organizational leaders, and policymakers so that the best decisions can be made about the issues that most intimately affect them.

Disproportionality. Research suggests that racial and ethnic disproportionality in foster care may be due to a variety of structural factors such as higher rates of child poverty and lower availability of services in communities of color, and bias, usually implicit, on the part of mandated reporters and agency staff (Myers, Sabol, Xu, & Vega, 2018). Disproportionality starts at the point of child abuse referrals, suggesting that reporters are more likely to report families of color (Myers et al., 2018). Although poverty is a risk factor for child maltreatment, research on the role of poverty to explain disproportionality has been mixed (Putnam-Hornstein, Needell, King, & Johnson-Motoyama, 2013; Sedlak, McPherson, & Das, 2010; Wulczyn, Gibbons, Snowden, & Lery, 2013). Finally, the reasons for underrepresentation of some groups in foster care are also not well understood. Possible explanations include cultural perceptions of others that lead to reduced reporting or greater community protective factors (Child Welfare Information Gateway, 2016).

Future Directions, Data, and Predictive Analytics

Child welfare agencies collect large amounts of data that, when used appropriately, can improve services and outcomes. Data can also inform evaluations of innovative child welfare programs and improve practice and outcomes, bolstering the ability to obtain funding and expand implementation.

An emerging use of data is *predictive analytics*, analyzing large amounts of data using statistical methods to predict a specific outcome. Such analysis may lead to more transparent decision making, direct resources to those most at risk, and improved outcomes for children. The use of predictive analytics in child welfare does not come without ethical concerns. As with any tool, predictive analytics could result in both benefits and harms to the families served. Ultimately, predictive analytics is a tool that, with proper training, may assist in making decisions about children’s risk and care.

POLICY STATEMENT

NASW supports

- prioritizing child safety, permanency, well-being, and respect for the civil rights of parents and children, without regard to race, ethnicity, language, capabilities, religion, sexual orientation, gender identity, geographic location, or socioeconomic status
- keeping siblings together in placement and maintaining connections if separated
- providing the same foster care and adoption services without regard to citizenship or immigration status
- maintaining a child's identity and their ethnic heritage in all services and placement actions
- institutionalizing ICWA compliance by establishing policies and procedures, active commitment to preventing Indian family separation, and meaningful inclusion of Tribal Nations, ensuring that Indian children have access to the rights and privileges of Tribal citizenship.
- recruiting and retaining a professional social work workforce with a manageable caseload consistent with national standards, strong supervision, competitive compensation, and the resources and tools necessary to do the work
- welcoming foster and adoptive parents from the community without regard to race, religion, sexual orientation, gender identity and expression, or economic level
- providing comprehensive training to foster parents as a precondition of licensure and inservice trainings as a condition of continuing licensure
- offering extended foster care services at least until age 21 and allowing youths who have aged out to return to care if so desired
- engaging parents and youths with child welfare system experience in improvement and reform efforts
- offering access to a full range of behavioral health services, including substance use treatment services, that help keep parents and children together

- providing kinship caregivers with benefits that include financial support, access to training, behavioral support, and targeted case management
- implementing predictive analytics with full and careful consideration to worker training in use of the output as a tool to support—not supplant—expert decision making and ensuring that all algorithms are openly available for external review to prevent perpetuating systemic biases
- actively engaging youths in foster care in making decisions that affect their lives
- assuring placement priority to kinship caregivers and working to provide placement with an approved foster resource family rather than group care settings
- engaging parents and the extended family in team decision making about the child's well-being without regard to where children are placed
- providing the same post-permanency services and benefits to relatives who obtain permanent legal custody of children as the postadoption services and benefits offered to adoptive parents
- promoting emotional and relational permanence as an intentional casework activity to boost the success of a youth's entrance into adulthood
- analyzing and addressing all policies, procedures, and regulations for ways in which they may perpetuate racial or ethnic disproportionality in foster care.

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Genetics

ISSUE STATEMENT

The science of genetics is the study of heredity, focused on the composition and functioning of specific genes (National Human Genome Research Institute [NHGRI], n.d.). Genetic information includes information about an individual's genetic makeup that can help to confirm or rule out a genetic condition. Genetic testing can also include information about family history and help identify whether a person might develop a disease or disorder, as well as identify the possibility of passing on a genetic disorder (U.S. Equal Employment Opportunity Commission [EEOC], n.d.; U.S. National Library of Medicine, 2017a). *Genomics* is the study of the functions and interaction of all the genes in the human body, and it addresses all genes and their interrelationships to identify their combined influence on the growth and development of the organisms. Genetic testing involves the identification of changes in chromosomes, genes, or proteins, and subsequent detection of rare disorders as well as the genetic components of common diseases and disorders such as Alzheimer's, cancer, mental illness, diabetes, heart disease, and autism (World Health Organization, 2017). The results of a genetic test can confirm or rule out a suspected genetic condition or help determine a person's chance of developing or passing on a genetic disorder. More than 1,000 genetic tests are currently in use, more are being developed, and the decision whether to be tested requires balancing both benefits and risks (U.S. National Library of Medicine, 2017b).

Active engagement of professional social workers in the arena of genetics and genomics is fairly recent. The National Coalition for Health Professional Education in Genetics was formed in 1996 and included social work representatives from the Council on Social Work Education and NASW. The Human Genome Education Model Project, funded by the National Institutes of Health and cochaired by two social workers from

1997 to 2001, offered workshops and training programs in genetics for social workers and other disciplines across the United States (Taylor, Mapp, Boutté-Queen, & Erich, 2010). NASW developed *Standards for Integrating Genetics in Social Work Practice* in 2003 and an online continuing education course titled “Understanding Genetics: The Social Worker’s Role” in 2007.

Social workers practice in a wide range of settings and provide health, mental health, and behavioral health services to vulnerable populations across the life span. Across practice areas and communities, it is critical for all social workers to have a basic understanding of the legal, ethical, and psychosocial implications of genetic assessment and diagnosis, genetic testing, and genetic research on individuals and communities. A professional social worker may be the first helping professional to provide psychosocial services to individual clients and families with genetic conditions and has an important role to play within the social work scope of practice. For example, social workers help those seeking genetic testing because of a family history of health conditions in deciding whether to screen a fetus during pregnancy. Social workers also endeavor to understand and monitor the effects of medications and help clients locate information about clinical trials. In addition, social workers are key stakeholders in relevant research, policy development, and implementation (Kings-berry, Mickel, Wartel, & Holmes, 2011; NASW, 2003; O’Brien, 2011).

Privacy, Informed Consent, and Confidentiality

Genetic testing is, most often, designed to (a) diagnose a health disorder, (b) determine whether people have a genetic disorder (currently asymptomatic) that may manifest in the future, (c) determine through prenatal or perinatal testing the existence of a health disorder, or (d) determine whether they are susceptible to a disorder. Effective social workers assure that the client has access to all information necessary to make the right decisions, for example, whether to consent to the testing. Genetic testing and screening of minors are commonplace, with over 4 million infants in the United States undergoing newborn screening for metabolic, hematologic, and endocrine abnormalities for which early treatment may prevent or reduce morbidity or mortality. The advantages of genetic testing, such as facilitating choices about family planning, preventive lifestyle measures, or increased surveillance, must be balanced against the risk of genetic discrimination. For example, the advent of genetic testing, now available for about 1,000 diseases, raises many ethical questions about how an individual’s genetic information can be used, and the threat of discrimination hinders both genetic research and clinical practice (Williams, Sarata, & Redhead, 2007). Direct-to-consumer marketing of genetic testing increases the risk that violations of genetic privacy will follow and eliminates face-to-face counseling. Clients need to be aware of possible limits of confidentiality of direct-to-consumer and home kit genetic testing, for both adults and children, because of the lack of oversight on test content, accuracy, and interpretation (American Academy of Pediatrics, 2013). Social workers can take an active role in advocating for clients and ensuring that clients are protected against genetic discrimination by insurance companies, employers, schools, adoption agencies, and the government.

Genetic testing brings forth practice issues of informed consent, confidentiality, and protection from discrimination. The right to confidentiality extends to both the decision to be tested and the decision of who is allowed access to the test results. Social workers are required to inform clients of the potential limitations to confidential test results and the consequences. The decision to be tested, based on informed consent, must be the client’s choice, without coercion from insurance companies or family members. To make an informed decision to have a genetic test, a client must have access to current, accurate information regarding benefits and risks of genetic testing to the client and to family members. Information includes limits of protection of confidentiality under federal and state law; strengths and limitations of the test itself; availability of prevention, treatment, and cure; and potential risks of stigmatization, discrimination, and psychological distress, including risk to intrafamily relationships. Social workers may be required to make referrals to other professionals, such as genetic counselors, to maximize the amount of knowledge available to the client for purposes of deciding whether to be tested.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104-191) includes privacy rules that set the national standards for the protection of individually identifiable health information within health plans, health care clearinghouses, and health care providers. A person’s genetic information is considered health information protected by the Privacy Rule under HIPAA. The security rule sets national standards for protecting the confidentiality, integrity, and availability of electronic protected health information (EEOC, n.d.). However, genetic or genomic testing challenges efforts to ensure privacy. The use of genomic testing has gone from rare to routine in many clinical settings, with many clear clinical benefits to the person, but concerns remain as to the use of genomic information to discriminate against applicants for life long-term care and disability insurance. Surreptitious DNA testing without the knowledge of the person being tested may also affect the privacy of a person’s genomic information. Currently surreptitious testing is not prohibited by federal law, and informed consent to test or share information varies across states. There remains a financial incentive for insurance companies, employers, the criminal justice system, and other government agencies to have access to people’s genetic information. Current federal and state policies do not protect the use of genetic tests for purposes of discrimination in underwriting of life insurance, disability insurance, and long-term care insurance (Hudson, 2007; NHGRI, n.d.).

Discrimination, Policy, Laws, and Ethics

Fear of genetic discrimination could limit participation in research or willingness to have genetic testing or genetic screening (Hall et al., 2005). Discrimination based on biological traits exists on the individual and societal levels. At the individual level, people can be labeled and stigmatized if they are found to be at risk for cancer or a physical or developmental disability. For example, an employer might not hire a person because the person is viewed as a potential future cost to the business as indicated by his or her genetic test results. At the societal level, social workers must consider the ramifications of using genetic findings to profile individuals on racial or ethnic lines; groups with diseases do not deserve concomitant stigma and discrimination (National Academies of Science, Engineering, and Medicine, 2015). Unfortunately, genetic information and genomic testing can result in stigmatizing and discriminatory actions because of a person’s race, ethnicity, or cultural identification. People from ethnically, geographically, and linguistically identifiable populations may have diminished privacy protections if research reveals that the group is at high risk of having a genetic variant associated with a disease (NHGRI, n.d.).

Legal protections ensuring confidentiality and countering discrimination provide guidance yet require ethical practice in implementation. The Genetic Information Nondiscrimination Act of 2008 (GINA) (P.L. 110-233) was enacted less than a decade ago. GINA protects the genetic privacy of the public, including research participants and in employment, and clarifies that it is illegal to discriminate against employees or applicants because of genetic information (EEOC, n.d.). The Newborn Screening Saves Lives Reauthorization Act of 2014 (P.L. 113-240), enacted in 2014 as an extension of the Newborn Screening Saves Lives Act of 2007 (P.L. 110-204), supports newborn screening programs across the United States. Since March 2015, researchers can no longer obtain a waiver from an institutional review board not to have to obtain parental informed consent for research involving newborn dried blood spots. Of note is that the Newborn Screening Saves Lives Reauthorization Act applies only to research funded by the U.S. Department of Health and Human Services (2015) that specifically involves the use of newborn dried blood spots.

The historical treatment of people living with disabilities calls for social workers to be aware of transference issues and subjective assumptions regarding the meaning of a disability or health condition for a client’s well-being and quality of life (O’Brien, 2011). Social workers may run the risk of labeling individuals and withholding services based on genetic testing information that has identified health conditions such as mental illness and mental retardation, and behavioral disorders such as alcoholism, drug use, and even anger. It is important to note that without specialized training, it is inappropriate for a social worker to assume the role of a genetic counselor. However, social workers have a critical role in ensuring that clients are protected from genetic discrimination in health care, insurance and other benefits programs, family planning (including adoption), educational access, and public health and welfare programs.

Research

There is increased interest in understanding the genetic determinants of, for example, psychiatric disorders, addictions, and social behavior. Although understanding the connection between genes and social behavior is in its formative stage, evidence suggests that brain development and activity, as well as human behavior, depend on both inherited and environmental influences. For example, genes encode molecular products that build and govern the functioning of the brain, through which human behavior is expressed (U.S. National Library of Medicine, 2017b). In an effort to better understand the rates of violence in communities, biomedical researchers, sociologists, and psychologists are increasingly seeking information on genetic markers and causes for violence. Advances in the understanding of neurochemistry and the use of imaging technology have shown how many emotional and control disorders (for example, violence, suicide, depression, and anxiety) are connected to disruptions in the brain's normal activity caused by altered gene expression, chemical imbalances, or environmental factors (Garcia-Arocena, 2015). The ability to identify susceptibility genes and genetic variations found to contribute to common diseases and disorders may well further the understanding of traumatic impact and posttraumatic stress disorder on individuals and communities (Cornelis, Nugent, Amstadter, & Koenen, 2011).

Historically, social workers have helped those exposed to environmental deprivation. Clinical social workers actively engage clients with genetic and neurobiological challenges in therapeutic interventions to help them manage serious emotional and mental illnesses. As more attention is paid to the benefits and risks of stem cell research, reproductive technology, tissue cloning, and gene therapy, social workers will be called on to develop and confront emerging policies related to genetic testing and treatment. Social workers can gain knowledge about a client's genetic makeup or the genetic makeup of his or her family members by completing comprehensive biopsychosocial assessments that consider neurobiological and genetic underpinnings. A genetic test may alert people about the prevention, treatment, and cure of some disorders, and may provide some information about inherited conditions. Genetic tests may not identify specific symptoms or whether a disorder will progress over time; however, once clients are diagnosed with a genetic challenge, they can be better guided to evidence-based care and treatment options (Taylor-Brown & Johnson, 1998; U.S. National Library of Medicine, 2017b).

POLICY STATEMENT

NASW maintains a commitment to ensure that the social work profession is a critical partner in the emerging field of genetics as it relates to research, laws and policy, and micro- and macro-level practice. NASW supports the following:

Practice

- staying informed about the current and emerging clinical evidence, policy issues, and laws regarding genetics
- reviewing and becoming familiar with the *NASW Standards for Integrating Genetics in Social Work Practice*
- ensuring client self-determination regarding genetic testing decisions that includes nonbiased and value-free education and resources to clients about the benefits and risks of genetic testing
- ensuring that the person's decision to be tested is based on informed consent and is made without coercion from insurance companies or family members
- advocating for the development of programs, training, and information that provide social work students and professional social workers with current genetics information to better serve clients and communities
- providing leadership to ensure that people are protected against genetic discrimination by insurance companies; employers; public and private schools; adoption agencies; and local, state, and federal governments
- advocating for skilled providers to ensure accessible and readily available comprehensive biopsychosocial–spiritual support for people with genetic disorders and their families that provide culturally competent, linguistically appropriate, and client- and patient-centered approaches

Law, Regulation, and Policy

- eliminating policies that interfere with an individual’s right to choose whether to pursue genetic testing eliminating genetics testing policies that may limit access to genetics services or might coerce a person into reproductive health decisions without full information or consent that they might not otherwise choose to make
- eliminating funding for and the use of genetic research to alter populations of people and to remove traits deemed by society as “unfit”
- advocating for policy, regulation, and laws that are person focused to protect the client’s ownership of his or her own genetic information and protects the confidentiality of, access to, and use of an individual’s genetic tests
- advocating for implementation of policies and regulations that provide protection for clients from discrimination in employment, insurance, or any efforts to limit freedom of education or other civil rights based on a genetic test
- advocating for policy, regulations, and laws that protect the rights of minors to be tested only when there is a present and current benefit to the child that would be lost if the test is not done until the child becomes an adult

Research

- advocating for evidence-based, responsible stem cell research
- promoting use of research protocols that encourage interdisciplinary research between social work and other disciplines, as well as ongoing collaborative research between social work practitioners and educators, to determine the effect of genetic testing on individuals and communities.

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Health Care

ISSUE STATEMENT

The vision for improving the health of the U.S. population is set forth in *Healthy People 2020* (U.S. Department of Health and Human Services [HHS], Office of Disease Prevention and Health Promotion, 2010). Through collective national action, *Healthy People 2020* seeks to create a society in which social and physical environments promote good health for all, health disparities are eliminated, and all people attain high-quality, longer lives. Accomplishing the goals of *Healthy People 2020* requires a health care system that meets the “triple aim” by simultaneously improving patient outcomes, advancing population health, and reducing health care costs (Institute for Healthcare Improvement, 2014).

The Evolution of Health Insurance Reform and the Impact of the Affordable Care Act

A single-payer system that ensures universal access to a continuum of physical and mental health services is the best means to achieve the *Healthy People 2020* goals and the Triple Aim objectives. The Patient Protection and Affordable Care Act (2010) (P.L. 111-148), commonly known as the Affordable Care Act, (ACA), although built on the existing fragmented heath care system, moves the nation in the right direction.

Thirteen percent of the U.S. population, or 42 million people, were uninsured in 2013 (U.S. Census Bureau, 2014). To address this, the ACA expands access to health insurance by providing federal subsidies for health plans purchased on public insurance exchanges, requiring access to parental insurance coverage for adult children under age 26, and broadening Medicaid eligibility. The law also addresses exclusionary insurance practices by guaranteeing coverage and comprehensive benefits, removing annual and lifetime coverage limits, and eliminating premium rating practices based on gender, health status, and age. It is estimated that the ACA will decrease the number of uninsured by 26 million by 2017 (Blumenthal & Collins, 2014).

The ACA is prompting fundamental changes in the delivery of health care in the United States, by shifting the traditional focus on episodic acute care to comprehensive care across the continuum (Golden, 2011). The ACA advances the patient-centered medical home (PCMH), a team-based model of care designed to comprehensively meet a patient's health care needs. Two distinguishing features of the PCMH are (1) care coordination, which emphasizes managing illness and facilitating preventive self-care, especially for those living with chronic health conditions, and (2) behavioral health integration, an approach to care that addresses the psychosocial issues that often underlie medical conditions. Unlike previous attempts at cost control, the ACA requires providers to meet quantitative and qualitative performance targets, including reductions in 30-day hospital readmissions and avoidable emergency room visits, delays in permanent nursing home placement, and improvements in patient satisfaction.

Despite significant progress in health care delivery and expansion of coverage, challenges remain. Millions of new enrollees in Medicaid and health exchange plans will exacerbate the nationwide health care provider shortage. Most notably, the ACA's failure to extend coverage to undocumented residents and the Supreme Court's decision rendering the Medicaid expansion optional for states, results in the continued health care disenfranchisement of millions of U.S. residents.

Health Disparities

The United States continues to experience significant health disparities. Racial and ethnic minority groups still lag behind in many health outcome measures. They are less likely to receive preventive care and more likely to suffer from serious illnesses, such as diabetes, heart disease, infant mortality, cancer, and HIV/AIDS. Expansion of health insurance coverage through the ACA should accelerate better health outcomes for disadvantaged populations and reduce racial and ethnic health disparities.

However, the benefit of insurance coverage will be mitigated by other factors that influence health outcomes. Stigmatizing practices in health care delivery, a lack of racial and ethnic diversity and cultural competence among health care providers, differences in health literacy between groups, and the failure to include minority populations in medical research produce a lower quality of health services for racial and ethnic minority groups, despite adjustment for socioeconomic characteristics and other access-related factors (National Research Council, 2009).

A concerted effort to address the social determinants of heath—income; housing and living conditions; education; food security; exposure to violence; employment and working conditions; social exclusion; and income, gender, racial, and sexual inequality—will be needed to meaningfully reduce health disparities in the United States (World Health Organization, Commission on Social Determinants of Health, 2008).

Access to Medicaid Services

With social work's historic commitment to meeting the needs of people who are vulnerable, oppressed, and living in poverty (NASW, 2008), strengthening the Medicaid program is an important focus of the profession's social justice efforts. Medicaid is the nation's single largest social safety net program, providing health care services to over 62 million Americans living in poverty, including pregnant women, children and families, individuals with disabilities, and older adults (Kaiser Family Foundation, 2013a). As a result of the ACA, millions of new Medicaid beneficiaries will be entering the health care system, many of whom have significant chronic physical and mental health disorders. However, accessing care will be a substantial challenge for this population. The nation's health care provider shortage is particularly acute in the mental health arena. Fifty-five percent of U.S. counties have no psychiatrists, psychologists, or clinical social workers (Fields & Dooren, 2014). An additional barrier is provider reluctance to accept Medicaid patients due to low reimbursement rates. Currently, Medicaid pays approximately 75 percent of the Medicare rate for the same service.

To expand provider participation in the Medicaid program, the ACA authorizes funding to increase the primary care workforce through scholarships and loan programs. An additional approach worthy of consideration is enactment of payment equity between Medicare and Medicaid for mental health services.

Managed Care

In the last decade, managed care has become the dominant form of health insurance in the United States. Examples of managed care organizations (MCOs) include health maintenance organizations, preferred provider organizations, point-of-service plans, and behavioral health carve-out programs. Most employer-sponsored health coverage includes some form of managed care. Currently, 14 million Medicare recipients are enrolled in managed care plans through the Medicare Part C benefit (Kaiser Family Foundation, 2013b). Nearly 50 million Medicaid recipients receive benefits through managed care (Gifford, Smith, Snipes, & Paradise, 2011). This number will grow with the Medicaid expansion, and as states increasingly require people to enroll in MCOs to receive Medicaid benefits.

Although managed care is a vehicle for providing comprehensive health services and containing costs, troubling issues have emerged. Despite the lack of evidence supporting the practice, there is a trend among state Medicaid agencies to contract with MCOs to provide care for children and adults with complex health care needs, dual-eligible (Medicare/Medicaid) beneficiaries, and other vulnerable populations not traditionally served by the managed care industry. Cost-control pressures will challenge the managed care industry’s compliance with the Mental Health Parity and Addiction Equity Act of 2008, which mandates equal benefits for medical and behavioral health services (Substance Abuse and Mental Health Services Administration, 2014). In addition, many health care professionals, including qualified physicians and clinical social workers, struggle to join MCO provider panels, thereby restricting patient choice and access. Ongoing federal and state oversight is necessary to ensure quality and protect consumers within managed care plans.

Accountable Care Organization (ACOs)

ACOs are provider-run organizations that assume responsibility for the health care needs of a defined population and are compensated for lowering health care spending and meeting specific patient outcome measures. Since passage of the ACA, there has been rapid growth of ACOs serving Medicare and commercially insured populations. ACOs for Medicaid beneficiaries are also emerging. These organizations provide a wide array of services to patients with multiple physical and mental health conditions, including intensive care coordination, behavioral health and substance abuse treatment, and long-term services and supports. In addition to medical personnel, ACOs will require care coordinators, behavioral health providers, patient educators, and outreach specialists to operate effectively. Few professions offer the skills and training to fulfill these roles more effectively than social workers.

Social Work as an Essential Component of the Health Care Workforce

At a time when the health care industry is under great pressure to demonstrate positive patient outcomes and reduce costs, there is a clear and present role for social work services across the care continuum. The federal Bureau of Labor Statistics has projected a 27 percent increased demand for health care social workers between 2012 and 2022 (U.S. Department of Labor, Bureau of Labor Statistics, 2014).

Social workers are essential in primary care settings, where the prevalence of psychosocial need is high (Bikson, McGuire, Blue-Howells, & Seldin-Sommer, 2009). Social work skills in team-based care, patient advocacy, psychosocial assessment, behavioral counseling, and resource identification can support treatment goals and improve the quality of life for individuals and families. Although social workers have always been present in acute care, there is a renewed emphasis on the value they bring to this setting. Hospital administrators grappling with new reimbursement structures and penalties for high resource utilization increasingly recognize the value of social work, particularly in care coordination and care transition services for patients with complex chronic conditions (Reisch, 2012).

Social work skills are distinctive and are not interchangeable with those of nurses or para-professionals. Educating allied health professionals about the scope of social work practice can improve service delivery in all health care settings. Social work engagement in research that contributes to the foundation of evidence-based practice and that demonstrates the efficacy of social work interventions will further solidify the profession's value in the health care system (Judd & Sheffield, 2010).

Independent Practice and Direct Payment for Social Work Services in Health Care Settings

In all states, social workers licensed at the clinical level are able to practice independently, yet this policy is applied inconsistently in health care settings. In many hospitals and health centers, social workers are often supervised by members of other disciplines. Billing and reimbursement issues often play a role in these circumstances, as illustrated by the use of the Health Behavior and Assessment Intervention (HBAI) codes. HBAI services, commonly used in primary care settings, identify and address psychosocial issues that can impede the treatment and management of a patient's chronic medical conditions (National Council on Aging, 2014). Although clinical social workers are appropriately trained to assess the nature and severity of psychosocial problems that interfere with medical treatment and recovery, HBAI services billable to Medicare may only be performed by or under the supervision of a clinical psychologist.

An additional concern is the lack of a national policy regarding direct Medicaid reimbursement to clinical social workers, which is a state option under the Medicaid program. By contrast, psychologists may bill and receive direct reimbursement from Medicaid in all states. Broadening the definition of clinical social work may address billing and reimbursement issues and expand access to social work services.

Research in Support of Social Work Services in the Evolving U.S. Health Care System

A growing body of research supports the effectiveness of social workers in core ACA functions, including care coordination, post-discharge care transition support, and traditional case management. Randomized control trials have measured the impact of social work interventions with high-risk groups, such as those with complex chronic conditions and those dually eligible for Medicare and Medicaid. Results from these studies demonstrated statistically significant reductions in hospital readmission rates for those receiving the social work intervention, compared with their control group counterparts (Adler, Lipkin, Cooper, Agolino, & Jones, 2009; Altfeld et al., 2013; Bronstein, Gould, Berkowitz, & Marks, 2013; Jackson, Trygstad, DeWalt, & DuBard, 2013). As health care cost-control pressures continue to build, more research on social work effectiveness is needed.

POLICY STATEMENT

NASW supports the long-term goal of enactment of a national health care policy that ensures access to the full continuum of physical and mental health services for all people regardless of age, race, ethnicity, religion, gender or gender expression, sexual orientation, cognitive or physical functioning, socioeconomic or immigration status, or geographic location.

NASW also supports

- full implementation of the Patient Protection and Affordable Care Act (ACA), including the adoption of the Medicaid expansion in all 50 states
- access for undocumented immigrants to federal health insurance programs, including Medicare, Medicaid, the Children's Health Insurance Program, and state-based health insurance exchanges
- direct Medicaid reimbursement of mental health services performed by licensed clinical social workers
- payment equality for Medicaid and Medicare services
- expansion of the federal clinical social work definition, through modification of the Social Security Act, to permit independently licensed clinical social workers' use of the HBAI codes
- policies and practices requiring that mandated social work services are provided by professional social workers in all health care settings

- consistent oversight and enforcement of the Mental Health Parity and Addiction Equity Act
- federal, private, and foundation funding for research activities to demonstrate the effectiveness of social work services in health care settings
- funding for interdisciplinary education and practice collaboration programs to increase understanding of the contribution made by each health care discipline—including social work—to improving patient outcomes loan repayment, loan forgiveness, and other efforts to increase the number of social workers, physicians, nurses, and allied health care professionals, to meet the growing need for primary health care providers
- efforts to strengthen and expand bachelor and master's-level degree programs in health care social work, in collaboration with the Council on Social Work Education
- development and promotion of social work professional education programs to respond to the expanding social work workforce needs in integrated primary care settings
- efforts to eliminate racial, ethnic, and economic disparities in health service access, provision, utilization, and outcomes
- active participation of social workers on public and private health care policy and planning bodies at the state, regional, and national levels
- efforts to promote full use of all available health and social supports for young adults aging out of foster care, individuals leaving the criminal justice system, and other at-risk populations
- collaboration between the health care system and employment, housing, education, and other systems that affect health status in equal or greater measure than access to health care services.

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HIV and AIDS

ISSUE STATEMENT

The human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS), generally referred to as HIV/AIDS, is a serious global public health concern with biological, social, political, and economic ramifications. As of 2014, there were almost 37 million people worldwide living with HIV/AIDS, including 2.6 million children (those 14 years old or younger). The HIV pandemic remains a global concern, with about 90 percent of people newly diagnosed with HIV living in 35 countries. The burden of HIV/AIDS remains highest in sub-Saharan Africa, where 60 percent of the global new HIV cases were diagnosed in 2014 (UNAIDS, 2014). That same year, over 44,000 Americans were newly diagnosed with HIV, and although these numbers remain relatively stable, the rate of new diagnoses in the United States was over twice the rate (5.9 per 100,000) than that of the European Union (Centers for Disease Control and Prevention [CDC], 2015b; European Centre for Disease Prevention and Control, WHO Regional Office for Europe, 2015).

Globally, HIV/AIDS disproportionately affects vulnerable, oppressed, and marginalized individuals and their communities. The intersecting sociocultural influences of heterosexism and sexism, poverty and geography, homophobia and transphobia, and racism have contributed to the spread of HIV/AIDS. In the United States, the burden of HIV/AIDS is disproportionately higher among African American and Latino populations, gay men and men who have sex with men (MSM), transgender women of color, injection drug users, youths, and the aging population. As of 2016, it is estimated that one in six MSM will be diagnosed with HIV in his lifetime, which translates to one in two African American MSM, one in four Latino MSM, and one in 11 white MSM (CDC, 2016). Roughly half of new HIV diagnoses in the United States occur in the southern states, despite the fact that only one-third of Americans live in the South (CDC, 2015a, 2015b). Of growing concern is the increased number of youths and young adults diagnosed with HIV, with youths ages 13 through 24 comprising one-fifth of all new HIV diagnoses (CDC, 2015a, 2015b). Heterosexual women now comprise one in four new HIV infections in the United States, with disproportionately higher rates among African American and Latina women (Kaiser Family Foundation [KFF], 2014). Studies also reveal high HIV prevalence rates among transgender women in the United States (CDC, 2015a). Discrimination toward people who inject drugs has increased the level of transmission risk for HIV/AIDS and hepatitis due, in part, to limited availability of sterile injection equipment, harm reduction services, and access to care. Only recently was the longstanding ban of use of federal funding for needle exchange programs lifted, now making it possible for state health departments to use federal monies to support some elements of syringe exchange programs (Wolitski, 2016).

Despite increasing rates of HIV among older people, this group continues to be overlooked and marginalized in data collection, instruments, education and prevention programs, and treatment studies, to name a few (Cox & Brennan-Ing, in press). In large part because of improvements in treatment and care, half of people living with HIV/AIDS (PLWH/A) in the United States today are age 50 or older (CDC, 2015a).

In the United States, HIV/AIDS prevention and treatment services are the result of significant biomedical and social advocacy efforts by diverse groups comprised of PLWH/A, providers, caregivers, researchers, and educators. In the early 1980s, to address gaps left from a limited government response to the HIV pandemic, PLWH/A, allies and peers, and professional providers collaborated to establish community-based AIDS service organizations (ASOs). The Ryan White HIV/AIDS Program, first funded in 1990, provides a critically important comprehensive system of care (primary medical care and essential support services) for people living with HIV/AIDS who are uninsured or underinsured (Health Resources and Services Administration [HRSA], 2016). The increased access to insurance through the Patient Protection and the Affordable Care Act (ACA) of 2010 (P.L. 114-148) and the growing efforts to integrate HIV/AIDS care into comprehensive health care has resulted in fewer resources, limiting the number of specialized ASOs. Yet, despite the efforts to integrate or mainstream HIV/AIDS care and treatment into general health care, over 13 percent of people infected with HIV still do not know they are living with

HIV or AIDS (U.S. Office of National AIDS Policy, 2015). HIV/AIDS continues to have catastrophic effects on communities, whether resource-poor countries, where people cannot afford medications or access treatments, or resourced countries, where HIV/AIDS is not viewed as a current or critical public health concern. The quality of HIV/AIDS-related medical care may depend on where people are living, because of limited access to specialized HIV/ AIDS providers and services and low rates of insurance coverage, particularly in rural communities throughout the United States (HRSA, 2016).

The National and Global Community Policy Response

The U.S. Office of National AIDS Policy (ONAP), first established in 1993 by President Bill Clinton, set the stage for the first U.S.-focused national strategic plan. In July 2010, President Obama released the *National HIV/ AIDS Strategy for the United States*, a report that outlined a federal response with specific targets. The report was updated in July 2015 to reflect the work accomplished since 2010, to highlight new scientific developments, and to update and expand targets. This report, titled *National HIV/AIDS Strategy for the United States*: *Updated to 2020* (ONAP, 2015), is guided by four overarching goals: (1) to reduce new HIV infections, (2) to increase access to care and improve health outcomes, (3) to reduce health disparities and health inequities, and (4) to achieve a more coordinated response to the HIV/AIDS pandemic. Through engaging individuals, agencies, and communities, the strategy stresses the broader support for PLWH/ A to remain engaged in comprehensive care and achieve and maintain viral suppression (ONAP, 2015).

In 2008, President George H. W. Bush founded the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), a multilateral program designed to help save the lives of PLWH/A around the world. As of 2015, PEPFAR has supported life-saving antiretroviral treatment for 9.5 million people (PEPFAR, 2016). In 2016 UNAIDS adopted a new strategy to end the AIDS epidemic as a public health threat by 2030, promising to fast-track approach aims to achieve the following global targets by 2020: a reduction of new infections and deaths from AIDS-related illnesses, and elimination of HIV-related discrimination (UNAIDS, 2016). The United Nations strategy is in alignment with the Sustainable Development Goals (SDGs), which include the global commitment to end AIDS by 2030 (United Nations, 2016). Putting policy into practice requires understanding the effects of HIV on individuals, families, and communities and the continued importance of programmatic and fiscal support of HIV/ AIDS prevention, testing, and ongoing care and treatment globally.

Effects on Individuals, Families, and Communities

Prevention, early intervention, and treatment efforts must take into account the whole person and the synergistic nature of HIV/ AIDS. Across the life course of living with HIV/AIDS, a person can experience a range of symptoms that can be attributed to HIV, and these factors can create stress and affect a person’s mental health and psychosocial wellness (U.S. Department of Health and Human Services [HHS], Office on Women’s Health, 2011; Sellevaag & Tomaszewski, 2016). Evidence has demonstrated the connection of depression, substance use, poverty, violence, and other forms of trauma to increased risk of contracting HIV and increased level of psychosocial problems (Patel, 2007). In addition, undiag-nosed mental health and associated psychosocial challenges are well documented as both increasing risk-taking behaviors and hindering successful medication adherence (Gonzalez, Batchelder, Psaros, & Safron, 2011).

Prevention

Prevention efforts continue to be under-funded and excessively influenced by perceptions and politics rather than empirical evidence. Limitations created by federal and state policies, and funding levels and regulations, hamper the efforts of community-based organizations to reduce HIV/AIDS incidence in populations at high risk. For example, partner notification laws cannot ensure client confidentiality and affect a person’s decision to seek HIV testing and treatment.

An effective national prevention strategy to address HIV/AIDS requires a coordinated approach that is evidence-based and culturally sensitive to the needs of at-risk populations (ONAP, 2015). Prevention strategies require involvement of affected and at-risk populations in all aspects of planning, development, and decision making to ensure that strategies are relevant to their needs. Important aspects of HIV/AIDS prevention include (a) accurate education about HIV risk, prevention, and treatment grounded in science; (b) free confidential HIV testing; (c) access to evidence-based prevention methods such as pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP); (d) harm reduction services; and (e) achieving viral suppression to reduce transmission risk.

Testing

In the United States, evidence suggests that people who do not know they are living with HIV contribute to almost one-third of new HIV infections (Skarbinski et al., 2015). HIV testing and counseling are important components of a comprehensive public health approach to reduce the incidence of HIV/AIDS. The ACA requires most insurance plans to cover HIV testing as part of routine preventive care for people between ages 15 and 65 (AIDS.gov, 2016). However, an analysis of HIV testing among U.S.-based patients accessing outpatient services using Medicaid and commercial insurance found little evidence to suggest that routine screening for HIV infection is widespread (Dietz et al., 2015).

The CDC’s (2006) *Revised Recommendations for HIV Testing in Health Care Settings* recommends for HIV testing to be voluntary and to be suggested for patients in all health care settings, unless the patient declines (or opts out of screening). This recommendation replaces the practice of informed, written consent. Nevertheless, many people obtain HIV tests without pre- or posttest counseling, especially when they test in a physician’s office or in their own home.

The availability of testing on an anonymous or confidential basis is thought to maximize the number of people who choose to get tested. To protect confidentiality of HIV status, all states apply confidentiality laws to HIV test results. Yet federal and state policies continue to impose mandatory testing or mandatory reporting of test results for certain populations, including prisoners, pregnant women, and child care workers.

Treatment as Prevention

Diagnosis of HIV is insufficient to prevent the spread of HIV; it is also essential for people diagnosed with HIV to be connected to medical treatment and care. Recent guidelines from both the World Health Organization and CDC recommend that physicians now start all people with HIV on highly active antiretroviral medications (aka HAART or ART) regardless of viral load or CD4 count so as to support immune system functioning, prevent opportunistic infections, and contribute to viral suppression. It is estimated that PLWH/A who know of their diagnosis yet do not receive medical care contribute to approximately 60 percent of new HIV infections (Skarbinski et al., 2015). This is particularly important as studies suggest that PLWH/A who are appropriately virally suppressed can reduce the risk of onward transmission by 96 percent (ONAP, 2015).

The emergence of antiretroviral therapies and increased access through private insurance, Medicare, and AIDS drug assistance programs have resulted in a positive, dramatic reduction of deaths. For many, the diagnosis is no longer a death sentence but rather means living with a lifelong, chronic illness, often with a renewed sense of hope and challenges (Tomaszewski, 2012). For others, however, the complexities of a strict medication regimen cannot be sustained over extended periods of time, because adherence is not as simple as taking medications. An increasing number of people living with AIDS are unable to tolerate the toxicity and severe side effects that are common with the medications (ART and prophylaxis treatments); others experience unexpected and unexplained health deterioration, or the drugs simply fail the patient (Cox & Brennan-Ing, in press).

Disparities, Social Determinants, and Structural Barriers

The HIV/AIDS pandemic is rooted in interrelated social determinants of health, the impact of multiple structural barriers, and the historically rooted stigma that emerges in the form of laws, regulations, and policies that single out people with HIV. Structural barriers can exist at the systems level through policy, governance, or laws, within the environment such as poverty and resulting living conditions that result in reduced health and well-being of individuals or entire communities and are associated with reduced access to HIV services (Gruskin, Ferguson, Alfven, Rugg, & Peersman, 2013). The *UNAIDS Gap Report* acknowledges that HIV stigma and discrimination, criminalization laws, and social prejudice are associated with low social support, poor physical and mental health, and a poorer quality of life for PLWH/A (UNAIDS, 2014).

In too many areas of life, PLWH/A continue to be denied basic civil and human rights. For example, laws regarding HIV/AIDS reporting and the criminalization of HIV transmission vary across states and are considered a barrier to HIV prevention and care (ONAP, 2015). A number of states have criminalized the potential transmission of the HIV virus through sexual contact, needle sharing, breastfeeding, or organ donation, and continue to criminalize HIV transmission based on behaviors that do not pose risk for HIV transmission, that is, through saliva or biting (Arreola et al., 2015; Center for HIV Law and Policy, 2013).

People living with HIV/AIDS continue to face discrimination in employment, military service, housing, child care, access to health care services, and social and community support programs, despite protections provided by federal laws and regulations. Structural barriers must be addressed in HIV/AIDS prevention efforts. The high rates of HIV/AIDS we see among communities of color are not the result of high-risk behavior in these communities, but structural inequalities that make them more likely to come into contact with people living with HIV and less likely to seek or be treated for HIV/AIDS (Movement Advancement Project [MAP], 2012). Poverty and economic issues continue to contribute to an increased vulnerability to HIV infection while intensifying its influence, thereby generating and amplifying the exact conditions that have enabled this pandemic to thrive.

Lack of insurance coverage has been, and remains, a large barrier for many PLWH/A to access care. The 2010 passing of the ACA has, for the first time, required all insurance plans in the United States to cover preexisting conditions, which is a victory for many who had been historically denied coverage for HIV/ AIDS. The passing of the ACA has also contributed to Medicaid expansion in opt-in states to allow more low-income Americans to have health care coverage. However, in 2016, it was found that those states that had not yet expanded Medicaid had a higher number of people uninsured because they do not qualify for traditional Medicaid under the states' rules and could not afford to purchase insurance on the Marketplace. These people fall into what is known as the "coverage gap." As a whole, more people—and in particular more poor uninsured adults—reside in the South than in other regions. Furthermore, the South has higher uninsured rates and more limited Medicaid eligibility than other regions (KFF, 2016).

POLICY STATEMENT

Social work practice addresses HIV/AIDS, directly or indirectly, across fields of practice, geographic locations, and practice settings. NASW supports the following:

Prevention and Education

- professional collaboration with existing HIV and AIDS educational, treatment, and research organizations to develop and implement programs that include educational and prevention strategies to meet the needs of all segments of our society
- prevention programs designed and implemented to be tailored to the specific needs and risks of diverse populations; programs must be culturally appropriate and consider the language, culture, ethnicity, sexual orientation, gender and gender identity, religion, and age of the target population
- the implementation of prevention strategies that focus on harm reduction
- an increase in and maintenance of comprehensive sexuality education that includes evidence-based prevention efforts that target children and

adolescents in both public and private school systems

- the establishment of both publicly and privately funded comprehensive syringe services programs that include syringe exchanges, syringe provision, harm reduction services, and risk reduction education in a safe environment
- an increase in the quantity and quality of substance abuse treatment programs
- addressing the health disparities of HIV and the social determinants of health that overwhelmingly affect people in higher-incidence and at-risk communities
- open, affordable and equal access to evidence-based prevention methods such as PrEP and PEP

Social Work Education and Professional Development

- the education of all social work students and professional social workers to ensure competency in assessment and behavioral intervention strategies to prevent the transmission of HIV, including safer sex and harm reduction, and address the range of health and mental health issues of PLWH/A and their families, support systems, and communities
- encouragement for social workers to take responsibility to continuously update their knowledge about all aspects of HIV disease, including new prevention strategies, treatment models, medication regimens, and policies
- interventions that address competency and skills through professional continuing education programs to evidence-driven holistic prevention and interventions strategies at the micro and macro levels of practice

Testing

- the education of social work practitioners across fields of practice about both the availability and the accessibility aspects of HIV antibody testing and referrals related to living with HIV and AIDS

- voluntary and confidential testing that is available anonymously and includes prior informed consent
- pre- and posttest counseling programs, provided by trained caregivers
- rapid testing conducted only by people trained and certified to do so and implemented only when consent is granted by the client or patient
- access to free competent professional counseling by phone for people using home-testing kits and referrals to a formal HIV testing site
- informed consent of pregnant and birthing mothers prior to mandatory HIV testing of themselves and their newborn child or children; prior consent for release of all clients’ test results

Service Delivery, Care, and Treatment

- a comprehensive service delivery system based on a quality case management model that includes access to suitable and affordable housing, mental and health care services, adult and child foster care, home health care, nursing home care, legal services, and transportation
- programs and policies that are inclusive of the unique needs of youths, immigrant populations, the aging adult population, and longterm survivors of HIV/AIDS
- readily available comprehensive biopsy-chosocial–spiritual support for people with HIV/AIDS and those affected; service programs that require culturally competent, linguistically appropriate, and client- and patient-centered approaches
- elimination of stigma and the inequities or obstacles to access medication, clinical trials, and HIV care specialists; or to services that ensure psychological, social, cultural, and economic well-being
- policies that facilitate access to affordable pharmaceuticals worldwide; sufficient supports to help clients maintain difficult and varied medication regimens
- the right to confidentiality relating to HIV/AIDS status (clients must be informed of the limits of confidentiality, including the existence of

partner notification and record keeping)

- education of social workers on applicable state laws, regulations, and federal guidelines

Political Action and Advocacy

- continued public and private funding and advocacy for health and mental health services programs that address HIV/AIDS and related health and mental health issues, including state, local, national, and international HIV/AIDS prevention and treatment programs
- domestic and international initiatives to address structural factors such as poverty, community disinvestment, and interpersonal violence to curtail the HIV/AIDS epidemic
- leadership in advocacy efforts at the local, state, and federal levels to improve the quality of life of all PLWH/A and to protect their civil liberties, including maximum access to confidential testing, diagnosis, and treatment
- advocacy for adequate funding of research on all aspects of HIV/AIDS, including prevention, clinical interventions, and vaccine development

Research

- research protocols addressing risk, behaviors, and prophylactic intervention based on a whole-person, inclusive population approach
- evidence-based research, including epidemiological, clinical, and comprehensive, biopsychosocial–spiritual studies, funded at appropriate levels by the federal government
- research protocols that address the unique biomedical needs of women, children, and adolescents
- funding for research to accurately assess the effectiveness of primary, secondary, and tertiary prevention and educational strategies, service delivery models, and the effect of related policies; research protocols must include the biopsychosocial–spiritual issues of PLWH/ A; the

distinctive needs of women, children, and adolescents; and the needs of all people affected by HIV/AIDS.

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Homelessness

ISSUE STATEMENT

The 1980s saw an increase in homelessness, resulting primarily from slashed federal housing subsidies, rising housing costs, economic restructuring, the decline in family supports, the deinstitutionalization of people with psychological or developmental disabilities, and the inadequate response to the needs of veterans (Dreier, 2004; Ficenec, 2011; Hudson, 1998). After several decades of disjointed efforts to address the crisis of homelessness in the United States, it remains a significant problem; however, recent years have shown progress in preventing and ending homelessness. In January 2013, more than 600,000 people were reported to be experiencing homelessness in the United States (Henry, Cortes, & Morris, 2013). Of these, 38 percent were unsheltered, struggling to survive on the streets and sleeping in cars, abandoned buildings, or other places not intended for human habitation (National Alliance to End Homelessness [NAEH], 2013). Individuals constituted 64 percent of the total homeless; families made up 36 percent. Since 2010, our country has seen a 6 percent reduction in the overall number of people experiencing homelessness, including a 24 percent reduction in homeless veterans; a nearly 5 percent drop in homeless individuals; a decrease of 8.2 percent among families; and a 15.7 percent decline in individuals meeting the U.S. Department of Housing and Urban Development's (HUD's) definition of being *chronically homeless*, that is, having been homeless multiple times or for longer than one year (Henry et al., 2013). However, even as the national number has declined, roughly half the states saw overall homeless populations increase between 2008 and 2013 (Keys & Peck, 2014).

Although federal resources allocated to ending homelessness were not increased in 2013, except for programs designed to assist homeless veterans, more effective strategies have been implemented, resulting in a drop in the numbers of people in homeless situations. These strategies include providing permanent supportive housing for chronically homeless people, the rapid rehousing of people so they exit from homelessness as quickly as possible, and focusing on people living in unsheltered conditions. Federal investments in such strategies have been working (NAEH, 2013).

Tempering these encouraging data, however, is the fact that homelessness continues to exist. Even with more effective strategies and more targeted spending, the lack of adequate funding to fully address the problem means that many people in the United States still experience episodes of homelessness. The persistence of homelessness is routinely recognized as evidence that poverty and the lack of affordable housing and other resources in the United States still persist and are likely to remain critical policy issues throughout this century (National Coalition for the Homeless, 2009).

The issue of homelessness is complex, and people experiencing homelessness are not a homogeneous group. In many cases, the only common factor among people in homeless situations is that they do not have a safe, decent, and affordable place to live. Even individuals who are working full-time, and families with at least one member working full-time, may not earn enough money to maintain their housing. There is a lack of decent, affordable housing in a wide range of urban, rural, and tribal communities (Bravve, Bolton, & Crowley, 2013).

The economic downturn in the late 2000s, including the bursting of the “housing bubble,” led to a housing crisis as well as an economic crisis, leaving homeless or at risk for homelessness people who were previously financially secure. The postrecession homeless crisis now affects more families than at any other time in recent history, with people who just a few years before had jobs, housing, and relatively stable lives becoming the “new face of homelessness in America” (Raz, 2010).

The economic turmoil has also resulted in more people becoming renters rather than homeowners. But salary erosion and the failure of incomes to keep up with increases in rent have led to record numbers of households “paying excessive shares of income for housing” (Joint Center for Housing Studies of Harvard University [JCHS], 2013, p. 1). “Nearly half (46 percent) [of renters] have incomes below $30,000, including 22 percent with annual incomes below $15,000 (roughly equivalent to working year-round at the minimum wage) and 24 percent earning between $15,000 and $30,000” (JCHS, 2013, p. 12). Homelessness can be understood in the context of economic factors and housing market factors (NAEH, 2013). Demographic and household factors include examining the rates of individuals living “doubled up” with friends or family because of economic need, the number of single-person households with low incomes, and the number of family households headed by a single adult who are living in poverty (NAEH, 2013).

Poverty creates a tenuous existence, whereby an illness, accident, or loss of a paycheck can destroy the ability to pay for housing. HUD defines a household as having a “rent or cost burden” if the household pays more than 30 percent of its income for housing costs, including utilities. Households have a “moderate rent or cost burden” if they pay between 31 percent and 50 percent of their income for housing, and a “severe rent or cost burden” if they pay more than 50 percent (Office of Policy Development and Research, 2000, p. A-20). In 2012, 21.1 million households, representing more than half of all renters, experienced a cost burden. For households with a housing cost burden, money spent on housing and utilities means less money to spend on food, transportation, health care, and retirement savings—all critical for surviving, working, and planning for the future. For people with a low income, even “inexpensive” housing absorbs a large proportion of funds and is too often abandoned when economic resources are insufficient to meet basic needs. Consequently, the cost and difficulty of trying to find affordable housing can present tremendous obstacles, and well-meaning policies not supported by adequate resources exacerbate this problem.

The National Low Income Housing Coalition’s (NLIHC’s) 2013 *Out of Reach* report found that “the cost of housing is simply too high for our lowest income neighbors to afford” and that affordable housing is “a cost-effective and proven solution to homelessness” (Bravve et al., 2013, p. 1). In 2013, extremely low income (ELI) households had incomes of no more than $19,810, meaning they could afford to spend no more than $495 per month on rent, even as the national Fair Market Rent (FMR) for a two-bedroom unit was $977, and for a one-bedroom unit $783. As a result, many households spent more than 30 percent or even 50 percent of their income on housing (Bravve et al., 2013). About 8 million people received Supplemental Security Income (SSI) because of a disability and lack of economic resources, and the maximum SSI payment in 2013 was $710 per month. “Among those reliant on SSI, there is not a single county in the U.S. where even a modest efficiency apartment, priced according to the FMR, is affordable” (Bravve et al., 2013, p. 4). In 1960, 25 percent of renters faced a housing cost burden, but by 2013, that number grew to 53 percent, more than half of all renters (Bravve et al., 2013).

Homelessness continues to be further exacerbated by eroding work opportunities, a decline in public assistance benefits, inadequate health care insurance, disabling behavioral health disorders, and domestic violence (Home Aid, 2014; Institute for Children, Poverty & Homelessness, 2013). Household median income declined between 2000 and 2011, postrecession job growth has consisted of primarily low-wage jobs (a trend expected to continue through 2020), and the 2013 federal minimum wage ($7.25 per hour) was “worth about 30% less than it was in 1968, based on purchasing power” (Bravve et al., 2013, p. 5). “With the exception of a handful of counties in Washington and Oregon (where the state minimum wage is $9.19 and $8.95, respectively), there is no county in the U.S. where even a one-bedroom unit at the FMR is affordable to someone working full-time at the minimum wage” (Bravve et al., 2013, p. 5).

Homelessness is also a human rights issue. The 1948 Universal Declaration of Human Rights (United Nations, n.d.) included a right to housing, but that right has not become a reality for many in the United States. Framing the right to housing as a means to ensure basic human dignity and expanding government expenditures to ensure that right as “government’s basic obligations to its citizens” can advance the cause of providing adequate housing for all people (National Law Center on Homelessness and Poverty, 2011).

A variety of research methods are used to research and measure homelessness on regional, local, and national levels, and methodological problems can negatively affect funding for existing and new programs to serve people experiencing homelessness. These problems also inhibit accurate predictions regarding the need for emergency shelter and transitional housing beds. The methodology selected can significantly influence everything from our understanding of the magnitude and dynamics of homelessness to the crafting of policy and the development of interventions. For example, point-in-time counts provide a “snapshot” of homelessness as they only include those who are homeless in a single 24-hour period. Over time, however, some people will find housing and new people will become homeless, so point-in-time studies do not accurately identify the intermittently homeless people, and therefore tend to overestimate the proportion of people who are “chronically homeless,” particularly those who experience severe mental illness or addiction disorders and therefore have a much harder time finding and retaining permanent housing (National Coalition for the Homeless, 2009). Narrower definitions of homelessness tend to exclude people who have previously been or are at risk for being homeless, those living in doubled-up situations, those living in transient housing (such as motels), or those who are intermittently living with friends and family members.

In the late 2000s, HUD began encouraging, and then requiring, local clusters of homeless services providers, Continuums of Care (CoCs), to collect and report data on people served with CoC-funded services. HUD designed specifications for the Homeless Management Information System software, which numerous software vendors created and marketed to CoCs. Over the past several years, data voluntarily gathered year-round from people participating in homeless services have become a rich source of information that has led to an increased focus on program performance and effectiveness, evidence-based practices, and proven funding strategies (HUD Exchange, n.d.).

The decades-long failure to adequately respond to the needs of homeless individuals has led to an even greater crisis in the 21st century, particularly among special populations such as veterans. Veterans make up just 9 percent of the total U.S. population, but are 13 percent of the people experiencing homelessness (Arnold, Bolton, & Crowley, 2013). HUD has estimated that 57,849 veterans are homeless on any given night. According to the U.S. Department of Veterans Affairs (VA), the nation’s homeless veterans are predominantly (92 percent) male (National Coalition for Homeless Veterans (NCHV), n.d.). Data show the veterans of color are also disproportionately represented within the population of veterans experiencing homelessness (NCHV, n.d.).

The U.S. Interagency Council on Homelessness (USICH) has prioritized efforts to end homelessness among America’s veterans by 2015. Data from recent homeless counts suggest that investments in effective, evidence-based programs, along with unprecedented collaboration between service providers and funders, has yielded substantial reductions in veterans’ homelessness. From 2010 to 2012, the number of veterans experiencing homelessness on a single night decreased by 18 percent (from 76,329 to 62,619). Whereas the number of sheltered homeless veterans dropped both years, the number of unsheltered homeless veterans dropped between 2010 and 2011, but stayed the same from 2011 to 2012 (USICH, 2013).

Other subpopulations at risk for homelessness that have been identified as needing special attention are survivors of domestic and dating violence, sexual assault, and stalking; adults with serious mental illness; adults with substance use disorders or dual diagnoses; unaccompanied youths and children (such as those aging out of foster care); lesbian, gay, bisexual, and transgender youths and adults; and people recently released from prison. Interventions for these subpopulations within the larger homeless population should address and support their specific needs and circumstances.

Acknowledging that no single remedy exists, a philosophical shift has occurred nonetheless on the federal level, from emphasizing shelters and temporary or transitional housing to focusing on rapid rehousing, Housing First, and permanent supportive housing. These practices have effectively reduced the number of people in homeless situations, decreased the length of time people remain homeless, and increased the stability of people in housing after exiting a homeless services program. Rapid rehousing involves getting a homeless individual or family back into permanent housing as quickly as possible, and working with them to successfully remain in that housing (NAEH, 2014b). Housing First is the philosophy of providing housing to people without any preconditions, such as the requirement for sobriety or sufficient income (NAEH, 2014a). Permanent supportive housing provides housing with supportive services, such as case management, education, and employment assistance, available to residents, and without an occupancy time limit (Wong et al., 2006). Homelessness prevention methods have shown mixed results in studies, but some communities have found them effective in decreasing the number of people falling into homeless situations, helping families to avoid the disruption in their lives that homelessness brings (Messeri, O’Flaherty, & Goodman, 2012; Wong et al., 2006).

The Homelessness Emergency Assistance and Rapid Transition to Housing (HEARTH) Act (S. 896), which was enacted by Congress in May 2009, mandated that the USICH produce a “national strategic plan” to end homelessness (USICH, 2010). The plan, released in a report titled *Opening Doors* (USICH, 2010), was presented to Congress and the president in 2010. This first-ever federal strategic plan to prevent and end homelessness set goals for ending homelessness for four subpopulations on the following timetable: veterans and people who meet HUD’s definition of chronically homeless, by 2015; and families or households with children and homeless youths, by 2020. The plan also called for all USICH member agencies on the federal level to work with state and local entities to make progress toward ending homelessness for everyone.

So far, such progress has been painfully slow and sporadic. Nevertheless, the positive results from the implementation of initiatives such as Housing First and CoCs have been sufficient to establish the value and efficacy of federal and state leadership and increase investment in the development of comprehensive systems of services and supports for the homeless.

POLICY STATEMENT

Given both the moral responsibility for ending homelessness and the practical possibilities for doing so, NASW advocates for the expansion of these efforts, including the needed research and training supports. Because “the primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty,” and because “social workers promote social justice and social change with and on behalf of clients” (NASW, 2008, p. 1), the profession of social work has a mandate to address the issue of homelessness from the dual-pronged approach of improving the lives of people experiencing homelessness and advocating for systems change, and social workers can—and should—be leaders in anti-homelessness efforts.

In keeping with an empowerment perspective, social workers can and must join with people who are experiencing or have experienced homelessness to advocate for changes in the social structures that surround them. To adequately address the problems of acute, chronic, and episodic homelessness, policies should include changing social and economic conditions that allow extreme poverty and increase the risk of homelessness, preventing and reducing episodes of homelessness, and strengthening the capacities of the many people who are experiencing homelessness. Individual-level competency-building strategies should be carefully coordinated with strategies aimed at community building. Ensuring access to affordable housing, employment, income, health care, mental health services, nutrition, education, and transportation is essential to preventing and ending homelessness. NASW advocates the following supportive and long-term conditions for solving the problem of homelessness:

- An affordable and adequate home within a suitable, safe, and healthy living environment for everyone in the United States.
- Greater investment in permanent and affordable housing that is commensurate with need and that reduces housing precariousness for people with low incomes. The NLIHC estimates that 4.5 million units of housing stock is needed to close the gap between the demand for and supply of housing affordable to people with ELI (Bravve et al., 2013).
- Greater investment in housing strategies that reduce homelessness, including rapid rehousing, permanent supportive housing, and Housing First models.
- Active partnerships in national, state, and local coalitions between social workers, people in homeless situations, and housing officials or advocates to create networks and advocacy groups, to identify significant problems in localities, and to create linkages to address and alleviate these problems. Homeless coalitions and CoCs—which integrate housing, income maintenance, and supportive services—already exist in many areas. Involvement of people with current or former experiences of homelessness, social workers, service providers, governments, and mainstream resources is valuable and important.
- The expansion of education, job training, and related support services to prevent homelessness and promote housing stabilization and maintenance.

- Prioritizing services to homeless children, youths, and young adults with the goal of ending the cycle of homelessness. The McKinney-Vento Homeless Assistance Act of 1987 (P.L. 100-77) outlines rights and responsibilities related to educating students in homeless situations (National Center for Homeless Education, 2008). The Runaway and Homeless Youth Act of 2008 (P.L. 110-378) has enabled programs for youths experiencing homelessness, including street outreach, drop-in centers, and transitional living (Administration for Children & Families, 2014).
- Expansion of early intervention, treatment, and rehabilitative services for special populations, including people with mental health and addiction issues; youths aging out of foster care; lesbian, gay, bisexual, and transgender youths who are displaced from their families; and people released from incarceration. Such services should be evidence based; examples include the Program of Assertive Community Treatment, psychiatric rehabilitation, supported employment, integrated dual disorder treatment, permanent supportive housing, and Housing First programs.
- Continued development of national efforts to reduce the extent of homelessness.
- Living wage measures to reduce poverty and help prevent homelessness. Living wages ensure that any person working full-time earns enough money to meet minimum standards of living. Living wages vary by community (Glasmeier & Massachusetts Institute of Technology, 2014).
- Systemic building of natural support systems involving families, friends, neighbors, faith communities, civic groups, other such entities, and geographic communities.
- State and local resources, including voluntary efforts, such as homeless coalitions and public and private partnerships and homeless demonstration projects, to develop creative solutions and stopgap measures for protecting people who are precariously housed.
- The development and implementation of effective approaches for research on the dimensions of and solutions to homelessness, which can lead to more appropriate allocations of funding and the development and maintenance of programming to meet actual needs.

- Federal investment allocated based on need, toward resources that have been proven to help veterans become or remain stably housed, including increased investments in HUD-VA Supportive Housing, which provides a permanent rental subsidy and long-term case management for chronically homeless veterans (HUD, n.d.-d), and Supportive Services for Veteran Families, which provides short-term assistance with a focus on making connections to mainstream assistance to prevent homelessness for at-risk veterans and rapidly rehouse veterans experiencing homelessness (VA, n.d.).
- Investment in the Emergency Solutions Grant Program (HUD, n.d.-a), Temporary Assistance for Needy Families, (Office of Family Assistance, n.d.), and strategies included in the former Homelessness Prevention and Rapid Re-Housing Program (HUD, n.d.-b) to help to prevent and end homelessness.
- Increased access to housing and stabilization services, including for veterans and family members not eligible for VA benefits (that is, those with discharge from service status that renders them ineligible for VA services).
- Initiatives to develop and implement programs and services to address the unique needs of veteran households most likely to experience moderate to severe housing cost burden, housing instability, and homelessness, including those headed by women and people of minority races or ethnic groups.
- Funding the National Housing Trust Fund (NHTF). Enacted in 2008, the NHTF has yet to be funded. Once funded, 90 percent of funding would go toward increasing and preserving the supply of rental housing for ELI and very low income (VLI) households. The other 10 percent could be used for assisting ELI and VLI first-time homebuyers (HUD, n.d.-c).

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Hospice Care

ISSUE STATEMENT

Hospice was the first holistic, person-centered approach to end-of-life care (Mor & Teno, 2016). It is an interdisciplinary model of care designed to maximize the quality of life—physical, psychosocial, and spiritual— of people with a terminal illness and their identified families. Hospice is not a place, but a philosophy of care and is palliative in nature. Hospice services reorient the focus of care from pursuing curative treatments or prolonging life to alleviating pain and other symptoms, allowing dying people to experience dignity and their loved ones' support. In accordance with this model, care may be provided at home or in a setting of choice and generally remains available when individuals transition care settings.

Support of Self-Determination

The cornerstone of hospice is the patient's right to self-determination, which includes the right to choose the types of care and services desired at the end of life. Hospice programs encourage advance care planning to ensure that each person's goals for end-of-life care are understood and honored. This philosophy mirrors that of the NASW (2017) *Code of Ethics*, which directs social workers to promote the right of clients to self-determination. With its strengths-based, person-in-environment perspective and prioritization of cultural awareness, the social work profession has long played a critical role in supporting individuals and families in dealing with the biopsychosocial complexities of illness, dying, and grief.

The Care Continuum

Many factors have contributed to growth in the utilization of hospice care, including the aging of our population, effects of terminal illness on individuals and families, medical advancements that enable life to be prolonged in the face of degenerative diseases, and renewed attention to home care and alternatives to hospitalization (Abt Associates, 2016). As the availability of hospice care has increased, the use of hospice services continues to be higher among white people than people of color (Abt Associates, 2016; Bullock, 2011; Johnson, 2013). There are racial and ethnic disparities in beliefs about hospice and the type and quality of care that individuals receive while enrolled in services (Abt Associates, 2016; Johnson, 2013; Shreenivas, Morillo, Seiden, & Smith, 2018). For example, one study showed that black and Hispanic patients with lung cancer were more likely to prefer palliative care over hospice and believed that the hospital was a better place to receive treatment compared with the home setting (Shreenivas et al., 2018). Other studies have found that minorities enrolled in hospice services are less likely to have advance care plans documented than do their white counterparts (Abt Associates, 2016).

Hospice programs are designed to serve any individual with a life expectancy of six months or less, regardless of the person’s disease or socioeconomic background. In response to the growing need of patients suffering from serious illness before they elect hospice care, some hospice providers now offer separate palliative care services. These services can be used for people not yet eligible for hospice or for those who decline hospice services. Palliative care is focused on the relief of pain and distressing symptoms; however, unlike hospice, these services can be provided at any stage of a serious illness and while life-extending or curative care continues. Access to the Hospice Medicare Benefit requires that all curative and life-extending treatments cease—often referred to as the “terrible choice,” which results in the refusal of some patients to elect hospice services. The Veterans Health Administration; pediatric services; and some pilot models, like the Medicare Choices Model, allow hospice support and curative and life-extending treatments to be delivered simultaneously (Mor et al., 2015; National Academies of Sciences, Engineering, and Medicine [NASEM], 2018; U.S. Centers for Medicare & Medicaid Services [CMS], 2017a).

Workforce and Role of Social Worker

The Medicare Conditions of Participation (CoP) originally mandated that hospice agencies hire individuals with a BSW or MSW (Social Work Policy Institute, 2010). In contrast, the 2008 CoP weakened social work personnel qualifications to include people with degrees in other fields related to social work (Medicare and Medicaid Programs: Hospice CoP, 2008). This change has presented grave challenges to social work job opportunities. More important, staff without social work education and training may lack skills to competently provide the psychosocial care that individuals deserve at the end of life and to meet the standards outlined in the *NASW Standards for Palliative & End of Life Care* (NASW, 2004; National Hospice and Palliative Care Organization [NHPCO], n.d.; Social Work Policy Institute, 2010).

The role of the social worker in hospice and palliative care is multifaceted; through all interactions social workers develop a therapeutic relationship with the patient and their support system in a culturally responsive manner. The social worker is uniquely qualified to complete assessments that identify patient and family strengths, needs, and treatment goals (NASEM, 2018; O’Donnell et al., 2018). The social work role includes advocacy for the patient’s wishes relative to care, care coordination, assistance with advance care planning or portable medical orders (commonly referred to as “POLST” or “MOLST” in states that allow such orders to be used), support for anticipatory grief, counseling and education regarding the illness, and guiding the post-death bereavement plan of care for the family (NHPCO, n.d.).

Interdisciplinary Group Composition

Federal law stipulates that Medicare-certified hospice programs include an interdisciplinary group (IDG) consisting of at least one physician, one registered nurse, one social worker, and one pastoral or other counselor (Social Security Act, Title XVIII, § 1861dd, 2008). The IDG plays a critical role in the provision of holistic, patient-centered hospice care services. Colocation, being physically close to other group members, helps the IDG enhance communication and collaboration within teams to better serve patients with complex needs (Ambrose-Miller & Ashcroft, 2016). Social workers, in particular, provide leadership in team collaboration with the goal of improving care coordination and engagement for patients (NHPCO, n.d.; O'Donnell et al., 2018). Common barriers to well-functioning IDGs include lack of role definition, difficulty receiving feedback, power differentiation, and time management (Ambrose-Miller & Ashcroft, 2016; Noreika & Coyne, 2015).

Hospice Trends

Hospice programs are caring for people with an increasingly broad range of illnesses. In the 1970s, most people using hospice care had cancer diagnoses. During the early 1980s and thereafter, many hospice programs were pioneers in caring for people with HIV/AIDS. By 2015, however, more than 70 percent of the people admitted to hospice had noncancerous terminal illnesses, such as heart disease, dementia, lung disease, or stroke (NHPCO, 2017b).

The provision of hospice care has changed over time, and the number of for-profit hospice programs has steadily increased, now making up 65 percent of hospices in 2015 (Medicare Payment Advisory Commission [MedPAC], 2017). Recognizing that one in four dying people in the United States is a veteran, the Veterans Health Administration has also made major investments to expand the number of palliative care teams, availability of inpatient palliative and hospice units, and the reach of community partnerships (for example, We Honor Veterans) to improve services for veterans (Abt Associates, 2016; Miller et al., 2017).

Given the national priority on controlling health care costs, the cost-effectiveness of hospice services is noteworthy. As demonstrated by multiple studies, the average cost of one day of hospice remains exponentially lower than a day of either hospital inpatient or skilled-nursing facility care, decreasing Medicare costs by more than $2,000 per beneficiary (Kelley, Deb, Du, Aldridge Carlson, & Morrison, 2013). Even more compelling than its cost-effectiveness is that hospice provides high-quality, compassionate care to individuals and families affected by terminal illness.

Reimbursement for Hospice Services

Since the Hospice Medicare Benefit became effective in 1983, there have been relatively no changes to its payment methodology (Stevenson & Huskamp, 2016). However, due to a dramatic increase in profit margins among for-profit hospice providers (Mor & Teno, 2016) and a substantial growth in the Medicare expenditure for hospice services (Hargraves & Brennan, 2016), the reimbursement model for hospice care is now experiencing greater scrutiny and reform. At the start of 2016, a two-tier payment model was implemented, paying a higher daily rate for a patient's initial 60 days under routine hospice care but a substantially lower per diem rate until seven days prior to that patient's death (CMS, 2017b). Although this model accounts for higher costs associated with a patient's hospice enrollment and death, most hospice providers will receive less reimbursement overall. This change forces hospice providers to balance the ever-increasing costs of providing quality end-of-life care with less-than-adequate reimbursement to do so (NHPCO, 2017a). In striking this balance, budgetary support for social work, pastoral counseling, and bereavement care staff and programs risk being reduced.

Length of Service

Although the number of individuals receiving hospice care continues to increase, the average length of service is declining (MedPAC, 2017). More individuals are dying within the first three weeks of their hospice enrollments, and fewer people are remaining under care for greater than 180 days (NHPCO, 2017b). Given the shorter length of service, individuals electing hospice care do so with greater psychosocial needs and higher acuity requiring more rapid and costly interventions. This decrease in patient days under hospice care will likely continue due to multiple factors: patient knowledge of end-of-life care options, the reimbursement model, and increased scrutiny of medical eligibility of those individuals with longer lengths of service (U.S. Department of Health and Human Services, Office of Inspector General, 2015). The expansion of palliative care programs, in which individuals can receive concurrent curative treatments or rehabilitative therapy services, may also be a contributing factor (Meier

& Bowman, 2017). Social workers serve an important function in preparing providers on the team to discuss end-of-life care options with families and facilitating conversations about a patient’s goals of care (NHPCO, n.d.; O’Donnell et al., 2018).

Underserved Populations and Access Barriers

Although the Patient Protection and Affordable Care Act of 2010 (ACA) (P.L. 111-148) has reduced the number of uninsured people in the United States, a significant portion of the population remains at risk of not accessing hospice or palliative care. As previously mentioned, people of color are underrepresented among hospice participants and there is need for further research about racial disparities in the use and quality of palliative and end-of-life care (Johnson, 2013; NHPCO, 2017b). Studies have identified several barriers to hospice access and use by African Americans: distrust of the health care system, low awareness regarding hospice services, economic factors, lack of racial diversity among health care staff, and spiritual beliefs (Bullock, 2011; Johnson, 2013; NASEM, 2017). Barriers to hospice care for Hispanic or Latino patients may include immigration status, language barriers, concerns about discrimination, and cultural values held within families (Carrion & Bullock, 2012; NASEM, 2017). Access barriers to hospice and palliative care programs are also significant in rural areas and community hospital settings (Hawley, 2017).

Quality of Care

In 2010, the ACA mandated a Hospice Quality Reporting Program, which includes data on quality assessment measures submitted by hospices through the Hospice Item Set and data on a post-death family caregiver survey (Social Security Act § 1814[i][5]). Both forms of quality reporting are similar to those for other Medicare providers and represent advancement in measuring hospice quality of care. The reporting of data is voluntary, but hospices face a reduction in Medicare payments for failure to report. The CMS Hospice Compare Web site publicly reports data from almost 4,000 hospices on required measures related to symptom management and goals of care. In addition, Medicare mandated a Quality Assurance and Performance Improvement program for hospices in 2010, with reporting to CMS. The measures allow providers and consumers to preview quality-of-care information and help patients make informed decisions about where to seek care.

POLICY STATEMENT

NASW supports

- promotion of optimal physical, mental, emotional, social, cultural, spiritual, and functional quality of life for individuals facing terminal illness and for their defined families and caregivers
- the right of self-determination in end-of-life choices; individualized, person-centered care; and dignity throughout the end-of-life process and after death
- elimination of disparities in access to and utilization of hospice and palliative care; availability of hospice services to individuals and families affected by terminal illness, without respect to race, ethnicity, language, or national origin; geographic location; migration background and documentation status; biological sex, gender identity, and gender expression; sexual orientation and marital or partnership status; spiritual, religious, and political belief or affiliation; mental and cognitive ability; ability to pay; and complexity of care
- promotion of culturally diverse staff and cultural and linguistic competence in the delivery of hospice and palliative care services
- enhanced consumer and professional education about palliative and hospice care
- continued implementation of reporting measures focused on quality of hospice care provided
- availability of hospice care across home and community-based settings to enable people to die in their setting of choice; expansion of in-home caregiver options to allow for hospice services in the setting of choice
- well-timed access (sufficiently early) for the patient and family to benefit from the full continuum of hospice services including ancillary services

such as physical therapy, occupational therapy, speech therapy, art therapy, and other services

- preservation and integrity of hospice benefits through Medicare and Medicaid, Veterans Health Administration, and private commercial insurance policies; access to multiple hospice benefit periods for individuals with terminal conditions
- restoration and maintenance of sustainable reimbursement rates for hospice programs and palliative care services expansion of concurrent care options (simultaneous hospice and curative care) for pediatric and adult patients
- participation of individuals with terminal illness and their families in the design, implementation, and evaluation of programs, policies, and research related to hospice care
- promotion of interdisciplinary collaboration as essential to quality hospice care delivery and professional sustainability
- adherence to IDG composition, as outlined in the Medicare CoP, across all hospice settings
- standardization of oversight across all nonprofit and for-profit hospice settings
- expansion of medical and psychosocial treatments to ease pain, anxiety, and other symptoms associated with terminal illness and dying
- commitment to enhance the essential role of professional social workers to provide comprehensive psychosocial support services within hospice care programs and to ensure access to the benefit of the full range of social work interventions
- professional social work education and training as a prerequisite for hospice social work and a commitment to ongoing professional development including availability of certification in hospice and palliative care.

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Policy statement approved by the NASW Delegate Assembly, November 2020. This policy statement supersedes the policy statement on Hospice care approved by the Delegate assembly in august 2011. For further information, contact the National association of social Workers, 750 First Street, NE, Suite 800, Washington, DC 20002-4241. Telephone: 202-408-8600; e-mail: press@socialworkers.org

Housing

ISSUE STATEMENT

Adequate, affordable housing is a basic right that is critical for the well-being of individuals and families and is recognized as a principle of international human rights law (Keyes, 2007; United Nations, n.d.). Housing and community environments that meet the universal need for shelter, privacy, and positive social relationships are essential for stable family life, personal development, and health and safety. The benefits of decent, affordable housing in financial and human terms are well documented. Consistently, the lack of affordable and high-quality housing is associated with poverty, racism, and declining social capital as well as homelessness (Nelson & Saegert, 2009). Social workers often encounter the devastating effects of housing instability on individuals and families, and we have a critical role in advancing programs and policies that promote access to stable housing opportunities. Historically, federal housing policy development has occurred in waves of disconnected housing policies (Marcuse & Keating, 2006). Still missing is a national policy on housing that ensures equity and champions human needs and healthy communities (Dreier, Mollenkopf, & Swanstrom, 2001).

Fair Housing

The foremost federal policy, the 1968 Fair Housing Act (P.L. 90-284), was passed by Congress in Title VIII of the Civil Rights Act of 1968. The U.S. Department of Housing and Urban Development (HUD) administers and enforces the act, through HUD’s office of Fair Housing and Equal Opportunity (FHEO). FHEO administers federal laws and policies that ensure all Americans have equal access to the housing of their choice and prohibits discrimination in housing on the basis of race, color, religion, sex, national origin, age, disability, and familial status.

Despite the passage of the Fair Housing Act in 1968, some individuals and families still cannot secure appropriate shelter because of the pernicious effects of racism, sexism, ageism, ableism, and other causes of disparate treatment and stigma. In 2014, the National Fair Housing Alliance (NFHA) catalogued more than 20,000 housing discrimination complaints nationwide and estimated that 4 million violations occur each year (NFHA, 2015). This inability to have affordable and accessible housing can trigger other negative quality-of-life indicators. According to NFHA (2015), "where you live determines whether or not you have access to a high-performing school, fresh foods, reliable transportation, good job, quality health care, and recreation in a green space" (p. 1). Thus, focused attention to enforcing fair housing can reverse the cascading events that contribute to poverty, health disparities, mortgage foreclosures, homelessness, and other factors that affect general well-being. Access to housing that is affordable and safe is aligned with the social work values of social justice and the dignity and worth of all people. Whether practices are intentional or have discriminatory effects, they can result in cumulative disadvantages and poor outcomes for vulnerable and marginalized groups.

Housing Supply and Affordability

In the 1949 Housing Act (P.L. 81-171), Congress determined the national goal to be "a decent home and a suitable living environment for every American family." Today, the supply of suitable and affordable housing to meet the diverse needs of individuals and families in the United States continues to be inadequate (Atlas & Drier, 2007; Bratt, Stone, & Hartman, 2006; Robert Wood Johnson Foundation [RWJF], 2011). In fact, housing has become more expensive as the rising costs have outpaced wage increases. The generally accepted standard of affordability is that one's housing is affordable if it costs no more than 30 percent of household income (Crowley, 2016). Housing costs include rent or mortgage payments, utilities, and property taxes and insurance. A household that spends more than 30 percent of income on housing is considered to be housing cost burdened; spending more than 50 percent of income is a severe housing cost burden. In 2014, there were 117.2 million households in the United States; of all households, 35 percent were cost burdened and 14 percent were severely cost burdened (Joint Center for Housing Studies of Harvard University, 2016).

Most low-income households are renters, and the affordability problems of low-income renters are stark (Joint Center for Housing Studies of Harvard University, 2016; RWJF, 2011). In 2014, there were 10.4 million extremely low-income renter households, and they faced an acute shortage of housing options. For every 100 extremely low-income renter households nationwide, there are only 31 affordable and available rental homes (National Low Income Housing Coalition, 2016a). Whereas some markets are more affordable than others, nowhere in the United States is there a sufficient supply of affordable housing. In no U.S. city or county can someone working full time at the prevailing minimum wage afford even a modest one-bedroom rental home.

The *housing wage* is what one must earn to rent a unit at the fair market rent, paying no more than 30 percent of income and working full time. In 2016, the national housing wage was $20.30 an hour for a two-bedroom home and $16.35 an hour for a one-bedroom home, which far exceeds the federal minimum wage of $7.25 per hour (National Low Income Housing Coalition, 2016b). The most expensive metropolitan area in 2016 was the San Francisco area, at $44.02 an hour (National Low Income Housing Coalition, 2016b).

These data contribute to an explanation for homelessness in the United States (Crowley, 2016), but the population of marginally housed people far exceeds the homeless population. The consequences of this acute housing shortage are dire. When a poor family spends an excessive amount of its income on housing, there is not enough left for other basic needs, let alone savings. The smallest disruption in income (for example, a sick child, a reduction in work hours) can force a downward spiral into eviction. An eviction makes every housing choice after that less desirable, with the threat of overcrowding, wretched physical conditions, and exploitation (Desmond, Gershenson, & Kiviat, 2015). Some people may have family or friends who will take them in, but “doubling up” is unstable more often than not. Being dependent on someone else for a place to sleep at night puts women and their children at risk of physical, emotional, and sexual abuse (Edin & Shaefer, 2015).

At-Risk Populations

Housing serves as an essential element in creating a stable environment for individuals living with special needs. Funds for particular populations are directed through various federal agencies and may include funding for housing infrastructure or support services. For example, the Family Unification Program extends housing vouchers to youths who have aged out of foster care (Torrico & Bhat, 2009). Under HUD, the McKinney–Vento Homeless Assistance Act of 1987 (P.L. 100-77) programs support a wide range of housing and service models at the local and regional levels for individuals and families experiencing homelessness. Housing assistance can include emergency housing or shelters, transitional housing, permanent housing, and supportive housing. For veterans, HUD and the U.S. Department of Veterans Affairs collaborate on offering specific voucher programs. Other opportunities that address housing needs include public housing, Community Development Block Grants, and tax credits that encourage the maintenance and development of housing stock.

Service-enriched housing models, whereby service providers are linked to housing developments, have the ability to provide early intervention and therapeutic services to at-risk populations and often employ social workers. Housing is perhaps the single most stabilizing factor in a person's health and a critical component of recovery for those living with a mental illness or substance use disorder. Research has established the benefit of supportive housing as a stabilizing, cost-effective model for addressing chronic homelessness for individuals living with serious and persistent mental illness (Center for Outcomes Research & Education, Providence Health & Services, 2013; Culhane, Metraux, & Hadley, 2002). The expanded use of supportive housing for other at-risk populations, for example survivors of domestic violence, youths aging out of foster care, chronically homeless families, high-use Medicaid recipients, and formerly incarcerated individuals will significantly decrease public expenditures by reducing the reliance on other publicly financed service systems. In the case of those who have frequent contact with the criminal justice system, supportive housing has been shown to reduce violations and recidivism (Frequent Users Service Enhancement, 2014). Rynearson, Barrett, and Clark (2010) determined that successful housing programs included low-barrier access and wraparound services that were not required for the housing itself, like the Housing First model, which encourages client self-determination. The NASW policy statement on homelessness includes a wider discussion of Housing First and other housing models for people in homeless situations (NASW, 2015b).

Housing, Community Infrastructure, and Quality of Life

In the past there was little integrated planning for housing and the community infrastructure where individuals could live suitably and meet their economic and social needs; such planning must be encouraged in urban and rural areas. Housing is inextricably linked to quality of life across the life span. The availability and affordability of a continuum of housing options, ranging from supportive to independent, is critically important to the domain of life satisfaction (Zebardast, 2009). Being properly sheltered is positively correlated with mental health and well-being. According to an RWJF (2011) report on health and housing, factors associated with housing quality have the potential to help or harm health in major ways. The links to health include the physical conditions of homes, neighborhood, and surroundings. Housing is a social determinant of health and is linked to the abilities of families and individuals to make healthy choices. *Social determinants of health* “are the economic and social conditions that affect health outcomes and are the underlying, contributing factors of health inequities” (Corporation for Supportive Housing, 2014, p. 2). Unfortunately, where people live or the absence of a place to live is too often determined by factors of race, income, and ethnicity (Johnson, 2016). Thus, social justice, a foundational value of the social work profession, is woven into the fabric of housing and must be a strong consideration throughout the life span in improving the human condition by preventing the loss of housing, lack of access to housing, and social isolation.

Predatory Lending Practices

Predatory lending tactics contributed to the 2008 financial crisis by targeting vulnerable people who lacked credit to qualify for conventional loans and directed them to high-cost, high-fee loans and mortgages that they were unable to pay. These legal but unfair practices led to foreclosures on homes across the country. The Dodd–Frank Wall Street Reform and Consumer Protection Act of 2010 (P.L. 111-203) and subsequent legislation, including the 2013 Home Ownership and Equity Protection Act Rule, sought to remedy these practices through measures that regulate financial institutions, demand more transparency, require consumer education, protect from excessive loan rates and fees, and require appropriate consideration of a borrower’s financial status. The Consumer Financial Protection Bureau supports consumers through enforcement of legislation and education of the public on these issues.

Equitable Development

Equitable development is an approach to creating healthy, vibrant communities through intentional strategies that encourage full participation in neighborhood life and decision making (PolicyLink, n.d.). Communities that afford equity include low and moderate income housing opportunities to live where housing costs are rising and where gentrification is forcing lower-income residents out. Strategies that can advance and support affordable housing include retaining subsidized housing by government renewing or refinancing subsidies, ensuring code enforcement to protect housing quality, rent control and eviction control measures, cooperative housing, and other practices like community land trusts that are owned by nonprofit corporations to support affordable housing and community development. Inclusionary development approaches that make use of local zoning and development regulations can promote equal access to good schools, economic opportunities, and healthy environments even in more exclusive neighborhoods.

Social Work Leadership

The profession's *Code of Ethics* (NASW, 2015a) compels social workers to combat social injustice and engage in social and political action to advance well-being. Social workers as individual practitioners, as well as through their agencies and organizations, can be instrumental in advocating for equal access to housing opportunities, preserving affordable housing, identifying best practices for housing assistance and homelessness prevention, and advancing policies that support these aims. The Grand Challenges for Social Work Initiative outlines an agenda for transformational social progress, and many identified areas are related to housing, including goals to end homelessness, reduce extreme economic inequality, and eradicate social isolation (American Academy of Social Work and Social Welfare, 2017). The initiative encourages the social work community to coalesce around identified challenges and elevate the role of social work education, research, and practice to stimulate social change.

POLICY STATEMENT

NASW supports the following:

- the right of all individuals and families to have affordable housing that meets their basic needs for shelter and provides for a rewarding community life
- a national housing policy that views housing as a social utility and a basic human need for all income groups and includes programs of government-sponsored or nonprofit rental housing, cooperative housing, the rehabilitation of housing, and homeownership
- fair housing laws that encompass discriminatory effects that are both unintentional and intentional
- housing policies that ensure the availability of accessible housing to meet diverse needs across geographically distributed areas
- the adoption of policies at all levels of government that stimulate and support the rehabilitation, construction, and maintenance of rented and owned dwellings to meet the needs of all populations
- programs to revitalize deteriorated public housing structured in such a manner as to ensure that there is no reduction in the number of affordable

housing units in the community and that maximum possible efforts are undertaken to preserve existing neighborhoods and communities

- investment in translational social work research to determine and implement best practices in housing assistance, housing programs, and housing policy
- federal, state, and local government programs, including housing trust funds and land trusts, that provide the maximum possible funding to assist with the production, operation, and maintenance of affordable housing, through both homeownership and rental assistance programs; such funding should be available to both public and private (including commercial and nonprofit) organizations
- varied public and private sector efforts to meet the housing needs of Americans with low incomes and vulnerable incomes; options should be based on the needs of the individual and provide maximum level of autonomy including shared or accessory housing, single-room occupancy housing, and congregate-living arrangements
- social work and citizen participation and community involvement in development of housing policy, specifically including individuals who will benefit from housing
- inclusive decision making about housing planning and operation by consumers, tenants, landlords, real estate and building interests, and community groups
- new housing development or existing housing rehabilitation linked to employment opportunities and community services
- social work education that highlights effective housing policy and practice
- expansion of supportive housing models that provide services for at-risk populations and facilitate integration in communities
- promotion of low-threshold housing and Housing First model as health interventions for those experiencing homelessness or marginally housed
- testing and enforcement of fair housing and financing laws
- enforcement and expansion of the Community Reinvestment Act of 1977 (P.L. 95-128)

- recognition of housing programs as integral to national economic growth and stability
- income tax codes, property assessments, and monetary policies that address the needs of low-income people.

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Human Trafficking

ISSUE STATEMENT

According to the U.S. Department of State (2015), *human trafficking*, which has been broadly cast as “modern slavery,” is a term used to represent the act of recruiting, harboring, transporting, providing, or obtaining a person for compelled labor or commercial sex acts through the use of force, fraud, or coercion that may or may not include movement. By definition, human trafficking includes, but is not limited to, involuntary servitude. According to the Victims of Trafficking and Violence Protection Act of 2000 (P.L. 106-386), as amended (and often referred to as the Trafficking Victims Protection Act, or TVPA) and further articulated within the United Nations (UN) Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children (UN, 2000), human trafficking includes a number of different terms related to compulsory service, including involuntary servitude, slavery or practices similar to slavery, debt bondage, and forced labor. The Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children (UN, 2000) specifically defines *human trafficking* as

> the recruitment, transportation, transfer, harboring, or receipt of persons, by means of threat or force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power, or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs. (p. 2)

Human trafficking is a complex criminal enterprise affecting millions of individuals and families domestically and internationally. The human trafficking industry is so extensive that it has become the second most profitable criminal industry in the world—second only to drug trafficking (Neumann, 2015). The International Labour Organization (ILO) (2016) reports that human trafficking generates approximately $150 billion within the private global economy, with this significant capital further fueling human trafficking and other criminal enterprises in the underground marketplace (U.S. Department of State, 2015). Across cultures, research has demonstrated that the most salient variable associated with human trafficking is poverty and the vulnerabilities poverty engenders (Sabella, 2011; Talbot & Ose, 2005). Although there are competing perspectives regarding the nature of human trafficking, it is important to note that it is a highly complex phenomenon driven by economic globalization and accompanying global migration (Alvarez & Alessi, 2013). Globalization and global migration are inseparable from gender-bound processes of negotiation that influence the social and economic status of women (Finn, Perry, & Karandikar, 2013). These realities underscore the disproportionate impact of human trafficking on the lives of women in the United States and throughout the world (Alvarez & Alessi, 2013). Intimately associated with economic globalization and global migration is the exploitation of Internet technology, which is another major contributor to the escalation of human trafficking throughout the world. Traffickers use Internet technology, smartphones, and other digital devices to recruit, market, and negotiate the sale of people, primarily for sexual services (Farley, Franzblau, & Kennedy, 2014).

Although individuals who are trafficked represent people across the developmental and gender spectrum, different types of trafficking demonstrate differing levels of vulnerability based on age and gender. The ILO (2016) estimates that of the approximately 21 million people who are ensnared in involuntary servitude, 11.4 million are women and girls and 9.5 million are men and boys. Internationally, there are 19 million victims exploited by private individuals or enterprises, and over 2 million by state or rebel groups. Of those exploited by individual traffickers or enterprises, 4.5 million are forced into sexual exploitation (ILO, 2016). Globally, women and girls account for approximately 56 percent of all people engaged in forced labor. These gender disparities are more profound as they relate to people who are trafficked within the commercial sex industry. It is estimated that women and girls account for a staggering 98 percent of all people trafficked for purposes of sexual exploitation, with men and boys, who are viewed as a profitable commodity within the sex industry, making up the remaining 2 percent.

Clearly human trafficking is a global problem; however, it is important to note that "global" is quite local. It is estimated that 14,500 to 17,000 individuals are trafficked across international borders into the United States annually (Muftic & Finn, 2013). It is further estimated that 400,000 domestic minors have been trafficked within the United States (Dovydaitis, 2010). Among the more than 188 countries reporting human trafficking activity, the United States serves as both a central transit and destination point for the trafficking of legions of men, women, boys, girls, and transgender people (U.S. Department of State, 2015). The United States has been identified as the most common destination point for people being trafficked from Mexico, Central America, and the Caribbean. The United States is also one of the primary destinations for people being trafficked from East Asia, South Asia, Africa, and Europe (Hepburn & Simon, 2010). The trafficking of people in the United States is evident in both legal and criminal industrial sectors inclusive of commercial sex, hospitality, sales crews, agriculture, manufacturing, janitorial services, construction, shipyards, restaurants, health and elder care, salon services, fairs and carnivals, peddling and begging, and domestic service (U.S. Department of State, 2015). Although the role of the United States as a major vehicle through which the trafficking of people from around the globe is significant, it must be understood that the trafficking of people with U.S. origins is an escalating problem with a long and veiled history. Data indicate that the trafficking of U.S. citizens and legal residents is heavily concentrated within the commercial sex industry (Hepburn & Simon, 2010).

The U.S. Department of State (2015), ILO (2012), and others (Godoy, Sadwick, & Baca, 2016; UN Office on Drugs and Crime [UNODC], 2012) have noted the incompleteness of statistical data regarding the sheer expanse of the global human trafficking industry; therefore, reported estimates must be interpreted with caution. Issues that impede the reliability of estimates regarding the incidence and prevalence of human trafficking include its illicit nature, the parallel crimes associated with human trafficking, the lack of uniform human trafficking reporting, and the lack of a centralized human trafficking database (Task Force on Trafficking of Women and Girls, 2014; UNODC, 2012). Despite the limitations of global estimates of human trafficking, existing numbers, which are arguably underestimated, clearly underscore the escalating proliferation of human trafficking in the United States and throughout the world. It should be further noted, however, that statistics regarding the global presence of human trafficking do not begin to capture the magnitude of its human toll. The multisystemic impact of human trafficking on individuals, families, communities, and societies across the globe is immeasurable. Human trafficking not only diminishes the human dignity of people being trafficked, but also represents a global assault on human rights and the pursuit of social justice. The threat of human trafficking to the safety and well-being of the world's citizens is indeed among the most pressing issues on the globe.

Forms of Trafficking

Identified in the literature are two primary forms of human trafficking: forced labor and sexual servitude, each with a host of subcategories. The most prevalent form of human trafficking is sexual servitude and forced prostitution. Internationally, forced prostitution takes many forms: street-level prostitution (to include forced drug-based sexual exchanges), computer-assisted prostitution, call operations, brothel operations, gang-related prostitution, male prostitution, cab operations, generational prostitution, and mail-order brides (Hoerrner & Hoerrner, 2013). Labor trafficking occurs in legal and illegal businesses such as mining, housecleaning, agriculture, dressmaking, child care, and others. The trafficking of children for child soldiering is a common phenomenon in underresourced countries (Farley et al., 2014). Although there are distinct categories of trafficking, it is important to note that quite often its victims simultaneously experience multiple forms of exploitation (Godoy et al., 2016).

People who are trafficked reflect a complex host of intersectional vulnerabilities inclusive of micro-level realities as well as broad, macro-level structural factors that contribute to marginalization and stigmatization. At the micro level, issues such as gender, age, membership in a marginalized group, family disruptions, history of trauma, developmental delay, substance addiction, cognitive or emotional disability, or immigrant or refugee status may contribute to human trafficking vulnerability. At the macro level, forces that maintain systems of inequality that contribute to microlevel vulnerabilities to human trafficking include globalization, poverty, political instability, war, and forced migration (Task Force on Trafficking of Women and Girls, 2014).

The trafficking of minors for sexual purposes is known as the commercial sexual exploitation of children (CSEC) or domestic minor sex trafficking. The use of children in the commercial sex trade is prohibited under U.S. law, and by statute in most countries in the world (U.S. Department of State, 2015). Despite existing legal barriers, the Federal Bureau of Investigation (FBI) indicates that CSEC is a growing phenomenon in urban and large metropolitan areas domestically and throughout the world (FBI, 2016; Kotrla, 2010).

Sex trafficking has devastating consequences for victims, especially children and adolescents. They experience long-lasting physical and psychological trauma such as disease, drug addiction, unwanted pregnancy, malnutrition, social ostracism, and death (U.S. Department of State, 2015). Victims come from all socioeconomic backgrounds. Many trafficked minors come from abusive or troubled families and from families with limited resources. Often they are homeless and have run away from home or from the child welfare or juvenile court systems. Common among these children and youths is the instability in living situations, physical distance from family and friends, and emotional vulnerability, placing them at risk for trafficking (National Center for Missing and Exploited Children, 2016). Some children and youths are estranged from their families because of their lesbian, gay, bisexual, transgender, or queer (LGBTQ) identity. These children are more likely to be homeless, making them increasingly vulnerable to traffickers (Ryan & Rivers, 2003). Technology has contributed to an increased vulnerability among children who meet traffickers online in chatrooms and through other Web-based social media outlets.

Traffickers

Traffickers come from diverse backgrounds, making them very difficult to identify. Hoerrner and Hoerrner (2013) described them as having "foxlike" intelligence. Often they are simultaneously involved in the selling or smuggling of guns, drugs, or other illegal activities. Frequently they are members of the victim's own ethnic or national community and living in the United States with legal status. Some are part of a mom-and-pop enterprise involving extended family, sometimes on both sides of national or international borders. Traffickers are male and female.

Traffickers may own, or have owned, businesses that provide laborers for agricultural work, construction, restaurants, or janitorial services and others. Traffickers may be from organized criminal networks and gangs but more often are found in loosely formed networks, or operating independently (Walker-Rodriguez & Hill, 2014). International traffickers may have greater social status in their home country than their victims. They may be diplomats or consular figures. They may be representatives of international organized criminal syndicates (Farley et al., 2014).

Frequently, U.S.-born traffickers are pimps and panderers with commercial sexual motives or predators with noncommercial sexual motives (Hoerrner & Hoerrner, 2013). Often they are relatives, casual acquaintances, close friends, or friends of friends of their victims. They use their relationship of trust to kidnap or lure the victim into the process of being trafficked (Walker-Rodriguez & Hill, 2014).

Federal Policies

The cornerstone of federal human trafficking legislation is the TVPA (2000), which was reauthorized in 2003, 2005, 2008, and 2013. This legislation was designed specifically to prosecute traffickers, prevent human trafficking, and protect victims and survivors of human trafficking. The TVPA established human trafficking and related offenses as federal crimes, attaching severe penalties for violations and mandating restitution for victims. It further authorized the establishment of the T visa, allowing victims and their families to become temporary U.S. residents and eligible to become permanent residents after three years.

Subsequent reaffirmations have enacted legislation that expands protection for victims and increases the ability of the government to take legal action against traffickers. Changes have included the following: civil right actions for victims to sue their traffickers, the establishment of human trafficking as a crime of racketeering, protection from deportation for families, a mandated annual report to Congress on the fight against trafficking known as the *Trafficking in Persons* report (U.S. Department of State, 2015), a pilot program to shelter minor victims of human trafficking, grant programs to assist law enforcement combat of human trafficking, a US$5 million program for treatment of victims abroad, strengthened regulation to ensure government contracts with individuals and organizations that have not engaged in human trafficking, provision of workers' rights to all people applying for work and education-based visas, new systems for reporting and gathering human trafficking data, expanded T visa protection, mandating that all unaccompanied alien children be screened as potential victims of human trafficking, enhanced criminal sanctions against traffickers, expanded definitions for greater strength in prosecution of traffickers, greater prevention in the sale of products made by victims of human trafficking, protection against child marriage, emergency response systems to disaster areas and crises where there is the potential for human trafficking, and strengthening the ability of state and local law enforcement to charge and prosecute traffickers (Polaris Project, 2016). In 2014, the Preventing Sex Trafficking and Strengthening Families Act (P.L. 113-183) was signed into law. This federal legislation provides for changes to existing child welfare laws to include specific actions states must take with respect to the identification and protection of children and youths who are trafficking victims or at risk of being trafficked. Two specific provisions of this legislation are of particular importance to social workers: (1) state child welfare agencies must immediately report children in their care identified as victims of sex trafficking to law enforcement, and (2) state child welfare agencies are mandated to report the numbers of children in their care identified as being victims of sex trafficking to the U.S. Department of Health and Human Services (National Conference of State Legislatures, 2016).

In addition to key federal legislation, it is also important to note that nationally, all 50 states and the District of Columbia have passed legislation aimed at combatting human trafficking (Polaris Project, 2014). Inclusive of state-based anti-trafficking legislation are safe harbor laws, which outline protective provisions for trafficked minors. The two key components of safe harbor laws are legal protection and service provision (Polaris Project, 2015). In 2014, more than 31 states enacted new anti-trafficking laws, with all of them including key provisions addressing child trafficking and the development of rehabilitative services for trafficked youths (National Conference of State Legislatures, 2014). Although safe harbor laws vary from state to state, they include measures designed to prevent trafficked youths from entering the justice system. These provisions include immunity from prosecution, affirmative defense, pretrial diversion, and record clearing policies. In addition to subverting involvement in the criminal justice system, these safe harbor laws also include requirements for reporting to Child Protective Services and provision of funding specifically allocated for provision of services to trafficked minors, coordination of services, and the collection of state trafficking statistics (National Conference of State Legislatures, 2014; Polaris Project, 2015).

Practice Implications

Given the profession’s positioning on the frontlines of intervention with vulnerable populations—including women, children, youths, LGBTQ people, and people living in poverty— whose vulnerable status contributes to them being the most common targets of human trafficking, it is essential that we sustain a leadership role in advancing the struggle against human trafficking in all of its forms and in both domestic and global contexts. Ultimately, our struggle against human trafficking is a fight for the advancement of social justice. This struggle necessitates that social workers not only gain fundamental knowledge regarding human trafficking, but also gain practical training regarding the application of professional knowledge, values, and competencies in the implementation of multisystemic interventions with people across the human trafficking continuum.

POLICY STATEMENT

The growing awareness of human trafficking in the United States and abroad requires governmental and nongovernmental entities to rethink old policies and develop new ones for identifying and serving victims. Many states have established their own definitions of commercial sexual exploitation and sexually exploited children. These definitions affect how these children are treated (as victims or as delinquents), the involvement of child welfare, and their eligibility for services.

NASW supports the following policies and practices:

Public Awareness and Advocacy

- public education campaigns that teach communities to recognize the warning signs of all aspects of human trafficking and to report suspicious behavior to the appropriate social services or law enforcement agency
- successful initiatives and best practices for service provision to human trafficking survivors, and to help survivors to engage in services that aid in the development of sustainable livelihoods
- improvement and continued reauthorization of the Trafficking Victims Protection Reauthorization Act of 2013 (H.R. 898, 2013) and the Preventing Sex Trafficking and Strengthening Families Act (P.L. 113-183) to continue and expand services to human trafficking survivors.

Professional Development and Continuing Education

- development and implementation of culturally competent, survivor-informed social work curricula that prepare students to meet the complex and specific needs of human trafficking survivors, whether global and domestic
- interprofessional education, training, and collaboration among social workers and human service, health care, and law enforcement professionals regarding the identification of human trafficking indicators, with strategies and tools to improve screenings in their respective settings

and knowledge of resources and technical assistance to develop and sustain services to survivors.

Services to Victims and Survivors

- social workers taking leadership in further developing multidisciplinary, comprehensive, coordinated services, applying best clinical practices, and formulating appropriate public policy for helping people emerging from trafficking
- helping government, tribal, nongovernmental, and community-based organizations to address both short- and long-term needs of survivors, including developing mechanisms to protect victims who come forward, and families vulnerable to retaliation and threats by traffickers in their home country or community; medical and psychological health; financial stability; and social and familial stability.

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Immigrants and Refugees

ISSUE STATEMENT

Immigration and the national approach to accepting refugees are complex policy issues for the United States. Often the terms “migrant” and “refugee” are used interchangeably, but there is a legal difference between the two. A *refugee* is a person unable or unwilling to return to their country of nationality due to the potential for persecution based on a variety of factors, whereas a *migrant* is a person seeking residence in another country for economic or other reasons and an *immigrant* is a person who moves from one country to settle in another with or without documentation (U.S. Department of Homeland Security, 2017).

It is important to note that both migrants and refugees who have resettled in the United States have helped increase the domestic work-force and have been critical to the establishment of our country (Zong & Batalova, 2017). Yet some Americans describe immigrants and refugees as threats and at risk of committing domestic terrorism or creating a financial drain on the economy. Immigration issues are often at the forefront of political debates. Social workers play a vital role supporting immigrants and refugees through behavioral, physical, and employment needs.

Comprehensive Immigration Reform

The national debate over the country’s response to the millions of undocumented immigrants living and working in the United States has been ongoing for decades. For the most part, it focused on the flow of undocumented individuals and families from Latin America, but immigration from other areas in the world is also rising as a result of turbulent conditions. It would be incredibly challenging, if not impossible, to completely seal our borders and equally impossible to deport the millions of undocumented individuals already here, as well as make up for the economic contributions to the U.S economy (Soregel, 2017). Therefore, the issue of passing a comprehensive immigration reform bill that would provide policies and procedures that clarify and redefine the immigration status of currently undocumented residents is integral to the social and economic health of our country. Recent steps taken by the executive branch to ban immigrants and refugees from certain countries is both legally questionable and antithetical to the principles of our Constitution and the social work profession, and indicates a rise in anti-immigrant sentiment on the populist level.

Deferred Action for Childhood Arrivals and Deferred Action for Parents of Americans and Lawful Permanent Residents

An issue directly associated with immigration reform is the dilemma of so-called dreamers or, more formally, childhood arrivals. These are undocumented individuals who were brought to the United States by their parents before the age of 16. Given that most early childhood arrivals grew up in this country, are fully integrated into U.S. society and may have never visited their country of origin, there was an effort to create a special immigration status and a path to citizenship for them. In 2014, President Barack Obama signed an executive action known as Deferred Action for Childhood Arrivals (DACA) to grant protected status to this population. Although the executive action was signed by the president, a federal court ruled that he exceeded his power to take such action. Therefore, DACA has yet to be implemented. Second, executive actions by a president can be overturned or modified by an incoming president who may disagree with policy.

Closely aligned with DACA is the Deferred Action for Parents of Americans (DAPA) program that is designed to limit the risk of deportation of the parents of dreamers. DAPA was also created by way of an executive action by President Obama. Court orders have prevented it from being implemented, and there is uncertainty as to whether President Trump will overturn the executive action that created it. Approximately 9 million children in the United States have parents who are not documented, the majority from Mexico and Latin America; of those, about half are U.S. citizens living in mixed-status families and incurring the negative biopsychosocial and economic repercussions of living under the radar (Passel, Cohn, Krogstad, & Gonzalez-Barrera, 2014).

Immigration Enforcement, Detention, and Deportation

The arrests and detention of many individuals daily has been an ongoing issue, resulting in racial profiling of entire communities. At present, U.S. Immigration and Customs Enforcement (ICE) maintains a capacity for detaining as many as 34,000 people in about 257 facilities, most of which are privately owned; lack necessary services, standards, and living conditions; and receive minimal federal oversight (American Immigration Center, 2015). The concerns for the conditions and circumstances of those who are detained include lack of due process and legal representation, with some detainees serving indeterminate sentences. Detention can precipitate family breakup, negatively affect mental health, and result in poor child welfare outcomes (Human Rights Watch, 2015).

Since 2011, the United States has seen a dramatic increase in arrivals of immigrant families across the southern border. During the last two years, ICE apprehended more than 100,000 immigrant families, primarily Central American women traveling with their children fleeing violence and economic peril (Gonzalez-Barrera, Krogstad, & Lopez, 2014). Despite potentially being eligible for a variety of immigration relief options, men, women, and children are often detained first in small holding cells and subsequently in large facilities without access to legal representation and other services. In fact, the summer of 2014 marked the reinstitution of immigrant family detention, a practice that had been largely discontinued in the United States following litigation in 2009. Negative and enduring biopsychosocial impacts of detention compound the trauma and violence many experienced before and during migration.

Unaccompanied Migrant Children

The issue of unaccompanied migrant children from Central America reached a crisis stage in 2014 when close to 70,000 children crossed the U.S.–Mexican border (U.S. Customs and Border Protection, 2016). That number dropped to about 40,000 in 2015, but rose to 59,000 in 2016. The concerns for this population include their uncertain immigration status, return to the country of origin from which they were fleeing, exposure to human trafficking and sexual exploitation, being maintained in U.S. resettlement centers that are de facto prisons, and being placed in state foster care systems and relocated.

Exploitation and Human Trafficking

Immigrants in the United States, and undocumented immigrants in particular, are vulnerable to exploitative work environments, ranging from unsafe work conditions and wage violations to human trafficking. Human trafficking includes the exploitation of men and women, both adults and children, through force, fraud, or coercion, into a wide range of industries, including construction, janitorial services, domestic servitude, agriculture, and the commercial sex industry. Some immigrants are trafficked from their country of origin to the United States, whereas others are trafficked in route to or after voluntarily migrating to the United States. Exposure and vulnerability to human trafficking and exploitation are exacerbated by a host of aspects often related to the context of immigration (gender and economic inequality; anti-immigrant and nativist sentiment; social isolation; language proficiency; access to employment; legal immigration status; and lack of knowledge of rights, laws, and services).

Given challenges with identification, low rates of formal reporting, and traffickers' strategies to evade detection, our grasp of the scope and prevalence of immigrant exploitation and human trafficking in the United States remains difficult (Nichols & Heil, 2015). Some estimates suggest that there may be as many as 2.4 million undocumented Mexican immigrants trafficked in labor settings alone—for example construction, janitorial services, and agricultural work (Reeves Miller Zhang & Diza, PLC, 2012). Challenges faced by immigrants of color; the immigrant lesbian, gay, bisexual, transgender, and queer community; and other marginalized immigrant groups are often aggravated or overlooked.

Humanitarian Response to the International Refugee Crisis

A global humanitarian crisis is now underway, with the largest number of people in transit since World War II. Refugees are the single most vetted group of immigrants who enter the United States, passing through a grueling screening process that takes a minimum of 18 months and up to an entire generation for individuals and families to enter our country. Since 1975 over 3 million refugees have resettled in the United States, and through the aid of more than 300 local resettlement agencies in every state, refugees are able to contribute to their communities by gaining employment, attending school, paying taxes, and integrating into our society while maintaining their cultural identity (U.S. Department of State, n.d.).

POLICY STATEMENT

NASW supports the following:

- spreading increased education and awareness of the dynamics of global migration and of the impact of the United States and other countries' immigration and foreign policies on human well-being, world peace, and stability
- promoting social justice and avoiding racism, discrimination, profiling, and visa and travel bans or otherwise preventing immigration opportunities on the basis of race, religion, country of origin, gender, sexual orientation, immigration status, or other grounds
- supporting the human rights of day laborers, migrant workers, sex workers, and all other immigrants involved in economic endeavors
- developing a comprehensive set of immigration laws and procedures with a fair, equitable, and comprehensive national plan

- supporting federal and state services and programs for immigrants
- providing adequate U.S. contributions to refugee assistance globally through support of the budget and other aid programs
- establishing comprehensive refugee resettlement programs adequate in length and substance that include supports to help with integration into communities, trauma and mental health counseling, and job readiness and placement
- ensuring access to emergency humanitarian aid, health, and mental health care for all immigrants and refugees
- ensuring that the biopsychosocial, legal, health care, and education needs of all children are met regardless of their immigration status
- providing support for immigrant victims of displacement, violence, exploitation, and human trafficking
- ensuring access to language-appropriate services in the form of interpreters, translated documents, and other resources as needed ensuring appropriate immigration-related services to undocumented minors in foster care and, if they are eligible, adjustment of their status before they leave foster care
- efforts to remove penalties on dreamers for their parents' immigration status
- protecting all immigrants from exploitation and violence, including those who are undocumented, with provisions to protect women and other vulnerable populations from gender-specific forms of violence
- allowing local jurisdictions the ability to remove certain offenses from the category of automatically deportable offenses to ensure reporting, protection, and safeguarding the long-term family preservation rights of children
- ensuring and affirming access to "English as a second language" language education
- providing fair refugee admissions policies and priorities that respond to displacement resulting from human emergencies, conflicts, and natural disasters, including review of policies such as interdiction at sea, which violate international human rights law

- ensuring due process and access to legal counsel to all immigrants and refugees in accordance with international human rights for all asylum seekers
- eliminating backlogs and lengthy delays in processing of immigration status and related applications
- restoring the right to judicial review and modification of expedited removal provisions, especially for those claiming the right to asylum
- supporting immunity from deportation for those who report incidents of severe employment abuses, exploitation, or criminal activities
- opposing mandatory reporting of immigration status by health, mental health, social service, education, police, and other public service providers, and allow jurisdiction the right to create sanctuary cities without any restrictions in funds
- providing reasonable student, temporary, and transit visa regulations and processes that welcome and encourage international intellectual exchange
- guarantee of citizenship for those born in the United States
- supporting the training of social workers and other human services providers on the impact of immigration status on access to human services
- promoting knowledge of immigration and immigrant issues as a factor in culturally competent service provision
- promoting the training of social workers and other human services providers on the effects of immigration status on access to services and supports
- expanding research on the dynamics of migration, especially as it relates to social work practice.

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International Policy on Human Rights

ISSUE STATEMENT

The human rights perspective has roots in the religious, political, and intellectual traditions of many cultures. From the Babylonian *Code of Hammurabi* (1750 BCE) to the present, there is written evidence of humanity's struggle to protect the rights of vulnerable people from exploitation by more powerful individuals, groups, or the state itself. In many cultures there is a common recognition of the inherent dignity and worth of the person and equality under the law. During the 17th and 18th centuries, the framework toward individual and societal rights began to take shape (Falk, 2005; Healy & Link, 2012). The emergence of concepts such as natural rights, the use of social contracts, limitations of state powers, and rebelling if people's rights were infringed on were hallmarks of this period. For example, decrees such as the U.S. Declaration of Independence (1776), the Bill of Rights (1791), and the French Declaration of the Rights of Man and of the Citizen (1789) each articulated a set of rights, including the rights to life, liberty, and the pursuit of happiness; freedom of speech, the press, and religion; property rights; and the right to a trial by jury.

Crossing cultural boundaries, human rights identify the essential qualities of life that must be valued and protected for all people everywhere. A poignant enactment of this was demonstrated under the leadership of Eleanor Roosevelt when representatives of the nations of the world came together in response to the horrors of the Holocaust, to find a way to prevent such an event from ever happening again. The first step was the Universal Declaration of Human Rights (UDHR) (United Nations [UN], 1948), which was presented to the UN General Assembly and the world as a foundational document on which an edifice of protections for human rights could be built. This document has become the standard reference for all subsequent UN human rights efforts. It has heralded the inherent dignity and equal and inalienable rights of both male and female adults and children as members of the human family. Human rights were defined from the start to include the universal right to a standard of living that is adequate for the health and well-being of individuals and their families. The document spells out the essential resources to meet such a standard—food, clothing, housing, and medical care. It calls for the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other circumstances beyond one's control, including a call for "necessary social services" (UN, 1948).

The UDHR is distinctive in that it gave the world the right to ask of sovereign nations questions that were previously considered to be their internal affairs. By 1990, the document had become customary international law. Now even nonmember nations, however reluctantly, recognize that the world should not turn its back on social and humanitarian concerns within their borders (Meckled-Garcia, 2006). Since the UDHR was affirmed in 1948, more than 100 UN human rights instruments have been ratified, providing an even stronger legal mandate to protect human rights and fulfill human needs (UN Human Rights Office of the High Commissioner, 2016). The UN has ratified nine core international human rights treaties (UN Human Rights Office of the High Commissioner, 2016). Their core documents and the status of the support by the United States, as of 2016, are as follows:

1. International Covenant on Civil and Political Rights (1976) addresses the right to life, liberty, and security; the right not to be subjected to cruel, inhuman, or degrading treatment or punishment; prohibition of slavery; and the right not to be detained arbitrarily (United States signed 1977, ratified 1992).
2. International Covenant on Economic, Social and Cultural Rights (1976) addresses the right to work, right to social security, right to protection of the family, and right to an adequate standard of living (United States signed 1977, not ratified).
3. Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (1981) contains provisions that cover all aspects of women's right to equality, including areas such as equal pay for equal work, domestic violence, access to health care, parental leave, and

discrimination linked to parenting responsibilities (United States signed 1980, not ratified).

4. Convention on the Rights of the Child (CRC) (1990) promotes and protects the well-being of all children, addressing issues such as education, health care, juvenile justice, and the rights of children with disabilities. Articles of the convention also include the prevention of child abuse and the protection of freedom of religion, expression, and association (United States signed 1995, not ratified).
5. Convention on the Rights of Persons with Disabilities (CRPD) (2008) promotes, protects, and ensures full and equal enjoyment of all human rights for people with disabilities. The convention emphasizes the principles of individual dignity and autonomy; rejects discrimination; and supports full inclusion and participation in society, respect for difference, equality of opportunity, accessibility and equality between men and women, and respect for children with disabilities (United States signed 2009, not ratified).
6. International Convention on the Elimination of All Forms of Racial Discrimination (1969) commits countries to the elimination of all forms of racial discrimination and to promoting understanding among all races. There is an obligation to not discriminate on the basis of race, not to sponsor or defend racism, and to prohibit racial discrimination within one's jurisdiction (United States signed 1966, ratified 1994).
7. Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) (1984) addresses the struggle against torture and other types of cruel, inhumane, or degrading treatment or punishment throughout the world by providing specific measures to address these issues (United States signed 1987, ratified 1988).
8. International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (CMW) (2003) focuses on the rights as applicable during the entire migration process of migrant workers and members of their families, including preparation for migration, departure, transit, and the entire period of stay and enumerated activities in the state of employment as well as return to the state of origin or the state of habitual residence (United States has not signed or ratified).

9. Convention for the Protection of All Persons from Enforced Disappearance (CED) (2006) states that no one shall be subject to enforced disappearance and that there will be no exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability, or any other public emergency, invoked as justification for enforced disappearance (United States has not signed or ratified).

As can be seen from this list, the United States has an inconsistent record of supporting, signing, and fully ratifying UN human rights documents.

The inconsistent formal recognition of global statements on human rights, including social, economic, and cultural rights across UN member states, can influence country-level policy in a wide range of areas including education, housing, health and safety, health care, income maintenance, and child care (Human Rights Watch, 2013). As of 2017, the United States has not ratified CEDAW, the CRC, or the CRPD. These documents are a necessary step to addressing the continued erosion of economic support and social services. Significantly, CEDAW provides a definition of discrimination and equality, identifying the state obligations with regard to ensuring women's entitlement of their human rights on an equal basis with men. The CRC is a critical tool that promotes protections and rights for the most vulnerable and marginalized children, and supports the importance of families and parents (Campaign for U.S. Ratification of the Convention on the Rights of the Child, n.d.). The United States has failed to take leadership to address three other critical human rights issues addressed through UN covenants: migrant workers and their families (CMW); torture and other cruel, inhumane, or degrading treatment or punishment (CAT); and protection of all people from enforced disappearance (CED). Each of these documents is essential to the human development and quality of life of people in the United States, as well as in other nations.

The aim of the human rights structure created during the past 75 years, which includes UN's declarations and treaties; UN administrative bodies; and regional, governmental, and nongovernmental organizations, is to root out oppression and to establish conditions in which human beings can meet their needs, develop their humanity, and flourish. This aim is closely akin to social work's mission. Discrimination and social exclusion based on racial and religious intolerance; gender inequality and violence; denial of the rights of women and children, refugees, and older people—all are social justice issues that long have concerned social workers (Meckled-Garcia, 2006; Wronka, 2008). Social workers understand that civil and political rights must be supplemented by economic, social, and cultural rights. Social work, with its person-in-environment perspective, is vividly aware of the deleterious effects of human rights violations on the development of individuals, families, communities, and societies. Social workers, across practice areas, advocate for the fullest range of human rights, from paid employment, adequate food, education, shelter, and health care, to the right to freedom from violence and freedom to pursue one's dreams (Healy & Link, 2012; Hokenstad & Midgley, 1997; UN, 1995).

Human rights violations are prevalent throughout the world, including in the United States. Civilians are injured, maimed, and killed in times of conflict, often in higher numbers than military personnel. Refugees and immigrants are fleeing their countries in record numbers (Segal, 2012). Women and girls globally continue to be treated as second-class citizens, subjected to discrimination and violence in epidemic proportions. The social situation of children and older adults is of grave concern the world over and appears to be deteriorating. Violence and oppression against ethnic and racial minority groups and lesbian, gay, bisexual, and transgender people continue to escalate in many regions of our globe (Ife, 2012; Together for Girls, 2016). Increasingly global issues are addressed through a collective and organized response from a human rights lens. These include efforts to promote full human rights through the elimination of torture and the elimination of the death penalty; ending discrimination and social exclusion based on race, ethnicity, caste, or religious identity; addressing gender inequality, domestic violence, rape, and the sale of women; promoting health equity through access to clean water, adequate nutrition, shelter, and health care; ending child abuse, sweatshops, child labor, and slavery; and the increased recognition of the rights of ethnic and cultural minority groups, migrants, refugees, asylum seekers, indigenous peoples, older people, and people with mental and physical disabilities (Healy & Link, 2012; Human Rights Watch, 2013; Mapp, 2014). The policies and practices of the United States influence and affect not only our own people, but also those in developed and developing countries. The human rights movement was formally recognized by the global community to identify barriers to the protection of human rights and to set up policies and procedures to abolish such barriers and thereby guarantee that human dignity and essential freedoms are protected for every person. These rights are reflected in the Sustainable Development Goals (SDGs). Put forth by the United Nations, the 17 SDGs address poverty, the environment, and secure equity and social justice globally (United Nations, 2015).

Social workers are trained to address the needs of people who are vulnerable and to work toward establishing a more just society. Social justice and human rights concerns are the bedrock of the social work profession in the United States (NASW, 2015). Social justice is a fairness doctrine, providing civil and political leeway in deciding what is just and unjust. Human rights, on the other hand, encompass social justice but transcend civil and political customs. The UN declarations, conventions, and treaties provide a human rights framework that benefits from the body of knowledge gleaned from more than 100 years of global professional social work and social work education (Council on Social Work Education, 2015; Wetzel, 1998). This commitment to human rights at the individual, community, and societal level is rooted in the values and ethics of the social work profession and brings a commitment to linguistically and culturally relevant programs, policy, funding, and advocacy. NASW, a member of the International Federation of Social Workers (IFSW), must continue to guide social work's role in promoting human rights globally. Its effectiveness in the 21st century will depend on the extension of its social justice values within the context of global human rights (IFSW, 1994; NASW, 1981).

POLICY STATEMENT

The struggle for human rights remains a vital priority for social work practitioners and advocates in the 21st century. NASW's position is

- to promote U.S. ratification of the Universal Declaration of Human Rights and of all current UN treaties and optional protocols as is necessary to ensure human rights and social justice
- to endorse the principle that the rights of people take precedence over social customs when those customs infringe on human rights (ritual female genital mutilation, a practice that persists internationally despite governmental sanctions, is a case in point)

- to confront human rights violations related to children's rights and exploitation such as child labor, child prostitution, and other crimes of abuse and to take leadership in developing public and professional awareness regarding the issues
- to endorse the UN resolution that women's rights are human rights, no longer simply to be considered civil and political rights
- to advocate for the rights of vulnerable people and to condemn policies, practices, and attitudes of bigotry, intolerance, and hate that jeopardize people's human rights
- to promote and afford full human rights to all, regardless of race, ethnicity, gender, gender identity or expression, sexual orientation, age, disability status, immigration status, or religion
- to advocate for the right not to be subjected to dehumanizing treatment and punishment, including torture, and to support the elimination of the death penalty
- to work for the eradication of modern-day slavery and human trafficking
- to advocate for U.S. government policies related to homeland security and combating terrorism that are consistent with human rights values and ethics
- to advocate for a UN Convention on the Rights of Older Persons
- to advocate for the rights of refugees and asylees and for their safe transit and living conditions
- to work to end efforts to deprive individuals of their human rights, including sexual orientation or gender identity change efforts, use of illegal deportations, and limitations on sexual and reproductive health choices
- to support the right to a standard of living that is adequate for the health and well-being of all people and their families, without exception, and the essential resources to meet such a standard: adequate housing; basic health care; education; security in the event of unemployment, chronic illness, disability, widowhood, old age, or other lack of livelihood beyond one's control; and necessary social services
- to promote the allocation of resources necessary to fully address SDGs and to include mental health and psychosocial care as part of universal

health care

- to work in collaboration with nongovernmental organizations and community groups when entitlements are nonexistent or inadequately implemented and to become a leading force for the health and welfare of all people
- to advocate, engage, and support the social work profession as a critical partner with the UN in advancing human development and human rights, including economic human rights, and closing the economic gap.

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Juvenile Justice and Delinquency Prevention

ISSUE STATEMENT

The juvenile court was originally founded on the principle of applying social services interventions in a legal forum. During the 1990s, as the "tough on crime" policies prevailed, the number of juvenile detentions increased sharply—the so-called school-to-prison pipeline (STPP)—and more youths were transferred to adult courts to stand trial. The juvenile justice system, just as the adult criminal justice system, has been plagued by racial and ethnic disparities that have resulted in disproportionate adjudications of African American and Hispanic youths (National Conference of State Legislatures, 2018).

We need comprehensive systemic reforms in juvenile justice. Advances in research on behavioral and neuroscience have become useful guides for juvenile justice reform (National Center for State Courts, n.d.). In response to an outcry about the severity of sentencing youths, even for serious crimes, the U.S. Supreme Court has limited sentencing practices such as the execution of offenders who are under the age of 18. Moreover, the court now disallows life sentences without parole for crimes committed by juveniles.

The juvenile justice system comprises a number of key stakeholders with a vested interest in preventing delinquent and criminal behaviors among young people and improving the correctional system once a juvenile is adjudicated. The major stakeholders include

- juvenile court systems
- federal and state juvenile justice policymakers
- juvenile probation agencies

- the adult criminal justice system
- child welfare agencies
- public school systems
- national youth advocacy groups
- service provider groups
- law enforcement agencies.

Nationally, stakeholders in juvenile justice reforms have grappled with addressing a range of concerns, including systemic racial disparities (implicit bias), the STPP, youth transfers to adult courts, and the lack of preventive behavioral health services. The following are the juvenile justice issues that have policy implications for social workers.

Racial and Ethnic Disparities

Racial and ethnic disparities are situations in which youths of color have a different and unequal experience in the juvenile justice system in comparison with white youths. Youths of color are more likely to be arrested, detained, and confined than white youths and are more likely to be tried as adults. These disparities are rooted in historical racism and discrimination existing long before the founding of the nation's juvenile justice system (Juvenile Justice Information Exchange, n.d.).

Between 2003 and 2013, the number of youths committed to juvenile facilities after an adjudication of delinquency fell by 47 percent. This decrease was a national phenomenon with every state experiencing this trend (Sentencing Project, 2016a). However, racial disparities continue to pervade the juvenile justice system. Between 2003 and 2013, the racial disparity between black and white youth commitments to detention facilities increased by 15 percent (Sentencing Project, 2016b).

Dual Status Youths: Juvenile Justice and Child Welfare

Dual status youths are juveniles who come into contact with both the child welfare and juvenile justice systems. This results in youths having active cases in two systems. An emerging body of research has confirmed that, in comparison with youths who are not active in both systems, dual status youths present a range of important challenges (Models for Change, 2013). Research and service delivery experience suggest that integrated care and multisystem approaches can be effective in producing outcomes for youths that reduce the likelihood of them becoming justice involved as adults.

STPP

STPP comprises the ill-advised policies and practices that can lead to school-age children, especially at-risk children of color, to be steered out of the educational system and put on a path to the juvenile justice system and eventually the criminal justice systems, a process that starts in elementary school. Because the STPP disproportionately affects children of color with disabilities, dismantling the STPP requires an intersectional approach that recognizes critical factors such as disability and racial discrimination (Disability Rights Education and Defense Fund, 2012). According to the Civil Rights Data Collection (U.S. Department of Education, n.d.), African American students represent 16 percent of the national student population, but 34 percent were expelled and 42 percent were suspended multiple times in 2014. Similar statistics are reflected for Hispanic and other racial minority youths nationwide.

It is also important to advocate against zero-tolerance policies that mandate harsh punishments for minor infractions and highly punitive suspensions and expulsions. Zero-tolerance policies, suspensions, and expulsions significantly contribute to the STPP.

Importance of Behavioral and Neuroscience Research in Sentencing Youths as Adults

Between 2010 and 2016, the U.S. Supreme Court has decided three cases that restricted the use of “life without parole” sentences for people arrested as juveniles. Together, the decisions clarified that life without parole could only be imposed on a juvenile convicted of homicide and that this sentence could not be mandatory. Courts must consider the specific circumstances of the individual youth and case before sentencing a juvenile to a life sentence.

Moreover, the decisions were retroactive, meaning the option for parole must be made for people who were previously given a mandatory sentence of life without parole as juveniles. Although life without parole can no longer be a mandatory sentence for juveniles, the sentence is still allowable on a discretionary basis in most states.

The U.S. Supreme Court decisions were made in light of research indicating that youths are less capable than adults of making rational decisions and have the capacity to change. The court also considered that a majority of young people sentenced to life in prison had witnessed regular violence during their early childhood. Nearly half were physically abused themselves.

Youth Transfers

A judicial or discretionary waiver is issued to transfer an individual juvenile justice case into adult court, a decision made by juvenile court judges in most states. Forty-four states and the District of Columbia allow for judicial waivers (Sentencing Project, 2016a). As of 2016, seven states routinely charge 17-year-old offenders as adults, including two states that also apply this practice to 16-year-olds. Strong advocacy led to states reexamining such harsh policies. Judicial waivers have a long history in the United States. During the early 1990s, politicians operated under a misguided notion that the country was producing a generation of so-called super-predators. This resulted in 40 states passing legislation to send even more juveniles into adult courts for a growing array of offenses and with fewer procedural protections (Sentencing Project, 2016a; Zimring, 2010).

Data indicate racial disparities in judges’ decisions to grant waivers to try youths in adult courts. State data on youth transfers clearly show that a disproportionate number of youths of color, as opposed to White youths, are waived to adult courts (Campaign for Youth Justice, n.d.).

Trauma-Informed Intervention

According to the National Center for Youth Opportunity and Justice (NCYOJ, 2019), the prevalence of self-reported exposure to traumatic experiences is as high as 93 percent among residents of juvenile detention centers. A number of sources note that symptoms of traumatic experiences are higher among juvenile justice system–involved girls than boys (National Center for Mental Health and Juvenile Justice, 2007). In addition, different types of traumatic experiences are reported by boys and girls. Girls are more likely than boys to report sexual abuse, physical punishment, and experiencing violence. Boys report witnessing violence more often than girls.

Trauma involving victimization by others is more likely than other forms of trauma to lead to impairment in psychosocial functioning and physical health. Although not every delinquent youth has experienced traumatic victimization, clinical and epidemiological studies indicate that at least three in four youths in the juvenile justice system have been exposed to severe victimization (Ford, Chapman, Hawke, & Albert, 2007). Seventy percent of youths in state and local juvenile justice systems have a mental illness. Incarcerated youths are up to three times as likely to die by suicide when compared with youths in the general population (NCYOJ, 2019). Social workers who work with juveniles are positioned to recognize the signs of post-traumatic stress and predelinquent behaviors. As a result, the profession plays a role in preventing children’s progression in the juvenile justice system during adolescence (Ford et al., 2007).

Transgender, Gender-Nonconforming, and Intersex Youths in the Juvenile Justice System

Transgender, gender-nonconforming, and intersex (TGNI) youths in confinement facilities are uniquely vulnerable. They are overrep-resented in the juvenile justice system and are also more likely than other confined youths to be mistreated and abused (Wilber & Szanyi, 2019). TGNI youths also have special housing, privacy, and health care needs.

Pervasive rejection and discrimination in their homes, schools, and communities contribute to the overrepresentation of TGNI youths in confinement facilities (National Juvenile Defender Center, n.d.). According to recent national data (NBC News, 2016), 12 percent of youths in juvenile facilities identify as transgender or gender-nonconforming and 85 percent of lesbian, gay, bisexual, trans, queer, or gender-nonconforming youths at these facilities are youths of color. These youths experience higher levels of sexual abuse and other mistreatment in confinement settings, particularly when facilities lack clear, enforceable guidance on how to protect their safety and promote their well-being.

Juvenile Detention Alternative Initiative

Annie E. Casey Foundation (n.d.) launched the Juvenile Detention Alternative Initiative (JDAI) as a pilot project in the early 1990s, a time when overreliance on detention was widespread and growing nationwide. Based on its success, JDAI has been adopted by an ever-growing number of jurisdictions, leading to dramatic declines in detention populations.

The JDAI model is built around the following eight core strategies that are consistent with social work values:

1. Promoting collaboration
2. Using rigorous data collection and analysis to guide decision making
3. Relying on objective admissions criteria and risk-assessment instruments
4. Implementing new or expanded alternatives to detention programs
5. Instituting case processing reforms
6. Reducing the number of youths detained
7. Combatting racial and ethnic disparities
8. Monitoring and improving conditions of confinement in detention facilities. (Annie E. Casey Foundation, n.d.)

In December 2018, Congress passed the Juvenile Justice Reform Act of 2018, once again amending and reauthorizing the Juvenile Justice and Delinquency Act. This reauthorization amended requirements for state plans to include prioritizing evidence-based programs, phasing out the use of restraints on pregnant juveniles, screening for human trafficking victimization, and screening and treating the mental health and substance use needs of youths in the care of the state’s juvenile justice system. It also clarified and expanded the purpose areas for formula grants to include programs that address needs of girls in or at risk of entering the juvenile justice system, assist youths with access to legal representation, and provide youths information on procedures to seal and expunge records (Office of Juvenile Justice and Delinquency Prevention, 2019).

POLICY STATEMENT

NASW supports the following:

- Continuation of the movement toward assisting children and youths who enter the juvenile justice system in a manner commensurate with their age, developmental level, and ability to differentiate between right and wrong
- Fair and equal treatment of youths regardless of socioeconomic status, race, ethnicity, gender, or sexual orientation
- Interdisciplinary collaborations and communication with key stakeholders in the juvenile justice system to focus on a child’s educational needs and stability
- Evidence-based policies and practices and ongoing research and evaluation, with input from families and stakeholders, to be used by service providers in the juvenile justice system
- Emphasizing the importance of ethnic and cultural equity in the juvenile justice system
- Encouragement of child welfare and the juvenile justice systems to partner in the development of strategies and policies that will provide for greater levels of collaboration, screening, data sharing, assessment, case management and supervision, and interagency collaboration
- Hiring professional social work practitioners who have skills in case management, counseling, intake, interviewing, cultural competency, and expertise in youth services to effectively handle individuals and their families who are involved in the juvenile justice system

- Interdisciplinary services that exemplify social work practice and values and provide effective and efficient services to youths and their families
- Treatment that continues to be delivered with a mind toward age-appropriate handling and management regardless of placement setting
- Support for the move toward replacement of state correctional systems by local systems of community-based care that are necessary for effective rehabilitation and change
- Alternate treatment options, such as small correctional and treatment facilities located around the state to promote person-in-environment treatment, which includes postrelease or discharge planning and aftercare programming
- Overall system improvement that results in periodic screenings of children in various care settings; use of evidence-based tools that can identify the mental health and emotional impact of early childhood trauma (such as child abuse and neglect, exposure to domestic violence) and physical trauma (such as traumatic brain injury)
- Use of coordination of service models to provide oversight and ensure adherence to relevant national standards and guidelines
- Culturally competent services delivery that is data driven
- Minimization of duplication of services and the incorporation of continuous quality improvement components
- The use of evidence-based and informed interventions
- Elimination of the death penalty for juveniles under the age of 18 years
- Elimination of life sentences without the possibility of parole for juveniles convicted of capital offenses in adult court
- Policies that promote the physical and emotional safety and well-being of confined and adjudicated TGNI youths through clear operational practices grounded in law, professional standards, and credible science
- Trauma-informed and culturally appropriate services delivery for the entire juvenile justice system, as best practice
- Mental health training for all staff in juvenile justice settings including suicide prevention strategies and best practices

- Screening all youths who enter the juvenile justice system for suicide risk.

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Language Diversity in the United States

ISSUE STATEMENT

The essence of the social work profession is to promote social justice and eliminate discrimination. Language and cultural diversity are recognized as issues that are intrinsic to the profession's mission and commitment to advocacy of access to services, to quality of care, and ultimately to outcomes. *Language diversity* refers to the number of languages spoken in the United States and the number of people who speak them (Rumbaut & Massey, 2013). Currently, social workers provide social and human services, education, case management, and clinical services and supports U.S. Department of Labor, (Bureau of Labor Statistics, 2015) in myriad settings to increasing numbers of people from linguistically diverse backgrounds. Social workers understand that language is a source and extension of personal identity and culture and, therefore, is one way individuals interact with others in their families and communities and across different cultural groups. Many of the populations served by social workers may include native-born, immigrant, and refugee groups, many with limited ability to speak and understand English. Communicating effectively with diverse populations is a critical aspect in the delivery of linguistically competent social services.

Linguistic competence is the capacity of an organization and its personnel to communicate effectively and to convey information in a manner that is easily understood by diverse audiences including people of limited English proficiency (LEP), those who have low literacy skills or are illiterate, individuals with disabilities, and those who are deaf or hard of hearing (Goode & Jones, 2009). In addition, linguistic competency requires provider and "organizational capacity to respond effectively to the health and mental health literacy needs of populations served" (Goode & Jones, 2009, p. 1). The *NASW Standards and Indicators for Cultural Competence in Social Work Practice* (NASW, 2015b) affirm the importance of cultural diversity and linguistic access in Standard 9, Language and Communication: “It is the responsibility of both social workers and organizations to provide services in each client’s preferred language or to seek the assistance of professional interpreters” (p. 45). The ramifications of discrimination are far-reaching and affect clients in all fields and settings in which social workers practice.

Health literacy is “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (Kindig et al., 2004, p. 32). *Mental health literacy* is defined as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (Jorm et al., 1997, p. 396). Mental health literacy consists of several components, including “(a) the ability to recognize specific disorders or different types of psychological distress; (b) knowledge and beliefs about risk factors and causes; (c) knowledge and beliefs about self-help interventions; (d) knowledge and beliefs about professional help available; (e) attitudes which facilitate recognition and appropriate help-seeking; and (f) knowledge of how to seek mental health information” (Jorm et al., 1997, p. 182).

Differing cultural beliefs and confusion about mental health literacy have been associated with communication challenges between providers and the culturally and linguistically diverse clients they serve (Jorm, 2000).

“Every human language is an exquisitely complex intellectual masterpiece” (Krauss, as cited in Wilkinson, 2006, p. 361) that expresses the culture that created it. There exists an intimate, deeply rooted, inextricable connection between culture and language. Language carries meanings and references that are bound by culture, and “the meanings of a particular language represent the culture of a particular social group” (Guessabi, n.d., p. 1). Learning a language is more than learning its alphabet, grammatical rules, meanings, and how words are arranged, it is also learning the behavior of a society and its cultural customs. Languages carry embedded cultural nuances and different languages represent different ways of thinking about our surroundings and us. “Every language offers a unique insight into the nature of speech and thought” (Vaux, as cited in Lewis, 1998, para. 14).

Historical Background

Contrary to popular belief, the United States has always been a nation of many languages. At the time of independence, about one-fourth of the population consisted of non–English speaking European immigrants, and it is likely that a portion of inhabitants spoke American Indian or African languages. For example, in Pennsylvania about two-fifths of the population spoke German, and many of the inhabitants of the new nation spoke a language other than English (Rumbaut & Massey, 2013). In the 1800s, as result of land purchases and treaties (that is, the Louisiana Purchase, in 1803, which nearly doubled the size of the nation; the Treaty of 1818 with Britain, which added Oregon Country to the United States; the Adams-Onís Treaty of 1819 with Spain, which added Florida; and the Treaty of Guadalupe Hidalgo in 1848, which procured nearly half of Mexico), the nation's linguistic diversity increased with tens of thousands of French and Spanish speakers, many more enslaved people, and a diverse array of indigenous peoples (Fleming, 2003; Gómez, 2007; Weber, 1992). Language diversity continued to increase with the acquisitions of Alaska and Hawaii toward the end of the 19th century (Weber, 1992).

Language diversity in the United States has been primarily driven by immigration. In the 1840s and 1850s Germans and Celts (Irish, Scottish, and Welsh) arrived in large numbers. Scandinavians arrived in the 1870s and 1880s, followed by Slavic, Jewish, and Italian immigrants from the 1880s to the early decades of the 20th century (Massey, 1995). Data from the 1910 Census indicates a national population of 92 million people, including 10 million immigrants who spoke languages other than English or Celtic (Irish, Scotch, Welsh), including 2.8 million German speakers, 1.4 million Italian speakers, 1.1 million Yiddish speakers, 944,000 Polish speakers, 683,000 Swedish speakers, 529,000 French speakers, 403,000 Norwegian speakers, and 258,000 Spanish speakers (Gibson & Jung, 2006).

The advent of World War I brought about an "end to European immigration, followed by the imposition of restrictive U.S. immigration quotas, a global depression, and a second world war, resulting in the steady decline of the percentage foreign born in the United States, from 14.7% in 1910 to 4.7% in 1970" (Gibson & Jung, 2006, p. 1). The decrease in immigration was also reflected in a decline in language diversity, which became so low that in 1970 the Census Bureau dropped the questions on mother tongue or language spoken.

Since then, the U.S. foreign-born population has grown exponentially as a result of extensive immigration, primarily from Latin America and Asia, from 9.6 million in 1970 to 14.1 million in 1980, to 19.8 million in 1990, to 31.1 million in 2000, to 40 million in 2010 (Gibson & Jung, 2006; Grieco et al., 2012). As a percentage of total population, the foreign-born population increased from 4.7 percent in 1970 to 6.2 percent in 1980, to 7.9 percent in 1990, to 11.l percent in 2000, and to 13 percent in 2010 (Gibson & Jung, 2006; Grieco et al., 2012).

Current History

With respect to the current foreign-born, the Latin American population is the largest region of birth, representing over half (53 percent) of all foreign born as compared with 28 percent of the foreign-born from Asia, 12 percent from Europe, 4 percent from Africa, 2 percent from Northern America, and less than 1 percent from Oceania (Grieco et al., 2012). Among the 21.2 million foreign born from Latin America, 11.7 million, or over half (55 percent), were born in Mexico. Of the total foreign-born population, 29 percent were born in Mexico. These demographic shifts have affected the care and services provided in multiple service sectors, including but not limited to education, justice, and health and human services providers.

There is great cultural and linguistic diversity among immigrant families in the United States. Immigrants come to the United States from diverse origins. They migrate for different reasons and arrive with different levels of English-speaking ability, literacy, education, and other resources. There is also considerable diversity in English use and English-speaking ability among the foreign born. Research has shown that educational level plays a part, as those who have a bachelor’s degree or higher are more likely to have higher English-speaking ability than those with less than a high school education (Beckhusen, Florax, de Graaff, Poot, & Waldorf, 2013; McArthur, 1993). English-speaking characteristics are also related to time spent living in the United States. Many foreign-born individuals with long periods of residence in the United States speak English well. However, some have limited English-speaking ability or may not speak English at all, even after residing in the United States for many years (Gambino, Acosta, & Grieco, 2014).

In terms of language diversity, recent census data indicate that about 350 languages are spoken in the United States by both native-born and foreign-born populations (U.S. Census Bureau, 2015). Detailed tables from the Census Bureau’s American Community Survey present an expanded perspective of language diversity in the United States organized into 16 language groups and provide information on English use and speaking ability. Data compiled from the Census’s 2009–2013 American Community Survey indicate that 15 percent of the foreign-born spoke only English at home, whereas one in 10 did not speak English at all. Approximately 85 percent of the foreign-born population speak a language other than English at home as compared with 10 percent of the native-born population. About 49 percent of the foreign-born reported speaking English very well, and across all language groups 25,148,900 people or 41.6 percent of the foreign-born reported speaking a language other than English and speaking English less than very well (Grieco et al., 2012).

Social work practitioners and organizations are challenged with not only significant language diversity, but also the impact of providing services and supports to *LEP individuals*, those “who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English” (LEP.gov, 2016). Individuals with LEP are entitled to language assistance to have meaningful access to a particular type of service, benefit, or encounter. Meeting language assistance needs of individuals factors in appropriate and realistic funding for interpretation and translation services by the primary payers of services— federal, state, and local jurisdictions and philanthropies.

Federal Policies

There are a number of legal mandates in place to support and ensure that LEP individuals receive language access and assistance to health care and other services. The federal government issued laws applicable to language access, including Title VI of the Civil Rights Act of 1964; Title VI regulations, prohibiting discrimination based on race, color, or national origin; and Executive Order 13166 issued in 2000. Title VI of the Civil Rights Act of 1964 and its related regulations for implementation provide that “no person shall be subjected to discrimination on the basis of race, color, or national origin by program or activity that receives federal financial assistance” (U.S. Department of Justice, Civil Rights Division, 2016).

Executive Order 13166 (“Improving Access to Services for Persons with Limited English Proficiency”) “requires Federal agencies to examine the services they provide, identify any need for services to those with limited English proficiency (LEP), and develop and implement a system to provide those services so LEP persons can have meaningful access to them” (U.S. Department of Justice, 2015). The executive order also requires that federal agencies work to ensure that recipients of federal financial assistance (such as grantees, and individual or organizational subcontractors) provide meaningful access to LEP applicants and beneficiaries (U.S. Department of Justice, 2015). Individual federal programs, states, and localities also have provisions requiring language services for LEP individuals.

On April 24, 2013, the U.S. Department of Health and Human Services (HHS) released the new enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (HHS, Office of Minority Health, n.d.). These standards provide a framework to health care organizations for the delivery of culturally respectful and linguistically responsive care and services. In addition, these standards provide a platform for organizations in their efforts to improve and reduce health disparities (HHS, Office of Minority Health, n.d.). The CLAS standards include the principal standard and 15 additional standards divided into the following thematic areas: (a) governance, leadership, and workforce; (b) communication and language assistance; and (c) engagement, continuous improvement, and accountability (HHS, Office of Minority Health, n.d.). For social workers the CLAS standards reinforce NASW’s policy to promote cultural and linguistic competence in all areas of social work practice, research, and education. Social workers should honor the ethical responsibility to be culturally competent practitioners as the NASW (2015a) *Code of Ethics* instructs.

However, the past several years have been rife with proposed English-only legislation— especially after the events of September 11, 2001. The ultimate goal of the English-only movement, which emerged in the 1980s, was to amend the U.S. Constitution to declare English the official language of this nation. It is a resurgence reflecting economic and political tensions. Supporters of the movement have worked energetically and have succeeded in obtaining passage of legislation. To date, 30 states have made English their official language. In practice, implementation of the official English language laws varies. In some states driver licenses and social service benefits applications are available in multiple languages, whereas in others the use of other languages may be prohibited. Some of the states that have enacted English-only legislation are among the largest and most populous in the country with extremely diverse cultural and linguistic populations (Crawford, 2000).

In terms of social work and mental health services, English proficiency not only affects treatment for adults, but also can affect the care of children. Yu, Huang, Schwalberg, and Nyman (2006) compared children in English-speaking households and in non-English-speaking households and found that children in non-English-speaking households are less likely to have access to health insurance and physician care and are more likely to go to other countries for their health care.

Recent developments in the immigration debate have sparked interest in the issues of diversity in the United States. The systematic issues of discrimination and social justice should be addressed to develop a system that is equitable to the growing immigrant population in the United States. For LEP individuals, language is often a barrier to accessing critical services and benefits, understanding and exercising important rights, complying with applicable responsibilities, or understanding information provided by federally funded programs and activities. “As society evolves, we encounter more diversity in our workplaces, in our neighborhoods, and in every other facet of our lives. Our entire country depends on individuals obtaining a greater understanding of the similarities and differences among ethnic, racial, linguistic and cultural groups” (Inouye, 1996, pp. ix–x).

POLICY STATEMENT

As social workers, we understand that language is a source and extension of personal identity and culture and, therefore, is a significant way in which individuals interact with others in families and communities and across different cultural groups. To limit or deny language as an extension of culture is to reject the aspect of human beings that helps to define them. Therefore, NASW supports the following:

- access to language services as a right and celebrating and encouraging people's native languages as an example of diversity
- the use of various languages as a right and a resource that is closely aligned with the ethical principles of service and social justice
- continuity and preservation of native indigenous languages such as the languages of Native Alaskan, American Indian, and Native Hawaiian peoples, rejecting any hostility toward foreign-born individuals or those who speak languages other than English as linguistically, racially, and culturally biased xenophobia
- human services programs with written policies that identify services and supports for LEP individuals that include the following elements: assessment of language needs and capabilities, recruitment and hiring of bilingual and bicultural staff of major groups in the program's service area, training on how best to meet language needs of clients, use of interpreters and translators, and translation of documents (Barnett, 2004; Goode & Jones, 2009)
- the development and implementation of language access plans "to ensure that agencies communicate effectively with individuals with limited English proficiency" (U.S. Department of Justice, n.d., p. 1) that would contain approaches for periodic monitoring and evaluation of language services for quality, usability, and usefulness
- the provision of information, referrals, and services in the language and cultural contexts appropriate to the client
- recognition of the critical role of interpreters as members of service teams
- research on linguistic diversity that enhances the lives of all people
- educational programs that accept the importance of other languages within the mainstream culture, such as bilingual education and

multicultural programs

- the implementation of linguistic competence at three intersecting levels: the individual, institutional, and societal
- collaboration with consumers, families, and linguistically diverse communities as a precondition for creation of culturally and linguistically competent services, reasonable accommodations, interventions, programs, and policies
- actions given to improving linguistic competence and a diverse workforce in the social work profession
- schools of social work recruitment of culturally and linguistically diverse students and faculty; developing curriculum to teach the skills necessary for cross-cultural communication, which might include approaches for working with interpreters and translators as members of service teams to increase access, quality, and service utilization
- legislations that embrace linguistic diversity; NASW opposes any legislation that promotes official English or English-only agendas.

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Lesbian, Gay, and Bisexual Issues

ISSUE STATEMENT

Discrimination against lesbian, gay, and bisexual (LGB) people has a long history in the United States, across nations, and across cultures. The subjugation of LGB people has been supported through federal, state, and local laws and public policy. For example, following World War II, President Eisenhower barred gay men and lesbians from all federal jobs, a ban that remained in place until 1975, when the Civil Service Commission officially ended job discrimination against lesbians and gay men for most federal jobs except those within the Federal Bureau of Investigation (FBI) and other intelligence agencies (Chandler, 2006).

By the late 1960s, the U.S. gay rights movement was beginning to gain momentum. On June 27, 1969, when New York City police raided a Greenwich Village gay bar, the community fought back. The community's response— known as the Stonewall Riots—remains a critical milestone in the ongoing struggle for LGB and transgender (LGBT) equity. Yet for decades the U.S. government continued to discriminate against LGB citizens. In 1993, in response to negative rhetoric about LGB military service personnel, President Clinton signed into law Don't Ask Don't Tell (DADT), placing LGB service members in jeopardy of dishonorable discharge because of their sexual orientation (Stewart, 2010). In 1996, President Clinton signed into law the Defense of Marriage Act (DOMA) (P.L. 104-199), which allowed states to refuse to recognize same-sex marriages granted under the laws of other states; the majority of U.S. states followed suit (Bernstein, 2011; Stewart, 2010). As of June 2013, 30 states had constitutional DOMA provisions and seven others had statutory DOMA provisions (Killian, 2010; National Conference of State Legislatures [NCSL], 2013).

The 2000s brought a range of legislative and policy changes that had a direct impact on the LGB community. In 2001, the creation of the White House Office of Faith-Based and Community Initiatives found the Bush administration having to publicly address concerns that funding recipients were providing exemptions to local and state antidiscrimination laws. The concern that faith-based groups used said exemptions to deny equal access to services based on sexual orientation and gender identity continues today. Two years later, in *Lawrence v. State of Texas* (2003), the U.S. Supreme Court invalidated sodomy laws in Texas, and by extension in 13 other states. The ruling ended the practice of using “illegal sexual activity” as a cover for institutionalized homophobia and made same-sex sexual activity legal in every U.S. state and territory. Later in 2003, the Massachusetts Supreme Court ruled that banning lesbians and gay men from marrying same-sex partners was a violation of the state’s constitution, resulting in the first state to allow same-sex couples to legally marry.

The 2010s have seen the momentum continue. In December of 2010, after years of public pressure, including from those in the military, the Obama administration signed the repeal of DADT (Broverman & Garcia, 2012). The following year, the Obama administration declared that they would no longer defend federal DOMA in cases that were pending in the state and federal courts (Human Rights Watch [HRW], 2011). In March of 2013, the U.S. Supreme Court agreed to hear two cases that focused on marriage equality: California’s Proposition 8 (*Hollingsworth v. Perry*), which did not recognize same-sex marriage in California; and a broader case (*United States v. Windsor*) based on DOMA that addressed the denial of federal benefits and programs to same-sex couples (see NASW, 2013). In June of 2013, the U.S. Supreme Court struck down DOMA as unconstitutional and ruled that the state of California must resume issuing marriage licenses to same-sex couples. As of October 2014, 32 states and the District of Columbia allow same-sex marriage; in addition, six states allow civil unions and three states allow some level of spousal rights to domestic partners. Although most of these states’ laws are the result of court action, legislative vote has made same-sex marriage legal in eight states, an important milestone in the fight for LGB rights (NCSL, 2014; Peters, 2014).

Marriage equality increases access to the over 1,000 federal protections and responsibilities historically denied to LGB families under DOMA.

However, same-sex couples cannot legally marry in most states and territories of the United States, creating uncertainty about the extent to which same-sex spouses will receive federal (marital-based) protections nationwide that are currently afforded opposite-sex spouses. The implementation of marriage equity for same-sex couples has created a domino effect in related federal policy. For example, in June 2013 the Social Security Administration published new rules that make it easier for the estimated 700,000 transgender Americans to update their social security records to reflect their gender designation. In July 2014, the Obama administration announced that same-sex marriages will be recognized for all federal tax purposes, that the Family and Medical Leave Act of 1993 (P.L. 103-3) will apply to LGBT couples (including those living in states where same-sex marriage is not legally recognized), that health insurance and retirement benefits will be available for same-sex spouses of all federal employees, and that the Department of Defense will provide spousal benefits for same-sex spouses of military service members.

Despite changes in state and national legislation and public policy, heterosexism and discrimination persist (Alessi, 2010). For example, although the majority of states have decriminalized homosexual acts between consenting adults in private, sodomy laws remain intact in many states. Sodomy laws have been used to deny lesbians and gay men employment, custody of their children, and the opportunity to foster or adopt children in state care (National Gay and Lesbian Task Force, 2004). LGB people do not have full civil and statutory protection under the law as defined in Title VII of the Civil Rights Act of 1964 (P.L. 88-352). The LGB population continues to face discrimination related to many state and federal laws along with religious exemptions within current law as well as proposed legislation such as the Employment Non-Discrimination Act (ENDA) (American Civil Liberties Union, 2013). The decades-long failure of the U.S. Congress to pass ENDA, which would have protected LGBT people from workplace discrimination, is particularly unfortunate. Currently, only LGBT workers in the federal government and its contracting agencies are protected under Obama’s July 2014 presidential order (Perez, 2014).

Internationally, other countries and international governing entities have addressed discrimination of LGB people on a limited basis. In 1994, the United Nations ruled that discrimination based on sexual orientation violates the International Covenant on Civil and Political Rights (UN, 1966). In 1996, postapartheid South Africa became the first country to include nondiscrimination based on sexual orientation in its constitution. From 1981 to 2003, the European Court of Human Rights overturned sodomy laws, recognized gay and lesbian partnerships, condemned discriminatory age-of-consent laws (that is, differing age of consent to engage in sexual relationships for heterosexual versus LGB youths), and gave transgender people the right to legally change their identity and to marry (HRW, 2004). In 1998, Denmark legalized same-sex partnerships; within two years, Norway, Sweden, Iceland, and France followed.

In 2001, the Netherlands legalized same-sex marriages, and Belgium followed in 2003. Other countries have also followed suit, predominately in Europe but also in two South American countries, Argentina and Paraguay, and one African country, South Africa; France, Brazil, and New Zealand are the most recent countries to legalize same-sex marriages. As of 2014, 15 (of 194) countries allowed same-sex marriage (ProCon.org, n.d.).

However, the increased recognition of “marriage equity” does not translate to equal rights for LGB people globally. The UN continues to lead the way in advocating for the rights of the LGB population internationally. In 2012, the UN Human Rights (UNHR)/Office of the High Commissioner released *Born Free and Equal: Sexual Orientation and Gender Identity in Human Rights Law* (UN, 2012). This document outlines five core legal obligations of UN member states in protecting the human rights of LGBT people: (1) Prohibition of discrimination based on sexual orientation and gender identity; (2) legal protections from homophobic and transphobic violence; (3) prevention of torture and degrading treatment; (4) decriminalization of same-sex relationships; and (5) respect for and freedom of expression, association, and assembly (UN, 2012). In July 2013, the UN initiated a global public education campaign called “Free and Equal” based on the publication (UN, 2012). Nevertheless, little has changed in the proportion between countries criminalizing same-sex sexual acts between consenting adults and those that do not—76 countries (roughly 40 percent of UN members) have such laws, versus 114 (roughly 60 percent of UN members) that do not (Itaborah & Zhu, 2013). The failure to introduce substantial changes has translated to continued use of violence, oppression, and persecution of sexual minorities throughout much of the international community (HRW, 2012).

The use of law and policy to devalue and marginalize LGB people is bolstered by cultural and community norms. The result has been ineffective and inappropriate service delivery for sexual minorities (Institute of Medicine, 2011). Taken to the extreme, a practitioner’s ignorance of or disregard for LGB people can lead to the use of Sexual Orientation Change/Conversion Efforts (SOCE) or reparative therapy, practices that are explicitly condemned by NASW, the American Psychological Association, the American Counseling Association, and the American Psychiatric Association (Just the Facts Coalition, 2008; NASW, 2000). Researchers and mental health practitioners have noted that these therapies, which emerged in practice in the early 1990s, are most often unsuccessful and in many cases harmful (Maccio, 2011). In 2012 the preeminent SOCE supporter and researcher, Robert Spitzer, admitted flaws in his research and formally retracted his 2001 study that claimed gay men and lesbians could switch their sexual orientation (Grindley, 2012; Hein & Matthews, 2010). Despite the lack of scientific evidence as support, supporters of SOCE continue to believe sexual orientation can be successfully changed (Panozzo, 2013).

Population Affected

In 2010 it was estimated that 3.4 percent of U.S. adults, or approximately 8 million people, identify as lesbians, gay men, or bisexuals (Gates & Newport, 2012; U.S. Census Bureau, 2011). However, this estimated number may not reflect the actual population. Nonhetero-sexual orientation continues to be stigmatized in the United States, resulting in those with same-sex attraction or behavior not identifying as part of the LGB community to avoid the stigma and ostracism (Gates & Newport, 2012). Consequently, the exact number of LGB adults in the United States is unknown. What we do know is that the LGB community in this country is heterogeneous.

The LGB community is made up of a diverse group of people characterized by their same-sex attraction; sexual behavior; or self-identification as lesbians, gay men, or bisexuals. This population’s diversity is recognized across many demographic characteristics, including gender, age, income, and race or ethnicity. The LGB community is disproportionately affected by multiple social issues, including poverty, violence, health disparities, and oppression, which influence their well-being just as they do other minority populations. In a study of poverty among LGB people, researchers found that lesbians and bisexual women were more likely than heterosexual women to be poor, whereas men have similar economic status regardless of sexual orientation (Albelda, Lee Badgett, Schneebaum, & Gates, 2009). Violence (including hate crimes and bullying) directed at LGB people is a persistent social issue that adversely affects LGB adults and youths (Katz-Wise & Hyde, 2012; Martin & Alessi, 2012). Hate crimes based on sexual orientation are on the rise. In 2003, the FBI reported that 16 percent of all hate crimes were attributed to sexual orientation bias; in 2011, that number is at almost 21 percent (FBI, 2012). Data suggest that LGB individuals overall may be at increased risk for sexual violence and victimization as compared with their heterosexual counterparts (Rothman, Exner, & Baughman, 2011). Negative personal responses to this discrimination and oppression, including serious depression and suicide, are indicators of the ongoing processes of oppression that affect the LGB community. Research suggests that harassment of LGB young people is related to higher rates of depression, suicide, high school dropout, and teenage homelessness (Centers for Disease Control and Prevention [CDC], 2014). Many LGB youths become homeless because of family abuse, neglect, conflict over their identity, or being forced to leave a foster or group home because of mistreatment or harassment. A six-state public health survey found that within the homeless youth population, the risks associated with youth homelessness are exacerbated for those who self-identify as LGB. Once homeless, the LGBT youths are at higher risk for victimization, mental health problems, and unsafe sexual practices (National Alliance to End Homelessness, 2009; Van Leeuwen et al., 2006).

Research has repeatedly shown that LGB youths report higher rates of sexual, verbal, and physical assault than heterosexual youths. LGB youths who experience bullying or violence at school are more likely to have more absences than their heterosexual peers and experience adverse educational and health outcomes that persist into adulthood (Center for American Progress, 2010). Schools continue to be hostile environments for a large number of LGBT students, the overwhelming majority of whom hear homophobic remarks and experience harassment or assault at school because of their sexual orientation or gender expression. The environment has a direct negative impact on school performance, educational aspiration, and mental health and well-being (Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012). For many young people who identify as LGB, school-based harassment and bullying are compounded by family rejection and social stigma-tization, putting them at high risk for substance use, physical health problems, depression, and other mental health challenges (CDC, 2014; Fisher, Poirier, & Blau, 2013). Both LGB youths and adults appear to be disproportionately diagnosed with depression and substance abuse relative to heterosexual youths and adults, respectively (Institute of Medicine, 2011).

The prejudice and discrimination experienced by LGB people may be coupled with the impact of discrimination because of other (sometimes multiple) identities (for instance, identities based on race, ethnicity, age, or gender). For example, older LGB adults are at an increased risk to experience depression, social isolation, and elder abuse (Hash & Rogers, 2013).

LGB people are also members of families. Unequal access to family planning (such as adoption, foster parenting, and reproductive health services), condoned by public policies and laws, not only diminishes family relationships, but results in fewer resources and increased poverty level for many LGB families. For example, LGB couples cannot adopt jointly in the majority of the United States (Family Equity Council, 2011). Voters continue to pass state-level constitutional amendments that prohibit same-sex marriage, and multiple states do not allow lesbians or gay men to adopt or to foster children. State laws continue to prohibit any discussion of homosexuality in school (Kosciw et al., 2012).

Sexual orientation stigma, prejudice, discrimination, and other elements that support a heterosexist system of oppression in the United States are the leading explanatory factors for the social issues that affect the LGB population (Institute of Medicine, 2011). Understanding the history of the LGB communities and the impact of discrimination, stigma, and laws and policies on individuals, families, and communities is critical to ensuring culturally competent social work practice (NASW, 2007). As noted in NASW’s (2008) *Code of Ethics*, “the primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty." Social workers are expected to "challenge social injustice" and "respect the inherent dignity and worth of the person" (NASW, 2008).

It is the position of the NASW that discrimination and prejudice directed against any group are damaging to the social, emotional, and economic well-being of the affected group and of society as a whole.

POLICY STATEMENT

NASW is committed to advancing policies and practices that will improve the status and well-being of all LGB people. It is important to note that LGBT people may share a similar history, identify with similar communities and cultural identities, and may have multiple identities based on sexual orientation and gender identity. NASW reaffirms its support of the Transgender and Gender Identity Issues policy statement, recognizing the intersection of oppression among LGB, transgender, and inter-sex people. It is essential that NASW take a strong stance on behalf of all people and work to end the prejudice, oppression, and discrimination experienced on a daily basis.

Nondiscrimination and Equality

- NASW supports all social agencies, universities, professional associations, and funding organizations in their efforts to broaden statements of nondiscrimination to include sexual orientation.
- NASW supports the adoption of local, state, federal, and international policies and legislation that ban all forms of discrimination based on sexual orientation. LGB people must be granted all rights, privileges, and responsibilities that are granted to heterosexual people, including, but not limited to, inheritance rights, insurance, marriage, child custody and visitation, employment, credit, housing, and immigration.
- NASW supports the adoption of local, state, federal, and international policies and legislation that protect the rights and well-being of the children of LGB people.

- NASW supports efforts to end discrimination and harassment of LGB youths in public schools. NASW also supports the rights of LGB youths and allies to organize and operate in schools.
- NASW will promote LGB human rights and support advocates and civil society groups in the United States and globally through programmatic and financial assistance.
- NASW strives for full representation and establishment of means to affirm the presence of LGB people at all levels of leadership and employment.

Professional and Continuing Education

- NASW encourages curriculum policies in schools of social work that eliminate discrimination against LGB people.
- NASW encourages schools of social work to articulate the NASW position in curriculum; to require content on LGB people throughout the curriculum, in field instruction, and in continuing education programs and through the selection of textbooks; and to provide training for classroom instructors, field supervisors, and field advisors regarding LGB issues.
- NASW encourages social workers to increase their awareness of oppression, heterosexism, homophobia, and the intersection of multiple forms of oppression.
- NASW encourages licensing bodies to include questions specific to LGB issues.

Education and Public Awareness

- NASW supports school-based programming that addresses and stops anti-LGB bullying, gender-based violence, and other forms of discrimination.
- NASW encourages the development of programs, training, and information regarding the specific health, mental health, and

development needs of LGB youths and their families.

- NASW encourages the development of programs to increase public awareness of the violence and social injustice experienced by LGB people.
- NASW encourages the development of programs, training, and information that promote proactive efforts to end the violence and stereotypes perpetrated against LGB people.
- NASW applauds and supports organizations that fund, develop, and provide programming that portrays LGB communities compassionately and accurately.

Health and Mental Health Services

- NASW supports the right of individuals to self-disclose, or to not disclose, sexual orientation and encourages the development of supportive practice environments for LGB clients and colleagues.
- NASW reaffirms its stance against reparative therapies and treatments designed to change sexual orientation and against referring clients to practitioners or programs that claim to do so (NASW, 2000).
- NASW strongly advocates for the availability of culturally appropriate, comprehensive health and mental health services for LGB people across the life span, including HIV prevention and treatment, substance use treatment, psychological stress and dysfunction prevention and treatment, and suicide prevention.
- NASW calls for expanded resources to help federally funded community health centers provide improved care for LGBT clients, including culturally competent training for health and mental health providers.
- NASW recognizes the increasing number of LGB people opting to create families through biological reproductive technologies, adoption, foster caregiving, and the formation of alternative family systems and encourages the establishment of legal, medical, and social-psychological supports for these families.
- NASW condemns the use of SOCE or so-called reparative therapies by any person identifying as a social worker or any agency that identifies as

providing social work services. Public dollars should not be spent on programs that support SOCE.

- Federal agencies must work to combat criminalization of status based on sexual orientation or gender identity, including protecting vulnerable LGBT refugees and asylum seekers both in the United States and globally.

Political Action and Advocacy

- NASW encourages all social workers to develop and participate in coalitions with other human rights, social action, and professional associations to lobby for the rights of LGB people and to defeat efforts that aim at limiting LGBT people’s rights.
- NASW advocates for increased funding for programs designed to eliminate hate crimes and anti-LGB violence.
- NASW advocates for expanded federal law that legalizes and recognizes marriage of same-sex couples and provides pathways to immigration and citizenship to binational same-sex families currently available to opposite-sex couples.
- NASW advocates for increased funding for programs designed to provide education, health, and mental health services for LGB people.
- NASW supports the legal recognition of LGBT families through comprehensive parental recognition laws at the state level to fully protect children raised in these families.
- NASW calls on the United States and our global social work allies to fund and implement changes necessary to meet the core obligations of states with respect to protecting the human rights of LGB people.
- NASW supports the expansion of ENDA to include perceived or actual sexual orientation to provide equal protections for LGB people from discrimination in employment, education, credit, housing, and other public and private spheres.

Research

- NASW advocates for increased funding for research that increases our understanding of issues affecting LGB people.
- NASW advocates for allocation of necessary resources to implement the research agenda recommended by the Institute of Medicine (2011) to advance understanding of LGBT health, including data collection, methodological research, research training, and policy on research participation of LGBT people.

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Policy statement approved by the NASW Delegate Assembly, August 2014. This policy statement supersedes the policy statement on Lesbian, Gay, and bisexual Issues approved by the delegate Assembly in 2005; there is also a separate policy statement focused on Transgender and Gender Identity. For further information, contact the national Association of Social Workers, 750 First Street, NE, Suite 800, Washington, DC 20002-4241. Telephone: 202-408-8600; e-mail: press@socialworkers.org

Licensing and Regulation of Social Work Practice

ISSUE STATEMENT

A central mandate for NASW, memorialized in both its Articles of Incorporation (3[2]b&c) and Bylaws (II.2.c&d; IV.B.2.e) (NASW, n.d.), is the establishment of standards of professional social work practice and participation in programs for the licensing of social workers. However, the constitutional power to license the various professions belongs with the states, and by 2017, all states had enacted licensing laws and established licensing boards to advance this mandate for social work. These laws and programs vary dramatically in respect to the appropriateness of these standards and the ways that they affect both the public and professional social workers. To support the periodic efforts of states to update and strengthen these laws, it is essential that the social work leadership advocate for model licensing standards; provide guidance for the states in their efforts to improve the consistency, transparency, and integrity of these standards; and to assure that they are responsive to emerging needs and practice trends, especially those that are empirically validated.

The credentialing of social workers was first launched in 1934, when Puerto Rico passed the first such statute. However, it was not until 1945 that California became the first state to register social workers (California Board of Behavioral Sciences, n.d.). By 1978, 23 states had developed social work credentialing systems. At that time, 12 of those states participated in the founding of the Association of Social Work Boards (ASWB), which has developed testing protocols that virtually all states now use as part of their licensing requirements. By 2017, all 50 states and the District of Columbia had enacted social work licensing laws that establish standards that define who may call themselves a social worker, as well as examination boards, continuing education requirements, and disciplinary procedures.

At this time, social work licensing laws vary dramatically between the states. Throughout the United States and Canada, 42 different titles are used to describe social work credentials (ASWB, 2013). These laws also vary in respect to the number of discrete levels of practice that are recognized and the ways that these levels are defined. A few states only have one level, for example, a license for those who graduate from MSW programs. Other states have as many as four levels that range from the associate degree level to the post-MSW independent level of practice. For most states, the entry level requires a bachelor's degree, sometimes specifically in social work (BSW); in others a bachelor's degree (BA/BS) in a related field is sufficient. This license usually permits social workers to perform basic, often concrete services within an agency under supervision. The two higher levels typically involve a level for those with an MSW and an advance level that permits independent practice, either within an agency or at a private practice, for those with an MSW and with at least two years of post-MSW experience. As of 2016, three states (Massachusetts, South Dakota, and Texas) recognized all four levels of licensing; 26 states and the District of Columbia have three-level systems; 14 states have two-tiered systems; and seven states have a single level.

The strength of licensing laws also varies dramatically, and this is particularly dependent on whether the system is a voluntary and private one, or a required one (that is, mandated by state laws). Many of the current state licensing systems, when initially launched, only required registration or certification. But most now attempt to provide some degree and combination of title and practice protection. Whereas title protection regulates those who may call themselves a social worker, licensing systems with practice protection attempt to define the types of practice activities that are regulated. Closely related to public or quasi-public licensing programs are private and voluntary credentialing services, such as those offered by NASW. NASW offers several advanced credentials and specialty certifications. The three nonspecialized ones are the Academy of Certified Social Workers (ACSW), the Qualified Clinical Social Worker (QCSW), and the Diplomat in Clinical Social Work (DCSW). NASW's specialty certifications include Certified Advanced Children, Youth, and Family Social Worker (CACYFSW); Certified Children, Youth, and Family Social

Worker (C-CYFSW); Certified Social Worker in Health Care (C-SWHC); Certified Clinical Alcohol, Tobacco, and Other Drugs Social Worker (CCATODSW); Certified Advanced Social Work Case Manager (C-ASWCM); Certified Social Work Case Manager (C-SWCM); and Certified School Social Work Specialist (C-SSWS).

The design and implementation of the various licensing and certification systems are complicated not only by the diverse terms and number of levels used, auspices, and institutional environments in which they are developed, but also by the varied goals and values that have motivated their development. Needs include protecting consumers from unscrupulous practitioners, assuring the highest quality of care, and demanding equity and transparency for both consumers and practitioners. There is also the need to protect practitioners and to limit competition, particularly from those who are unqualified and who might underbid those who have invested considerable time and resources into their education and training. As such, licensing provides a type of franchise intended to incentivize individuals to make the requisite investment into the development of professional practice skills. These and other values all inform the selection of licensing requirements and other protocols. These provisions include arrangements for reciprocity between states, continuing education, supervision requirements, and appeal procedures that collectively may generate a system that, at one extreme, may be excessively lax, permitting practice on the part of unqualified individuals, or excessively restrictive, minimizing opportunities for practice on the part of otherwise qualified social workers.

There have been several efforts to establish consistent standards between the states. Most notably, the American Association of State Social Work Boards in 1998 published a recommended Model State Social Work Practice Act (1998). This model promotes multilevel licensing that includes the BSW level, strict disciplinary procedures, and privileged communications, and it urges standardization of credentialing statutes so as to enhance reciprocity between states. It also would extend licensing requirements to the public sector, a field of service that is currently exempted in many states. The many sources of variation in public and private systems for the regulation of practice throughout the United States, and the resulting efforts to bring some consistency to the diverse regulations, form the essential backdrop of many of the problems that social workers are currently encountering in their efforts to assure high standards, fairness, and accessibility in the licensing of social work practice.

The central issues involving the nation’s diverse licensing systems arise from the needs of consumers for protection and transparency and the needs of professional social workers for recognition and legitimation of their expertise. These needs usually operate in concert and often do not conflict. However, there remain many countervailing forces that too often bring these needs into conflict and, thus, undermine the integrity of existing licensing systems. Some parties, such as unions, politicians, and state administrators, may compete to satisfy their constituencies by defining standards for social work, rather than implementing those established by professional social work associations. These forces may sometimes result in lax licensing requirements or even the failure to require professional social work degrees. Some states license individuals with only associate degrees, or even just with a high school degree. Because the Council on Social Work Education (CSWE) does not accredit social work programs at either of these levels, these licenses are essentially awarded without any professional social work education (as happens in Massachusetts, for example). In other states, lax licensing requirements are exemplified by exemptions from licensing for large and important groups of workers, such as public employees.

The claims of allied helping professions to provide the same or similar services as social work can often result in a lack of adequate definition of social work services, and conversely, rejection of legitimate claims from other professions can lead to overly restrictive definitions that fail to recognize the need for interdisciplinary collaboration. In some cases, the advocacy of other professional groups can result in a rejection of the role of professional social workers in recognized areas of practice, such as psychiatric diagnosis and assessment.

The breadth of social work as a profession presents important challenges in the establishment of appropriate licensing laws. Frequently there is overlap of recognized social work activities with those of other groups. This problem may be minimized if the other professional groups themselves have established rigorous licensing standards, but when they have not, and when they inappropriately claim any social work activities as their sole purview, resulting professional rivalry only serves to weaken standards and, consequently, professional practice. Conversely, in many states the licensing standards do not include regulation of important areas such as policy practice, management, and community organizing. This de facto exemption of major areas of practice can potentially result in the marginalization of a significant body of social work practitioners, inadequate public protection, and a skewed public definition of social work as an exclusively clinical profession.

With the development of evidence-based practices, both in general and specifically in social work, increasingly concerns are being raised about the empirical reliability and validity of existing standards, particularly licensing tests (Woodcock, 2016). Licensing boards understandably need to contract with national testing services, such as those offered by ASWB, but it is essential that these boards demand evidence of not only the achievement of recognized psychometric benchmarks of reliability and validity, but also the cultural and linguistic appropriateness of these tests. The privatization of professional testing highlights the need for the vigilant and systematic oversight of the privatized services.

Another critical issue affecting many social workers in the United States is the lack of reciprocity. Too often when social workers move to another jurisdiction, they must retake tests and resubmit materials that may no longer be available to become relicensed in the new state, even when there is a substantial similarity of licensing requirements. This is a significant problem, not only for the individual social worker, but for the social work workforce as a whole, which, as a result, is inhibited in its movement to adapt to changing workplace needs and trends. And with the development of online technologies and Internet-based practices, the growth of practitioners attempting to practice across state lines only serves to highlight the problem of inadequate reciprocity of licensing standards across states.

POLICY STATEMENT

One of the hallmarks of a mature profession is that it is self-regulating; that its practitioners are the ones who establish standards and regulate their peers; and that external groups, such as the public, politicians, and bureaucrats, have only a secondary role in assuring accountability. Thus, it is essential that professional social workers assume the leadership role in the development and oversight of social work licensing laws, whatever legal jurisdictions may be tasked with this responsibility. The preeminent means for social workers to fulfill this responsibility is through their professional associations. NASW, according to its Articles of Incorporation, regards its role in the licensing of social workers as one of its core responsibilities, and this includes support for and close collaboration with public licensing boards, collateral professional associations, and other social work organizations, particularly ASWB, CSWE, and the Society for Social Work and Research. Thus, NASW supports the following:

- strong laws that provide for both title and practice protection, that is, regulation of the use of the terminology of social work and similar terms and specification of the range of practice roles, methods, services, and activities that professional social workers are entitled to perform or provide
- minimum standards for entry into professional social work practice that should consist of, at minimum, a degree from an accredited social work educational program; demonstration of ethical conduct; and an appropriate level of supervised practice, either within a social work educational program or in professional practice
- recognition of the full range of levels of practice (beginning, intermediate, and advanced); the major fields of practice, such as clinical and policy practice; and organizational auspices, such as private nonprofit and for-profit organizations, governmental and military organizations, quasi-public organizations, and private practice, where professional social workers are known to work (when a group is exempt from licensing and regulation—as in the case of macro social workers—efforts should be made to determine the most appropriate strategies for filling the gap)
- the importance of licensing laws that, at once, provide equitable access of cultural, racial, linguistic, and other minorities, to opportunities for social work practice, and also maximize consumer protection, based on testing and other regulatory protocols for which there is empirically demonstrable reliability and validity for the most widely recognized best practices in professional social work

- systems for the licensing of social work professional practice that provide for multiple levels of licensing, ones that recognize the greater needs for supervision and support of those new to the profession and, at the same time, assure appropriate level of independence and autonomy for those at advanced levels of practice, whether they work in formal organizations or private practices
- the inclusion in licensing systems of requirements for appropriate supervision, depending on the level of licensure, and for career-long continuing education and training
- the requirement for, among those who are licensed, knowledge of and adherence to the NASW (2015) *Code of Ethics*, as well as an appropriate and just system for investigating allegations of infringements of ethical standards, and the sanctioning, with due process, of those found in violation of the code
- collaborative work among social work professional associations involved with licensing and practice regulation, and licensing boards and other concerned groups, toward developing common licensing standards and protocols, including common continuing education requirements; the maximum possible reciprocity should be developed between states and other legal regulatory bodies so as to minimize unnecessary duplication of application, testing, and other credentialing requirements for those who need to move or obtain licenses in multiple jurisdictions
- maximum transparency in the dissemination of the results of monitoring, research, and advocacy efforts involving the licensing and regulation of social work practice.

The essential policy is that social work professionals, through their various associations, should assume leadership roles in the licensing and regulation of social work practice. These roles should include monitoring; assessing; and responding to trends, needs, and other developments among the many licensing and regulatory systems that have an impact on professional social workers and the clients that they serve.

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Long-Term Services and Supports

ISSUE STATEMENT

Long-term services and supports (LTSS) help individuals with disabilities and older adults to maximize their independence and quality of life. Though typically defined as assistance with activities of daily living and instrumental activities of daily living (Commission on Long-Term Care [Commission, hereinafter], 2013), LTSS are intended to form a comprehensive continuum that maximizes both physical functioning and psychosocial well-being, building on community, individual, and family strengths. Individuals use LTSS in a variety of locations, including in their own homes and in a range of community-based and residential care settings. Families—including both legally recognized family and family of choice—provide the majority of LTSS in the United States, usually on an unpaid basis (O'Shaughnessy, 2013a). Family care-givers' efforts are supported and complemented by an interdisciplinary workforce that includes professional social workers.

The number of people relying on LTSS has grown dramatically as the population ages and the number of people living with chronic conditions increases. LTSS users number more than 12 million (Commission, 2013), a figure anticipated to more than double by the year 2050 (Henry J. Kaiser Family Foundation, 2013). Although the mounting prevalence of Alzheimer's disease and related disorders contributes greatly to LTSS need (Alzheimer's Association, 2013), people of all ages and conditions depend on LTSS.

Across LTSS settings, numerous policy strategies to coordinate and improve access to services, enhance quality, and increase participant and family involvement and satisfaction are being implemented, many as a result of the Patient Protection and Affordable Care Act (ACA) of 2010 (P.L. 111-148). However, much work remains to create a comprehensive, integrated system of high-quality, affordable LTSS. Many LTSS continue to be based on a deficit-focused, medical model that does not fully support the self-determination of participants and families. Fragmentation and lack of monitoring, navigation, coordination, advocacy, and psychosocial supports can prevent many people with disabilities and older adults from living to their fullest potential. Furthermore, LTSS access, coordination, and quality are limited by disparities related to a variety of cultural factors, including (but not limited to) class, ethnicity, gender, gender identity, geography, health conditions, immigration status, language, race, and sexual orientation.

The lack of a sustainable system of LTSS financing is widely recognized as a crisis—one that is inseparable from both access and quality. Public, private, and out-of-pocket spending for LTSS in the year 2011 totaled more than $210 billion, and this figure is far from exhaustive (O’Shaughnessy, 2013b). The private long-term care insurance market, once thought to be the solution to LTSS financing, is dwindling (Gleckman, 2012). Those policies that do remain are unaffordable for most people in the United States (Kassner, 2013)—especially people of color (Rhee, 2013) and women (Gross, 2013)—and a significant number don’t cover many integral LTSS (Commission, 2013). In 2010 the ACA created a voluntary, national long-term care insurance system, Community Living Assistance Services and Supports (better known by its acronym, CLASS), but the program was subsequently deemed financially unsustainable and was withdrawn (Appleby & Carey, 2011; Span, 2011). In 2013 Congress established the bipartisan, independent Commission on Long-Term Care, which was charged with developing a national LTSS plan within six months (Commission, 2013; Norman, 2013). When the commission failed to generate substantive recommendations to address the LTSS financing crisis, a subgroup of commissioners published a separate report advocating for a publicly financed social insurance program (Butler, Claypool, Feder, Ruttledge, & Stein, 2013).

Financial pressures have contributed to the continued growth of managed care within Medicaid, Medicare, and entire service sectors. Managed care plays a particularly prominent role in initiatives to improve care and decrease costs for dually eligible beneficiaries. However, the implementation of these initiatives has raised ethical concerns, such as elimination of beneficiary choice (Community Catalyst, 2012; Musumeci, 2013). Thus, managed care's success in improving the quality, coordination, and integration of LTSS remains in question.

On the other hand, the most critical LTSS receive almost no funding whatsoever. Families remain the primary providers of LTSS in home and community-based settings and provide invaluable support in residential care settings, as well (O'Shaughnessy, 2013a). Such caregiving—which has been valued at $450 billion per year but is usually uncompensated—places significant physical, emotional, and financial stress on families, especially women (Feinberg, Reinhard, Houser, & Choula, 2011; National Alliance for Caregiving, 2009). Despite growing attention to the contributions and strains of family care-giving, neither the public nor the private sector has implemented sufficient changes to support families in their caregiving roles. Moreover, decreasing fertility rates, shifting family structures, and changes in population health will likely decrease the availability of family caregivers (Feinberg et al., 2011). This decreased availability contrasts with the increased need for family caregiving, as the population experiencing functional limitations grows.

Although the Program of All-Inclusive Care for the Elderly (better known as PACE), home health, and hospice have long provided LTSS in home and community-based settings, few home and community-based services (HCBS) have been publicly funded until recently. Changes in public policy have increased the availability of publicly funded HCBS over the past two decades, but these efforts have been limited by insufficient resources and infrastructure. Spurred by the disability rights movement, the Supreme Court's *Olmstead v. L.C.* decision (1999), and the ACA, a growing proportion of publicly funded LTSS are now provided in home and community-based settings. Thanks to various rebalancing initiatives, such as Money Follows the Person, the proportion of Medicaid funds spent on HCBS grew from 20 percent in 1995 to 45 percent in 2011 (Henry J. Kaiser Family Foundation, 2013). However, HCBS availability under Medicaid waivers and state plan amendments (SPAs) varies greatly by state, and access to such services is both limited and inequitable (Isaacson, Carlson, & Rich, 2012). Moreover, though waivers and SPAs may enhance LTSS access for certain beneficiaries, they may also introduce other changes that can negatively affect beneficiaries (Families USA, 2012). In addition to Medicaid, numerous programs authorized by both the Older Americans Act (OAA) most recently amended in 2006 (P.L. 109-365) and the

Developmental Disabilities Assistance and Bill of Rights Act of 2000 (P.L. 106-402), among other funding streams, support community living for individuals with disabilities and older adults. However, inadequate funding, federal budget cuts, and difficulty securing congressional reauthorization have limited older adults' and families' access to OAA-funded services.

Beyond these traditional public funding sources for HCBS, other resources and initiatives have emerged to support people with disabilities, older adults, and family caregivers. For example, employer-based eldercare programs and professional geriatric care management have become increasingly popular, and social workers play strong roles in both. Innovative initiatives to create supportive environments for people with disabilities and older adults include age-friendly communities, Communities for All Ages, Livable Communities, NORC (naturally occurring retirement communities) Supportive Service Programs, and Villages. Such initiatives may be more difficult to implement in rural and frontier communities, however. Technology also plays an increasingly important role in enabling individuals with disabilities and older adults to live in their communities, though assistive technology and other tools remain unaffordable to many (Commission, 2013). Lack of affordable, accessible housing and transportation also poses a barrier to community living.

The limitations of government, the private sector, and communities notwithstanding, the shift toward HCBS over the past quarter century reflects some movement toward a person-centered LTSS system. The social work profession has long promulgated a person-centered approach, which promotes each individual's choice and dignity. Enabling people to live in the least restrictive setting possible is one indicator of such an approach. At the same time, residential care settings, such as nursing homes, remain an integral component of the LTSS continuum, and the social work profession has been at the forefront of advocacy for nursing home residents and families (Kane, 2008). The Omnibus Budget Reconciliation Act of 1987, popularly known as OBRA '87 (P.L. 100-203), marked a watershed in federal policy to ensure the rights and safety of nursing home residents. Yet, much work remains to realize the law's goals, such as reducing the use of physical and chemical restraints (Centers for Medicare & Medicaid Services, 2013; National Consumer Voice for Quality Long-Term Care, 2007, 2011b). Meeting residents' psychosocial needs also remains an ongoing problem; although the revised Resident Assessment Instrument Minimum Data Set (MDS 3.0) includes enhanced psychosocial screening requirements, insufficient training and high caseloads preclude meeting resident needs identified therein (Simons et al., 2012). Other efforts to improve the quality of nursing home care include the culture change movement, which has strived to transform services—across settings, but with a historical focus on nursing homes—in accordance with person-directed values (National Consumer Voice for Quality Long-Term Care, 2011a; Pioneer Network, n.d.). This work has not only spawned the development of various socially oriented care models, but has also begun to influence federal requirements for nursing home care. Nonetheless, the quality of nursing home care remains problematic, in part because of insufficient staffing, cuts in reimbursement, lack of financial accountability, and inadequate state regulatory enforcement (Alliance for Quality Nursing Home Care, 2012; Bern-Klug et al., 2009; Harrington, 2013; U.S. Department of Health and Human Services Office of Inspector General, 2014; U.S. Government Accountability Office, 2008, 2009).

Numerous workforce concerns also affect access to high-quality LTSS. Providers are diversifying their service offerings and supporting people with increasingly complex needs, sometimes without proper training or planning. Although teamwork among provider organizations and within interdisciplinary teams has never been more critical, many struggle to collaborate amid growing demands and shrinking resources. An insufficient supply of well-trained, well-compensated, experienced practitioners constitutes a growing challenge (Congressional Budget Office, 2013; Institute of Medicine, 2008, 2012). The demand is particularly high for direct-care workers, who provide essential LTSS with minimal training, low wages, limited access to insurance, and few advancement opportunities (Paraprofessional Healthcare Institute, 2013). Improved working conditions for direct-care workers are integral to the provision of quality LTSS.

Workforce shortages and challenging working conditions also affect the social work profession’s ability to provide high-quality LTSS. The supply of social workers has not kept pace with the need (Assistant Secretary for Planning and Evaluation, 2006; Institute of Medicine, 2008, 2012; Whitaker, Weismiller, & Clark, 2006a, 2006b). Many within the profession’s predominantly female workforce have unmanageable student debt, often combined with low salaries (Whitaker, 2008; Whitaker et al., 2006a, 2006b, 2006c). The social work role in LTSS is not always well defined, and many social workers struggle with conflicting role expectations. Furthermore, the deprofessionalization of social work roles in a variety of LTSS settings compromises individuals' and families' access to high-quality psychosocial care (Herman, 2012; Zimmerman, Connolly, Zlotnik, Bern-Klug, & Cohen, 2012). Thus, the continued development of LTSS presents both opportunities and challenges to the profession to define and strengthen its role in service delivery, planning, and administration; expand its evidence base; and engage in policy advocacy on behalf of, and in collaboration with, people with disabilities, older adults, and family caregivers.

POLICY STATEMENT

NASW advocates for each individual's right to attain and maintain optimal biopsychosocial functioning in the least restrictive environment. Accordingly, NASW supports legislation, policies, practices, programs, regulations, and research that promote person-centered LTSS based on the following principles:

- a comprehensive, integrated continuum of supports, services, settings, and delivery models to meet each individual's and family's biopsychosocial needs related to aging, chronic conditions, disability, cognitive impairment, functional limitations, and caregiving
- equitable access to high-quality, affordable LTSS for all who need them, without regard to age, disability, ethnicity, gender, gender identity, geographic location, immigration status, income, language, medical diagnosis, preexisting health conditions, race, sexual orientation, or other factors
- collaboration with clients in all aspects of LTSS planning and provision (including advance care planning) to maximize dignity and self-determination
- educational, emotional, financial, and physical support for family caregivers, including recognizing each individual's definition of *family*

- coordinated assessment, service planning, and service delivery by well-trained interdisciplinary teams, with particular attention given to client transitions between LTSS practitioners and settings
- access to professional social work services in all settings, regardless of medical diagnosis, payer, or involvement of other disciplines
- recognition of, and support for, the integral role of direct-care workers in LTSS
- protection of consumer rights, including privacy and confidentiality, and application of ethical principles throughout the LTSS system
- strengthening the regulatory enforcement system to ensure high-quality care and protect individuals from harm
- expansion of specialized education, training, standards, and staff development—both within and beyond the social work profession—to enhance the quality of LTSS
- expansion and integration of tools, training, and research to facilitate culturally and linguistically appropriate LTSS
- expansion and integration of research on LTSS systems, service delivery, and participant needs
- development of research infrastructure to expand the evidence base for social work in LTSS
- incorporation of program evaluation findings in advocacy efforts and service delivery, to improve LTSS access and quality
- promotion of a comprehensive social insurance financing system that provides universal access to affordable, high-quality LTSS
- preserving the integrity of social security, Medicare, Medicaid, and other economic and social support programs
- increased federal and state funding to enable individuals to access high-quality, cost-effective LTSS in the setting of their choice
- implementation of innovative models to support individuals, families, and communities in preparing for and responding to LTSS needs
- increased compensation for the LTSS interdisciplinary workforce, especially for social workers and direct-care workers.

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Mental Health

ISSUE STATEMENT

Mental health is a state of successful performance of mental function resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. It is essential to personal well-being, family, interpersonal relationships, and the ability to contribute to community and to society (U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion [HHS, ODPHP], 2020).

Mental disorders are health conditions in which alterations in mood, thinking, or behavior result in distress or impaired functioning. They are diagnosed by qualified health care professionals, including clinical social workers. Examples of mental health illnesses include anxiety, depression, posttraumatic stress disorder (PTSD), and schizophrenia. Nearly 20 percent of adults and 17 percent of youths ages 13 to 18 live with a mental illness (National Institute of Mental Health [NIMH], 2020a). Approximately 4.5 percent of adults experience severe and persistent mental illness (SPMI). Mental health disorders are among the leading cause of disability in the United States (HHS, ODPHP, 2020). They are also highly associated with suicide, which is a leading cause of death overall in the United States. Suicide rate has increased by 31 percent since 2001, and 46 percent of people who die by suicide had a diagnosed mental health condition (NIMH, 2020c).

Depression and anxiety are the most common mental disorders. Sometimes these and other mental health disorders occur together. The costs associated with mental health conditions are staggering, in terms of individual human suffering and impacts on communities and society.

Mental health disorders are amenable to treatment or intervention. More individuals are seeking and receiving mental health services, especially with more and easier ways to access services through technology platforms and the increasing integration of behavioral health services into primary care settings (National Association of Social Workers [NASW], Association of Social Work Boards, Council on Social Work Education, & Clinical Social Work Association, 2017). However, significant barriers to care remain, including social stigma, cost, and lack of sufficient availability of qualified providers. This often results in either long delays in treatment or no treatment at all. There are also significant disparities in mental health care. Almost 50 percent of White Americans received mental health treatment, compared with 31 percent of African Americans and Hispanics and 20 percent of Asian Americans (National Alliance on Mental Illness, 2019). Additional reasons for mental health disparities include lack of insurance, lack of diversity among mental health care providers, lack of culturally competent providers, language barriers, and distrust in the health care system (Agency for Healthcare Research and Quality, 2016).

Compared with the general population, individuals with SPMI (for example, schizophrenia, other psychotic disorders, or bipolar disorder) tend to have a shorter life expectancy (Liu et al., 2017). These premature deaths are associated with preventable somatic causes even when we control for suicide. The mortality gap is widening in developed countries (Lomholt et al., 2019) and has been observed to exceed two decades (Lee et al., 2018). Disparities in the provision of health care services have been identified as causing poor health outcomes among individuals with SPMI (Lawrence & Kisely, 2010). These disparities are attributed to pervasive social stigma and to systemic problems such as lack of integration between physical and mental health services. Case management and care coordination interventions are effective in reducing health disparities and premature mortality among this vulnerable population (Druss et al., 2010). Collaborative-care and integrated-care models, in which primary care and mental health providers regularly interface, are emerging as best practices in addressing the comorbidities of physical and psychiatric disorders (Kroenke & Unutzer, 2017).

Mental health challenges are concentrated on those who experience SPMI resulting in functional impairment or distress that interferes with or limits one or more major life activities. With the onset of integrated health care and the increased awareness of the correlation between physical and mental health, there are a greater number of social workers in a variety of health care settings, which makes services more accessible to clients.

Over 17 percent of U.S. children ages two through eight have a diagnosed mental, behavioral, or developmental disorder (Cree et al., 2018). The most common mental health issues for children and adolescents are attention-deficit/hyperactivity disorder (ADHD), anxiety, depression, and behavior disorders (Danielson, Bitsko, Ghandour, Holbrook, & Blumberg, 2018). Major depression among adolescents ages 12 to 17 increased 52 percent from 2005 to 2017 (Twenge, Cooper, Joiner, Duffy, & Binau, 2019). Fifty percent of mental health disorders develop before age 14, and three-quarters begin by age 24 (American Psychiatric Association, 2020).

Exposure to adverse childhood experiences (ACEs) negatively affects mental health outcomes throughout the life span (Kerker et al., 2015; Merrick et al., 2017). ACEs are common and prevalent across socioeconomic groups and often co-occur (Hughes et al., 2017). Poverty, racism, and other community-level stressors exacerbate the cumulative impact of ACEs (Cronholm et al., 2015; Mersky, Janczewski, & Topitzes, 2017). Toxic stress is known to disrupt normal brain development in young children and can lead to impaired self-regulation and executive functioning in adulthood (Center on the Developing Child, Harvard University, 2020). Prolonged exposure to multiple ACEs interferes with the ability to manage life stressors, compromises meaningful functioning in various roles, undermines resilience, and increases vulnerability to severe mental health problems in adulthood (Nurius, Green, Logan-Greene, & Borja, 2015).

Social determinants of health (SDOH) are taking center stage in the discourse regarding health disparities. There is a growing awareness outside the field of social work that the conditions in which people are born, grow, live, work, and age greatly influence their well-being. Health care professionals and policymakers are increasingly aware that improving population health and reducing disparities requires attention to social, economic, and environmental factors (Artiga & Hinton, 2018). It is important to note that ACEs significantly overlap with the commonly agreed-on SDOH. In other words, ACEs and childhood trauma are directly associated with poor health outcomes in adulthood (Monnat & Chandler, 2015). Policies aimed at closing health disparities must, therefore, also address and prevent the prevalence of childhood trauma (Larkin, Shields, & Anda, 2012).

There is a growing consensus among practitioners and researchers that the impact of ACEs differs from that of a single traumatic experience, in that the first leads to complex PTSD and the latter to simple PTSD (as described in the DSM-5) (Karatzias et al., 2017). There is often a distinction between interpersonal trauma and trauma caused by accidents and natural disasters (Yehuda & Hoge, 2016). Availability of community support and perceived locus of control are linked to successful recovery (Hyland et al., 2017). Unfortunately, children who experience chronic exposure to multiple ACEs do not meet criteria for PTSD and are instead diagnosed with ADHD, oppositional defiant disorder, disruptive mood dys-regulation disorder, conduct disorder, and so on (van der Kolk, 2014). As adults, they may be misdiagnosed with anxiety, depression, bipolar disorder, or borderline personality disorder.

Sixty-one percent of areas with a mental health professional shortage are rural or partially rural (HHS, Health Resources and Services Administration, Bureau of Health Workforce, 2017). The shortage of mental health providers in rural areas, compared with those in urban areas, has a significant impact on access to mental health services. Other factors include higher poverty rates, geographic isolation, and a lack of transportation, which can make it challenging for individuals in rural areas to access behavioral health services. Suicide rates in rural areas continue to be higher than in urban areas, regardless of age, gender, race, or social class (HHS, National Advisory Committee on Rural Health and Human Services, 2017).

Military personnel and veterans also encounter trauma through being at war, multiple and extended deployments, and separation from loved ones. These factors contribute to the development of mental health issues such as PTSD, depression, substance use, and anxiety. Mental health problems experienced by this population have an effect on military personnel’s families during deployments and when they return home.

Substance use in combination with mental illness is known as co-occurring disorders or dual diagnoses. Individuals with substance use disorders are 50 percent more likely to also suffer from a mental illness, and vice versa (National Institute on Drug Abuse [NIDA], 2020). Many individuals with a mental health disorder use alcohol or drugs to manage their mental illness, which is referred to as self-medication (NIDA, 2020). Approximately 7.9 million adults in the United States have both a substance use disorder and another mental illness (NIMH, 2020b). Co-occurring disorders run across all backgrounds and geographical locations (Somers, Moniruzzaman, Rezansoff, & Brink, 2016). Although most social workers understand the strong correlation between substance use and mental health disorders, there is a shortage of providers who have received specialized training in how to treat co-occurring disorders simultaneously. Integrated treatment that takes place in a community setting and that involves an interdisciplinary team, as well as relapse prevention services, such as ongoing aftercare and support, are considered to be effective interventions in treating co-occurring disorders (Pettinati, O'Brien, & Dundon, 2013).

Interventions and treatment of mental health disorders, either with or without a co-occurring disorder, are a continued focus for social workers. When delivering services by using new and emerging technologies, social workers need to balance the profession's tenets—such as self-determination and meeting the client where they are—with their best interest, ethics and boundaries, professional conduct, and standards of care. Social workers should use technologies that ensure privacy and confidentiality and that pose no harm to the client. Technological innovations can improve the quality of and access to mental health care. Social workers are encouraged to explore the potential of innovations such as virtual reality and artificial intelligence (Hudlicka, 2016; Luxton, 2014a) while remaining mindful of new ethical and moral challenges that these technologies may present (Lovejoy, Buch, & Maruthappu, 2019; Luxton, 2014b).

POLICY STATEMENT

NASW maintains its commitment to enhancing the well-being of people living with mental illness and working toward increased access to appropriate services and interventions. This commitment is based on the premise that a holistic view of clients integrates the need for services in both physical and mental health. NASW is committed to improving mental health services and for public policy advocacy to improve the quality of care, access, reimbursement, research, and education in mental health. NASW encourages providers to embrace evolving technologies, in an effort to maximize accessibility of services and minimize barriers to mental health treatment using nontraditional interventions.

To further the advances that have been made in the prevention, diagnosis, assessment, and treatment of mental illness, NASW supports the following:

Prevention and Education

- Routine screening for mental health disorders in primary care, other health care, and school settings Prevention and outreach programs, including education, consultation, and early screenings/ assessments that should be fully funded and provided to the public to promote
    - an understanding of the strong, reciprocal relationship between physical and mental health
    - awareness of the major role of social determinants or social factors in individual mental health
    - design and implementation of mental health policies and programs that recognize and address the role of social determinants

Access to Services

- Fully integrated, comprehensive services available for all who experience mental illness. Besides the traditional methods of service delivery such as in-person psychotherapy and case management, social workers should use telehealth services to increase access to behavioral health services, particularly in rural and inner-city areas that are facing severe shortages of behavioral health services due to isolation and a paucity of local providers.
- Clients with a mental illness should be able to continue services with the provider of their choice and should not be restrained by lack of social worker license mobility from one jurisdiction (for example, state or territory) to another.

- Culturally responsive interventions in the client’s native or preferred languages should be included in the provision of effective mental health care.
- With patient consent, family members and significant others should be included, if appropriate, in the process of assessment, treatment planning, and intervention, and should have access to supportive services to help them address the problems posed by the mental illness of a loved one.
- Mental health care parity with medical or physical health care is essential and should be defined consistently among health plans and payers. Plans and payers should not impose co-pays, deductibles, and lifetime caps on coverage for mental health and substance misuse coverage that is different from physical health care coverage. Health care plans and payers covering any health care services must also provide coverage for mental health and substance misuse services, and that coverage and cost must be on a par with all other health care services covered under such policy.
- To reduce mental health disparities, the focus should be on improving the quality of mental health treatment and services for all, which in turn will benefit communities of color who tend to suffer the most from mental health disparities. Mental health parity includes improved quality of and access to services delivered by telehealth technologies.
- A broad range of options for housing and vocational services should be available to people who have SPMI so as to strengthen their independent living skills, support their efforts to build stable and supportive relationships, and improve their quality of life. These services should be tailored to the individual’s needs and abilities.
- Employment status should not affect social insurance, public assistance, or access to other programs.

Intervention and Treatment

- Treatment should be evidence based.
- Behavioral health care payers and plans should rely on the best judgment of mental health clinicians, along with the client’s desired goals and

outcomes when making service determinations, including the type, level, and duration of services.

- Clients should be given treatment options that meet their needs, including telehealth services, that are provided in the most therapeutic and least restrictive environments possible.
- Universal suicide assessments should be provided for clients of all populations, and across the life span.
- Clients screened and treated for mental health disorders also need to be screened for substance use disorders.
- Clients with co-occurring conditions of mental health and substance use disorders should not be given undue weight in the assessment of functional capacity or in eligibility determination for social insurance, public assistance, and social services. Clients should not have to relinquish treatment for coverage.
- The mental health challenges faced by veterans and their families should be addressed in a comprehensive and readily accessible manner. Education and early intervention for returning service personnel and their families should be provided as an integral part of their transition.
- Clients in the criminal justice system should be provided full access to mental health services, including screening, assessment, medication, counseling, and discharge planning.
- To strengthen best practices, social workers should pursue research funding to evaluate mental health treatment methodologies and outcomes. Underserved populations should be included in the design of research projects whenever possible.

Workforce

- Mental health clinicians, including social workers, should be adequately reimbursed and compensated by government and commercial payers.
- Employers should ensure manageable client caseloads.
- Employers should provide sufficient training, education, and professional development to mental health clinicians, including social workers.

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Parental Abduction

ISSUE STATEMENT

Parental abduction, kidnapping, or taking of children is linked with major social changes that have affected families in the United States during the past half century. Changes include the rising number of never-married parents, normalization of divorce, ongoing changes in family roles that affect child care and parenting time, increased mobility of families across state and international borders, and the growing awareness of family violence. The percentage of children under 18 years of age living with only one parent increased from 9 percent in 1960 to 27 percent of 20.2 million by 2016 (U.S. Census Bureau, 2016a, 2016b). Approximately one in four children live in homes with foreign-born parents (U.S. Census Bureau, 2011). In addition to children who have a noncustodial parent, children with parents in a high-conflict relationship, a parent who is violent, or parents who dispute sharing custody are also potential targets for parental abduction.

Abduction of children by their parents is a complex social and legal problem that has received sporadic public and professional attention. Much of the social work literature addressing parental abductions dates from the 1990s, when both relevant research and policy changes were prevalent. However, many of the issues that underlie this form of family disruption continue to require increasing attention in multiple social service and legal arenas (Stoever, 2017). Among the problems interwoven with parental abduction are the acrimony of many child custody disputes (Elrod, 2001), dissatisfaction with custody and visitation rights within many separated and divorced families, the international nature of many families' lives (Lindhorst & Edleson, 2012), high rates of domestic violence and the special difficulties of parents who take their children and flee abuse (Jaffe, Johnston, & Crooks, 2008), and the need for specialized services of all types to prevent and resolve abductions and help the families who experience them (Spilman, 2006; Zawis, 2008).

Definition and Incidence

The pool of children at risk is linked to the legal definitions of parental abduction, which vary among state, national, and international jurisdictions. Some legal definitions include any parent whose actions deprive the other parent of custody or access to the child, whether the couple is separated, divorced, or never married. This can also include other relatives or others acting on behalf of parents (*United States v. Miller*, 2015). At the other end of the continuum, some states have laws that define abduction only in terms of violating a court order. The most recent National Incidence Studies of Missing, Abducted, Runaway, and Thrownaway Children (NISMART-3) (Sedlak, Finkelhor, & Brick, 2017) estimated that 230,600 American children were abducted by family members in 2013. Reports to police dropped by half compared with an earlier survey. Likewise, Lindhorst and Edleson (2012) have pointed out that “the actual number of international abduction cases is likely higher than those reported to the U.S. Central Authority. Left-behind parents may choose not to engage in legal or governmental action, may attempt to negotiate directly with the other parent, or they may pursue cases in state of federal courts and not report their activity to the U.S. Department of State” (pp. 9–10).

Historically, studies that defined parental abduction broadly identified men and women as the abductors in roughly equal proportions (Hegar & Greif, 1991; Janvier, McCormick, & Donaldson, 1990). International surveys of abducting parents find 69 percent to be mothers (Lowe, 2011). More recent analysis indicates that when using an expansive definition of abduction, mothers and other female relatives were more likely to take children than fathers or other male relatives (59.9 percent and 40.1 percent, respectively); however, when that definition was narrowed to the more serious kidnapping of children, men were more likely than women to take children (64.4 percent and 35.6 percent, respectively) (Finkelhor, Henly, Turner, & Hamby, 2017).

Motivations of men and women who abduct their children appear to be different. Historically boys and girls were abducted in almost equal numbers; however, a more recent analysis by Finkelhor et al. (2017) reported that slightly more girls (58 percent) were taken than boys (42 percent). Younger children have been consistently noted at greater risk of abduction than older children.

A newer, rising issue is parental abduction within same-sex relationships. Although there have been conflicts in state and federal law (Lindevaldsen, 2009) regarding civil unions, the Supreme Court's *Obergefell v. Hodges* (2015) decision appears to reinforce the equal application of the law to same- and opposite-sex parents. Although there have been high-profile media cases regarding specific same-sex parental abductions, there has been little demographic study of this issue.

Effects on Children and Families

The impact of abduction by a parent on children can vary greatly depending on myriad factors, such as the child's age, the length of the abduction, and the circumstances. Parental abduction may place a child in isolation, away from not only their other parent but also all of their other social and familial connections. This sudden loss can be traumatic and lead to both short- and long-term emotional, developmental, and psychological struggles (Finkelhor et al., 2017; Leary, Cooper, Wetterling, & Broughton, 2015). These effects are not limited to the abducted child and may be devastating for the parents, siblings, other family members, and friends left behind (Alexander & Klein, 2009; Greif, 2007, 2009; Greif & Hegar, 1993; Sagatun & Barrett, 1990). However, an abduction by a protective parent may remove the child from the threat of an abusive parent (Lindhorst & Edleson, 2012).

When recovered, many children are fearful, sad, or apprehensive about reconnecting with a parent they may view negatively based on limited memories of life before the abduction, misinformation provided by the abductor, or concerns that the searching parent did not try hard enough to find them (Leary et al., 2015). Availability of mental health professionals who are well trained in family reunification is often inconsistent, as is the care such children receive.

State, Federal, and International Policies

Although public awareness of parental abduction has grown because of coverage in the print and broadcast media, it is a long-standing problem that has been recognized in federal and state policies for decades. For example, for most of the 20th century parents who abducted their children were specifically exempt from criminal prosecution under the federal Kidnapping Act.

Interstate Domestic Abduction

Historically the issue of family law, and particularly child custody determinations, has been left to the individual states, where a wide variety of legal presumptions regarding division of parental rights and duties has existed. Enforcement options for parental abduction within each state vary greatly, but such proceedings can result in modification of parenting time, including restriction to only supervised access for a parent who has been found to have wrongly withheld a child from their coparent, coercive contempt, and even criminal prosecution. Civil suits (torts) arising out of loss of parenting time are also possible in many states, and some have made or proposed statutory provisions for civil suits in parental abduction cases (Berger, 2000; Stern & Oehme, 2003).

To date, most efforts to combat parental abduction have emphasized primarily one approach: preventing abducting parents from going to another jurisdiction to obtain a custody order in their favor. In recognition of the growing mobility in society and need for uniformity between states, an initial attempt to harmonize divergent state approaches was first offered in 1968 by the National Conference of Commissioners on Uniform State Laws (NCCUSL) in the form of the Uniform Child Custody Jurisdiction Act (UCCJA), which was adopted by all 50 states. The UCCJA recognized the damage that could be done to children by parents feuding over their care and control, listing that one of its primary purposes was to “avoid jurisdictional competition and conflict with courts of other states in matters of child custody which have in the past resulted in the shifting of children from state to state with harmful effects on their well-being” (NCCUSL, 1968, section 1.a.1).

At the federal level, the Parental Kidnapping Prevention Act (PKPA) (P.L. 96-611) was enacted in 1980 in response to failures in the UCCJA and the "often inconsistent and conflicting" state practices in cases where parents were disputing custody. The PKPA encourages cooperation among states and provides for Federal Bureau of Investigation (FBI) assistance in locating and returning abducted children (Chiancone, 2008; Cracchiolo, 2007). However, enforcement of the PKPA depends in part on state criminal law, because its Unlawful Flight to Avoid Prosecution provisions apply only if a state felony has been committed. In addition, in 1988 the U.S. Supreme Court, in *Thompson v. Thompson* (484 U.S. 174), interpreted parts of the PKPA and reiterated that parents are generally unable to resort to the federal courts to resolve conflicting awards of custody in state courts, even when there has been noncompliance with the PKPA.

In response to continuing developments, the NCCUSL revisited the issue of parental abduction and interstate child custody determinations and in 1997 published the Uniform Child Custody Jurisdiction *and Enforcement* Act (UCCJEA, *italics* added). Not only did it address inconsistent state interpretations and harmonize its predecessor (the UCCJA) with the PKPA, but as its name implies, the UCCJEA added provisions for enforcement of child custody determinations that have been historically lacking. As of 2018, all but one state has adopted the UCCJEA, and as of this writing the remaining state (Massachusetts) was in the process of finally fully adopting it.

As part of enhancing the interstate enforcement of court orders, the UCCJEA provides clarity in rules regarding custody determinations, addressing complicated issues regarding prioritization of the child's home state in taking jurisdiction of a case, establishing exclusive continuing jurisdiction to the original court to make subsequent rulings until such time as that court relinquishes authority to another jurisdiction, and managing situations when courts must make emergency determinations because a child has been abandoned or is at risk of abuse or neglect. A clear duty to enforce existing orders, coupled with expedited hearings and enhanced judicial remedies, provides protections for children wrongly removed from their home jurisdictions.

International Abduction: The Hague Convention and Implementation

In 1980, participants from 29 countries, including the United States, drafted the Hague Convention on the Civil Aspects of International Child Abduction. The Hague Convention provides for children under the age of 16 years to be returned to the country in which they habitually resided immediately before a breach of custody or access rights. As of 2017, 98 nations had adopted the Hague Convention by ratification or accession (Hague Conference on Private International Law, 2017). The Convention included a number of exceptions to the return of a child. There remains a pattern of uneven compliance with the provisions of the Convention and varying interpretations of the exceptions.

Enforcement of the Convention was slow to take effect. For example, the United States signed the convention in 1981 and ratified it in 1986, but its provisions were not implemented until July 1988, when the International Child Abduction Remedies Act (P.L. 100-300) took effect. That law provides specific mechanisms for the United States to comply with the Convention and makes the U.S. Department of State's Office of Children's Issues the federal office in charge of enforcement and assistance (Estin, 2010; Pfund, 1997). Subsequently, the United States enacted the International Parental Kidnapping Crime Act of 1993 (IPKCA) (P.L. 103-173), criminalizing international abduction for the first time in the United States. Although the IPKCA faced various legal challenges (Alanen, 2008; Weiner, 2008), its constitutionality has been repeatedly upheld.

Despite these policy developments on state, national, and international levels, there is evidence that U.S. state laws remain uneven in their provisions and judicial interpretations (Freeman, 2000; Maxwell, 2005; Stoever, 2017). There is growing international awareness of the role family violence plays in abduction cases (Schuz, 2013). For example, the Hague Secretariat is developing a new global judicial guide on cases involving grave risk to children, including child exposure to domestic violence.

POLICY STATEMENT

NASW supports

- developing social services, such as supervised visitation, that are fair, affordable, and sustainable to provide both parents equal opportunity to visit with their children, to prevent child abduction
- educating social workers in schools, workplaces, and through continuing education to become more knowledgeable about the problem of parental abductions, its causes, dynamics, and the laws regarding parental abduction
- providing postabduction counseling and mediation services when safe to do so to minimize the effects of abduction and diminish the likelihood of recurrence
- promoting high-quality training for mental health professionals in postabduction reunification services
- promoting consensual models, such as parenting coordination and facilitation, coparent education, and collaborative legal efforts to work out legal conflicts regarding child custody, with appropriate safeguards and accountability for families experiencing domestic violence, the threat of violence, child abuse and neglect, or sexual exploitation
- in cases involving domestic violence, providing support and safety for all victims of violence, be they adults or children, and providing access to rehabilitation services for perpetrators of violence
- collaborating with other professions, particularly those within the legal system, to curb and resolve parental abductions of children
- participating in shaping public policies at all levels to prevent or reduce the occurrence of parental abduction
- adopting statutes in each state that include custody and parenting time arrangements that reinforce the well-being of the child
- advocating for state criminal statutes that allow distinction among abductions on the basis of circumstances, such as safety of the child, use of force, harm done to the child, length of absence, and whether the child was concealed from the searching parent; statutes should include a defense against the charge of parental abduction if the abductor acted to prevent or avoid imminent actual harm to the child

- establishing public awareness programs about the problems associated with parental abduction and using print, broadcast, and social media to educate the public and to locate abducted children
- strengthening policies of agencies in which children usually are present, particularly schools and child care facilities, to reduce the likelihood that those agencies will become sites of parental abduction
- strengthening state and federal laws concerning parental abduction, particularly toward achieving uniform definitions of, compliance with, and enforcement of child custody orders across state borders
- ensuring availability of services to help both victims and perpetrators of parental abduction
- working toward a coordinated national network for the safe reunion of abducted children and their families, including appropriate therapeutic services for such families
- encouraging the full assistance of law enforcement agencies, particularly the FBI, in locating abducted children, with increased efforts to eliminate all discriminatory barriers that affect the definition of parental abduction
- working through international professional organizations to encourage adoption of the Hague Convention on the Civil Aspects of International Child Abduction by more countries, advocate for safety in cases of alleged domestic violence, and promote compliance with the Convention by signatory countries.

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Peace and Social Justice

BACKGROUND

The social work profession in the United States has its roots in the principles of peace and social justice. Jane Addams, winner of the Nobel Peace Prize in 1931 ("The Nobel Peace Prize 1932"), is likely the most notable of pacifist social work pioneers and is also known to be among the first in the United States to speak out against strengthening military might (Sullivan, 1993). Sullivan also noted that the first call to action by the public was made by social workers. At the beginning of the World War I, meetings focused on protesting war were held by social workers at the Henry Street Settlement House in New York. It was here and in other settlement houses and meeting places that Addams, Florence Kelly, and other social reformers of the time worked toward the creation of several peace and justice organizations, some of which still exist today, including the Women's International League for Peace and Freedom (formerly known as the Women's Peace Party) (see http://wilpf.org/US_WILPF).

Although the global trend is toward demilitarization (Grebe, 2011), we still live in a world where armed conflict exists and peaceful solutions to disagreements and social inequities can be preempted by militaristic solutions. Full participation with organizations such as the United Nations and international allies are critical steps in finding constructive, collaborative means to deal with international conflicts. The United States has a long history of supporting United Nations human rights mechanisms. Former First Lady Eleanor Roosevelt, who is well known for her support of social reforms for the poor, led the effort to develop the Universal Declaration of Human Rights (UDHR), adopted by the United Nations General Assembly in 1948. The UDHR recognizes that "the inherent dignity and the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world" (UDHR, 1948, p. 1). In 2009, the United States joined the United Nations

Human Rights Council. Their participation on the council has helped to identify constructive mechanisms to fight discrimination and increase scrutiny of serious human rights violations around the world (Fassihian, 2011). However, the United States continues to fall too short in promoting social justice around the world. The United States is one of a small number of countries that have not ratified the Convention on the Elimination of All Forms of Discrimination Against Women and the Convention on the Rights of the Child.

Moreover, the gap in human standards of living continues to widen on a global and national level Kreutzmann, 2008). In the United States the gap between wealthy and poor people continues to widen (Sherman & Stone, 2010) as it does worldwide. As social justice takes a backseat in our national and world economies and social institutions, tensions grow and conflicts erupt. Ironically, those whose lives are most vulnerable and over whom these conflicts often are instigated are the very people who suffer the most damage from war— physically, emotionally, and economically. Poor people, especially children, are the primary casualties of conflict, whether that conflict be in the form of street violence, or civil or international war (Office of the Special Representative of the Secretary-General for Children and Armed Conflict, n.d.). Social workers are united by their *Code of Ethics* (NASW, 2008) in which the promotion and well-being of humans regardless of location or nationality and advocacy for attainment of basic human needs and the actualization of social justice for all are among their professional obligations.

Full participation with organizations such as the United Nations and international allies are critical steps in finding constructive, collaborative means to deal with international conflicts.

ISSUE STATEMENT

“Peace is not merely a distant goal that we seek, but . . . a means by which we arrive at that goal.”— Martin Luther King, Jr. (1967). According to the *Social Work Dictionary* (Barker, 2003), *social justice* is “an ideal condition in which all members of a society have the same basic rights, protection[s], opportunities, obligations, and social benefits” (pp. 404–

405). The important factors that affect peace and social justice are as follows:

- Poverty as a result of weakening the power of organized labor, reduction in government social expenditures, and abandoning of full employment as a standard (Cornia, 2004; Lynch, Smith, Kaplan, & House, 2000; Putnam, 2000; Rank, 2008; Sapolsky, 2005; Schoen, Collins, Kriss, & Doty, 2008).
- Economic disparities within geographic societies, with recognition that groups with lower economic status include disadvantaged populations such as immigrants, the poorly educated, those who are victims of bigotry based on race, gender, religion, age, or sexual orientation (Anderson, & Atkinson, 2007; Benabou, 2000; Bergensen & Bata, 2002; Himmelstein, Thorne, Warren, & Woolhandler, 2009; Pickett, Kelly, Brunner, Lobstein, & Wilkinson, 2005; Wilkinson & Pickett, 2006, 2010).
- Limited and or unequal parity to health including morbidity and mortality, infant– mother mortality rates, obesity, drugs, teenage birth rates, and mental illness (Gold, Kawachi, Kennedy, Lynch, & Connell, 2001; Gold, Kennedy, Connell, & Kawachi, 2002; Health Development Agency, 2003; Hudson, 2005; McMunn, Bartley, Hardy, & Kuh, 2006; Pickett, James, & Wilkinson, 2006; Pickett, Mookherjee, & Wilkinson, 2005; Putsch & Pololi, 2004;
- Ritsher, Warner, Johnson, & Dohrenwend, 2001; Tunstall, Shaw, & Dorling, 2004).
- The quality of social relationships measured through the level of trust, competitiveness, the lack of commitment to civic duties, reduction of hostility, discrimination, and homicide rates (Chong, 2009; Lobmayer & Wilkinson, 2002; McMunn et al., 2006; Uslander, 2002; Wilkinson, 2005).
- The level of educational performance in math and literacy for all children and the rate of secondary school dropouts that are contributing factors to social instability (Claussen, Smits, Naess, & Davey Smith, 2005; U.S. Department of Education, National Center for Education Statistics, 2004; Wilkinson & Pickett, 2010).

- The death penalty and imprisonment rates which relate more to sentencing patterns than to actual crime rates (Marsh, 2003; Mauer, 2001; Sen, 2008; United Nations Crime and Justice Information Network, 2000; Uslander, 2002).
- Carbon emissions, waste production, and use of the earth's resources in a way that contributes to stagnation and economic instability. The development of sustainable economic systems requires rapid innovation and change, much of which must be resource and energy saving (International Federation of Social Workers, 2007; Johnson, 2005; Kawachi, 2002; Lundy & van Wormer, 2007; Mackenbach, 2006; Wilper et al., 2009; World Health Organization, 2000).
- The lack of social mobility or the ability to improve on income between generations (Bladen, Gregg, & Machin, 2005; Claussen et al., 2005; Ritsher et al., 2001).

POLICY STATEMENT

NASW supports

- advocacy for peace initiatives at the local, state, and national levels and with international organizations and public leaders to achieve social change consistent with social work values.
- efforts to address and redress violations of peace and economic and social justice by emphasizing nonviolent and peaceful solutions and remedies.
- inclusion of formalized coursework in peace and social justice studies as part of the undergraduate and graduate generalist curriculums.
- federal funding of social programs that ensure progress toward social and economic justice.
- a U.S. foreign policy approach that includes all of the tools of diplomacy and development, including mediation and reconciliation, and recognizes the urgency and importance of development assistance.
- the promotion of U.S. ratification of critical United Nations treaties and conventions that support human rights and social justice, such as the

Convention on the Elimination of All Forms of Discrimination Against Women and the Convention on the Rights of the Child.

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People with Disabilities

ISSUE STATEMENT

The term “disability” itself is difficult to define; people with disabilities vary widely and experience physical, sensory, and cognitive impairments, as well as mental, physical, and chronic illness. Disabilities can be acquired, congenital, physical, cognitive, or a combination of multiple conditions. The experience of disability may be different for each person. Disabilities may be visible; in some instances disabilities are invisible and are not readily apparent to others. Functional limitations from disabilities range from minor to profound (Mackelprang & Salsgiver, 2015). The Developmental Disabilities Assistance and Bill of Rights Act of 2000 (P.L. 106-402) states, “Congress finds that disability is a natural part of the human experience that does not diminish the right of individuals with developmental disabilities to live independently, to exert control and choice over their own lives, and to fully participate in and contribute to their communities through full integration and inclusion in the economic, political, social, cultural, and educational mainstream of United States society.”

A common experience that the vast majority of people with disabilities share is that of social and economic injustice. Access to employment, health care, housing, education, and full community participation are often barriers that people with disabilities face. People with disabilities are at higher risk of a range of different types of victimization, including sexual abuse and assault, as well as child abuse and neglect (Basile, Breiding, & Smith, 2016; Slayter, 2016).

Although there are tens of millions of people with disabilities, actually having a disability can be a very solitary experience. Negative attitudes regarding people with disabilities continue to facilitate discrimination and segregation. Other challenges may be created by the devaluation and discrimination of people who are perceived to have a disability, such as people who are HIV-positive, people who have a mental illness, or people with chronic medical conditions. Services are often interrupted and are not available throughout the lifetime. Many people with psychiatric diagnoses are inappropriately or forcibly treated (Fleischer & Zames, 2011).

The U.S. Census Bureau (2016) noted that 12.3 percent of the civilian noninstitutionalized population has a disability, although this percentage shifts across the lifespan. With medical advances and an aging population, the number of people with disabilities grows daily. Of special note are increasing rates of traumatic brain injury, especially due to combat experience for veterans of foreign wars/conflicts (Faul, Xu, Wald, & Coronado, 2010; Speziable, Kulbago, & Menter, 2010).

Although it is certainly true that social and economic justice issues are intrinsically connected to race and gender, those same issues are just as relevant to disability. Many adults and children with disabilities are denied or cut off from benefits and experience serious income inadequacy and poverty with inadequate health care, food, and shelter (Ingstad & Eide, 2011). Women with disabilities are especially likely to experience poverty and material hardships in the United States (Parish, Rose, & Andrews, 2009). The poverty rate for people with disabilities is 28.2 percent compared with 13.0 percent of the general population (U.S. Census Bureau, 2016).

During the past 40 years, social attitudes and policies in the United States have slowly begun to recognize the civil rights of people with disabilities (Hirschman, 2014). Since the late 1960s, Congress has passed more than a dozen laws addressing issues related to people with disabilities. Yet these laws continue to afford only limited protection to people with disabilities. In 1975 the Education for All Handicapped Children Act (P.L. 94-142) provided federal funds to states that afforded appropriate and free public education to children with disabilities. Numerous reauthorizations have expanded this law, such as the Individuals with Disabilities Education Act (IDEA) (P.L. 90-247). The advocacy efforts of people with disabilities, joined by people without disabilities, created a sociopolitical force that resulted in the passage of the Americans with Disabilities Act of 1990 (ADA) (P.L. 101-336). In 1999, the *Olmstead v. L.C.* decision determined institutionalization to be a form of discrimination when a less restrictive setting is suitable (Zendell, 2007). In 2008, Congress strengthened protections for individuals with disabilities through the ADA Amendments Act of 2008 (P.L. 110-325) by expanding the definition of impairment in life activities to include “major bodily functions” and prohibiting discrimination in a civil rights framework.

The Patient Protection and Affordable Care Act (ACA) (P.L. 111-147), passed in 2010, has increased access to health care for millions of Americans and eliminated barriers such as discrimination based on pre-existing conditions. The ACA has also required health insurance plans to cover essential health benefits and preventive services and has increased the availability of support services including home and community-based programs. Some people with disabilities experience increased access to preventive services and health care, whereas others with multiple types of limitations have health care access problems and unmet health needs (Horner-Johnson, Dobbertin, Lee, & Andresen, 2014).

Social workers have worked with the disability civil rights movement in a variety of roles, including in promotion of the self-advocacy movement. Historically, however, some social work professionals have abrogated decision making by people with disabilities and denied them self-determination (Mackelprang & Salsgiver, 2015), including involuntary sterilization, which disproportionately affected men and women of color with disabilities. The traditional medical model of disability services emphasizes pathology, deficit, and malfunctioning, according to which disability is a chronic disease requiring various forms of treatment (Shakespeare, 2013). Although this framework is no longer used exclusively, it still has an overwhelming effect on disability issues and on stigmatizing people with disabilities by inappropriately viewing them as passive, dependent, and deficient. The more progressive social model identifies environments as disabling and supports people with disabilities in their efforts to participate in and contribute to society. For example, the disability rights movement and the independent living movement, specifically, were founded on the belief that people with disabilities have the right to participate fully both in society and in the development and implementation of social policies affecting people with disabilities.

A mantra that describes this sentiment, “nothing about us without us,” reflects a strengths-based perspective and the core social work value of self-determination (Charlton, 2000; Iezzoni & Long-Bellil, 2012). Accordingly, these principles support the notion that social workers should work with clients, rather than providing services for them. This approach encompasses a continuum that ranges from involving the client in the decision making about the treatment plan to having people with disabilities define the goals of such a plan. People with disabilities may define program objectives in organizations where they are employed as decision makers, content experts, and peer providers, using social workers as necessary to access information and resources (Barnartt, 2007).

Although many in the disability communities do prefer person-first language (for example, “people with autism,” “people with mobility impairments”), some people very strongly prefer identity-first language (for example, “deaf people,” “blind people”). Neither approach is better than the other, and social workers should look to their clients for guidance on how they would like to be referred to.

POLICY STATEMENT

NASW supports

- a national policy that ensures the inherent right of people with disabilities to participate fully and equitably in society. This participation includes the freedom, to the fullest extent possible, to live independently, to exercise self-determination, to make decisions about their living conditions and treatment plans, to obtain an education, to be employed, and to participate as citizens.
- local, state, and federal funding to allow people with disabilities to participate fully and equitably in society with appropriate supports to meet individual needs.
- the right of people with disabilities to have public access to goods and services available to others, including transportation and reasonable accommodations to provide physical access to buildings throughout the community. Physical access includes internal and external building access (for example, ramps, doors, restrooms, drinking fountains, and elevators), telecommunications, and alternate means of communication (for example, Braille, sign-language interpreters).

- the right of people with disabilities to a basic level of income that allows all people with disabilities to have the necessities of life and to participate in the community.
- the right of people with disabilities to obtain and maintain affordable and accessible housing.
- the right of people with disabilities to pursue vocational and occupational opportunities that pay competitive wages in accessible environments with reasonable accommodations, in accordance with laws that ensure nondiscriminatory access to employment.
- the right of individuals with disabilities to affordable, accessible, and comprehensive health care.
- the right of individuals with disabilities to have early and continued access to individualized appropriate educational opportunities that are accessible in the least restrictive environment possible.
- the right of individuals with disabilities to fully participate in family life, including reproductive justice, the right to be parents, and the right to adopt.
- the development of social workers' expertise in partnering with people with disabilities, by incorporating the study of disability history, culture, research, best practices, and civil rights in the curricula of schools of social work and in continuing education opportunities.
- the inclusion of social workers as well as other people with disabilities in all areas of professional organizations, including policy-making boards, staff and administrative positions, and boards of directors.
- the inclusion of people with disabilities in policymaking, design and delivery of services, and the evaluation of services.
- advocacy in collaboration with people with disabilities and their families to reduce discrimination, stigma, and restriction of rights based on inaccurate perceptions of individuals with disabilities in their communities and in society.
- social work promotion of collaborative, inclusive engagement of people with disabilities resulting in enhanced self-determination, allowing achievement of highest level of inclusion and participation in society.

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Professional Impairment

ISSUE STATEMENT

Professional impairment has been a topic of concern and attention for several decades, including within the field of social work. The literature demonstrates the prevalence and seriousness of impairment and the detrimental impact it has for social workers, consumers, and the profession as a whole. Impairment manifests in various ways and has wideranging implications for social work.

Professional impairment presents complex individual and organizational dilemmas that often impede efforts to obtain accurate data through research. Studies examining the prevalence of impairment and its impact are further challenged by a lack of awareness among professionals and underreporting of the issue due to its sensitive nature. There is still significant work to be undertaken to effectively prevent and address the multilevel and multisystemic implications of social worker impairment.

The *Social Work Dictionary* (Barker, 2014) provides the following definition of an *impaired social worker*: “One who is unable to function adequately as a professional social worker and provide competent care to clients as a result of a physical or mental disorder or personal problems, or the inability or desire to adhere to the code of ethics of the profession. These problems most commonly include alcoholism, substance abuse, mental illness, burnout, stress, or relationship problems” (p. 208). Furthermore, the NASW (2015) *Code of Ethics* charges social workers to action when their work or the work of their colleagues might be affected by impairment. Standard 4.05 of the code states,

> (a) Social workers should not allow their own personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgment and

> performance or to jeopardize the best interests of people for whom they have a professional responsibility.
>
> (b) Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties interfere with their professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others.

Professional impairment is not always easily identifiable because of the unique nature of the work and roles that social work professionals assume. Moreover, impaired functioning should be distinguished from incompetence or inexperience by evidence that the social worker has previously functioned acceptably according to standards of social work practice.

The following list highlights common causal factors for social worker impairment; however, these factors are not exhaustive of all conditions that might underpin professional impairment:

- alcohol and drug use
- mental health impairment such as depression or anxiety
- physical illness
- cognitive impairment, including dementia, traumatic brain injury, or Alzheimer’s disease
- emotional contagion
- burnout and empathy fatigue
- secondary traumatic stress and vicarious trauma
- unresolved personal problems
- lack of self-care.

Mental health conditions such as depression, as a form of professional impairment, have received little attention in terms of research in the field of social work. Wulsin, Alterman, Bushnell, Li, and Shen (2014) evaluated prevalence rates by industry and concluded that social services workers have the fourth highest rate of depression as a result of work stress.

Impairment due to physical illness presents unique workplace challenges. In a study investigating how serious physical illness affects social work practice, Poorvu (2015) found that social workers with physical illness diagnoses reported providing inadequate care to clients on numerous occasions as their ability to fully attend to the needs of clients was compromised. Poorvu (2015) also cited a tendency to deny the impact of cognitive and physical illnesses.

Burnout, empathy fatigue, secondary traumatic stress, and vicarious traumatization are also conditions that may contribute to professional impairment. These conditions are often influenced by organizational climate, work stressors, the negative psychological effects of helping, or unresolved personal issues. Specifically, burnout and empathy fatigue have been examined in the literature as precursors to health conditions that place social workers at risk for professional impairment. In a three-year longitudinal study, Kim, Ji, and Kao (2011) found that within a year, burnout leads to increased physical health concerns in social workers such as headaches, gastrointestinal issues, and respiratory infections.

Research also connects social workers' emotional well-being to the risk of impairment. Siebert, Siebert, and Taylor-McLaughlin (2007) defined emotion contagion as "the phenomenon of experiencing the emotions of others" (p. 47). Siebert et al. (2007) found that emotional contagion can interfere with helping others and is correlated with higher burnout, emotional exhaustion, depressive symptoms, and being overly distressed.

Social workers suffering from substance use disorders, psychiatric stressors and disorders, secondary traumatic stress, and other causal factors of impairment may compromise performance, jeopardizing the rights of clients and the effectiveness of the treatment provided. Because of heavy workloads and job-related stress, social workers often fail to practice self-care, which can serve as a preventive tool for impairment (Lee & Miller, 2013). Once impaired, social workers may pay inconsistent attention to work requirements, fail to complete assignments, engage in excessive absenteeism, or commit treatment errors that may lead to serious ethical violations.

The NASW (2015) *Code of Ethics* addresses impairment of colleagues in standard 2.09. The code implores social workers who have direct knowledge of a colleague's impairment that interferes with practice effectiveness to take action. Gino, Ayal, and Ariely (2013) stated that people often behave unethically when they feel they are acting altruistically for the good of others and their colleagues. Moreover, social workers' inability or unwillingness to identify and address impairment in a colleague's performance, resulting from lack of knowledge and guidance about how to respond, are stumbling blocks to the cause of effectively preventing and addressing impairment as called for by the *Code of Ethics*.

Some other potentially detrimental outcomes that professional impairment might yield include the following:

- professional negligence
- violation of ethical standards such as sexual involvement with clients and other boundary violations
- lack of personal and professional insight and sound judgment
- decreased productivity in the workplace
- negative perceptions of the social work profession.

The issue of impaired practice presents major predicaments and dilemmas not only for the individual, but also for organizations. Pooler, Siebert, Faul, and Huber (2008) explained that professional impairment should be of concern not only to the social worker, but also to the organization, because an impaired worker can affect the overall service provision and fiscal health of an organization. Dealing with the consequences of an impaired worker can take time away from other important matters within an agency, decrease productive work time, and increase health benefit costs. These impairment-related consequences are among many that have serious implications for the well-being of an organization.

The literature emphasizes the need for appropriate intervention. Kim et al. (2011) concluded that social work impairment is a serious problem as it has the power to adversely affect the quality and stability of services rendered. If action is not taken to thwart the physical and psychological impact of impairment, the social work profession will struggle to maintain and sustain a strong, effective, and competitive pool of social workers. Moreover, Reamer (2015) identified professional impairment as an ethical pitfall for social workers. It is imperative that the social work profession and all of its stakeholders are proactive in addressing impairment by promoting education, recruitment, retention, research, and reinvestment efforts nationally.

Finally, impairment has far-reaching implications for the social work profession. Although all misconduct is not the result of impairment, highly publicized cases of unethical actions caused by impairment portray social workers in a negative light, damaging the reputation of the profession and raising questions about the competence of the profession overall.

POLICY STATEMENT

The social work profession must address the needs of its members and ensure the welfare of its clients and society at large. NASW recognizes that the prevention, identification, and treatment of professional impairment are vital to protect the welfare of clients, practicing social workers, the work environment, and the integrity of the profession. A multisystemic approach, focusing on prevention, identification, and treatment, must be used to address professional impairment among social workers.

NASW supports the following:

Prevention

- the incorporation of material about student and professional impairment and the ethical responsibilities related to impairment in all social work education programs, including evidence-based research on the identification of risk factors associated with professional impairment, the characteristics of impaired functioning, the strategies available for approaching and assisting social work colleagues believed to be impaired, treatment and other options available for professionals with impairments, and the ethical obligations of social workers with regard to professional impairment
- implementation of procedures to detect and address impairment in the recruitment, screening, curricula, and outcome measures of all social work education programs

- mandatory continuing education addressing professional impairment as part of the competency and ethics requirements of each state's regulatory board
- accessible resources for social work students and practitioners to identify and address workplace stressors and the physical and psychological effects on social work practice
- social workers' need to have knowledge of their agency-based human resources, practices, and policies regarding issues of impairment and their rights and responsibilities
- programming through workplaces, colleges and universities, NASW, and other venues to facilitate social and professional networking and mutual support, worker self-care, and other strategies to reduce the taboo surrounding impairment and bolster identifiable protective factors
- comprehensive advocacy efforts to ensure that the settings that employ social workers create conditions to optimize employee health and safety; the conditions associated with employee well-being include adequate resources, reasonable caseloads, sufficient salaries and benefits, safe physical space, accessible supervision and staff development, employee assistance programs, health, fitness, and stress reduction programs
- advocacy for policies such as tuition debt relief that alleviate the financial stress experienced by social work professionals
- funding and facilitation of research on professional impairment, including prevention, assessment, treatment, and help-seeking behaviors among impaired social workers and social work students
- access to health care coverage for integrated care and prevention services

Identification

- social work education programs with student conduct policies and procedures to address signs of impairment arising in class and field settings
- confidential and nonpunitive treatment options to identify and assist impaired social workers, such as employee assistance programs

- impaired professionals making self-referrals and seeking treatment as needed to ensure clients and others are protected
- the education of clients concerning their rights as service consumers and the procedures for reporting concerns regarding professional impairment
- social workers familiarizing themselves with the current literature on identifying professional impairment in peers and acquiring the skills to ethically respond to signs of possible impairment
- the development and dissemination of protocols to evaluate social workers suspected of impairment
- the development and dissemination of contemporary, evidence-informed practical guidelines for social workers to identify and approach at-risk and impaired colleagues
- colleague-assistance programs that help to identify professionals with impairment and assist with taking appropriate remedial action

Treatment

- confidential and nonpunitive treatment options to assist impaired social workers, including programs to help social workers identify and access appropriate treatment options and facilitate integration back into the workplace after recovery
- fair, nondiscriminatory, and accessible rehabilitative policies and practices that address all forms of professional impairment and are enforced by employers, regulatory boards, schools of social work, and other professional organizations
- transparent and accessible organizational processes to assist employees who have experienced traumatic personal or professional events or who may otherwise be at risk for impairment
- access to health care coverage for integrated care and prevention services
- supportive services, including additional supervision and consultation, for social workers who are at risk for or recovering from impairment
- the development of “return to work” guidelines for professionals who stopped practicing due to impairment.

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Professional Self-Care and Social Work

ISSUE STATEMENT

Social workers are skilled at performing emotional labor, including managing emotions, stressors, and reactions to social problems that are chronic and entrenched (Greer, 2016). Because of the demands of the work, professional self-care is an essential underpinning to best practice within all practice settings.

Social workers are increasingly engaged in thoughtful discourse on the unique challenges of our profession and ways of addressing and managing the stresses encountered in practice. Professional self-care is an essential component in competent, compassionate, and ethical social work practice, and it requires time, energy, and commitment.

Practice demands, workplace climate, and exposure to stories of trauma require social workers to promote professional self-care practices. Research has supported a supervisory process rooted in strong supervisory relationships responsive to the need to process emotional reactions and to reinforce supervisee resilience (Cox & Steiner, 2013a). Individuals exposed to traumas who develop secondary trauma, compassion fatigue, or distress require opportunities for respite, assistance in increasing self-efficacy, and professional supports to promote resiliency (Finkelstein, Stein, Greene, Bronstein, & Solomon, 2015).

The critical key to prevention and management of adverse conditions such as stress, burnout, compassion fatigue, and secondary traumatic stress or vicarious trauma is the practice of professional self-care. Although the practice of professional self-care applies to all social workers, it is especially critical for social workers providing care to traumatized populations. Professional self-care places emphasis on primary prevention of these unwanted conditions and implies that tools and strategies should be part of one's overall professional self-care plan. Actively preparing social workers with knowledge and skill for overcoming these experiences is key.

Professional self-care can be conceptualized as the combination of three processes: self-awareness, self-regulation, and self-efficacy (Cox & Steiner, 2013b). It is a core essential component to social work practice and reflects a choice and commitment to become actively involved in maintaining one's effectiveness as a social worker. Furthermore, in promoting the practice of professional self-care, a repertoire of self-care strategies is essential to support the social worker in preventing, addressing, and coping with the natural, yet unwanted, consequences of helping (Lopez, 2007).

Grant and Kinman (2011) have described social competencies that predict resilience. High levels of emotional intelligence, reflective abilities, social competencies, and empathy were seen as necessary elements. According to Windle, Bennett, and Noyes (2011), "resilience is the process of negotiating, managing and adapting to significant sources of stress or trauma. Assets and resources within the individual, their life and environment facilitate this capacity for adaptation and "bouncing back" in the face of adversity. Across the life course, the experience of resilience will vary" (p. 2).

Acknowledging professional self-care in social work is an important first step in preserving the integrity of social workers and in retaining valued professionals in the profession. Actively preparing social workers to effectively face adverse conditions will support social workers in maintaining their commitment to the profession. Social work education plays a critical role in introducing the importance of professional self-care to beginner social work practitioners (Newell & Nelson-Gardell, 2014).

POLICY STATEMENT

In recognition of social workers as valued professional resources across diverse practice settings, NASW supports the following:

- the integration of professional self-care as a best practice within social work curricula, including the field practicum

- the development of professional self-care plans by social workers as a means of preventing and addressing the adverse impact of helping and to promote resiliency
- ongoing opportunities to process and debrief after traumatic or stressful occurrences
- promotion, support, and modeling of the practice of professional self-care by social work supervisors with social work supervisees across education and practice settings
- the promotion and support of the practice of professional self-care by social work administrators
- organizational policies and practices that address and enhance professional self-care in the workplace, clarity in workload demands, employment expectations, and ensuring supportive supervision practices
- psychologically healthy workplaces that recognize the need for social work professional self-care and promote safety and employee well-being
- the development of creative and innovative support services for social workers
- continuing education programs related to professional self-care and prevention of conditions such as burnout, compassion fatigue, secondary traumatic stress, and vicarious trauma
- further research exploring the prevalence of secondary traumatic stress and vicarious trauma among social workers in a variety of settings, resiliency factors, and professional self-care practices among social workers
- publications of best practice strategies that address professional self-care.

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Racism

ISSUE STATEMENT

Racism has been pervasive throughout U.S. history. However, it goes without saying that racism is not unique to the United States. Historians and cultural anthropologists have documented that racism and ethnocentrism have been present in societies worldwide for many thousands of years. Given those facts, it is useful to provide a standard definition of the term "racism." According to the *Encyclopedia Britannica*, "Racism, also called racialism, is any action, practice, or belief that reflects the racial worldview—the ideology that humans are divided into separate and exclusive biological entities called 'races,' that there is a causal link between inherited physical traits and traits of personality, intellect, morality, and other cultural behavioral features, and that some races are innately superior to others" (Smedley, 2014).

Relatively recently, an expanded definition of racism emerged in the concept of *institutional racism* which first gained prominence in Great Britain with the issuance of the MacPherson Report. The background of the report is as follows: On April 22, 1993, Stephen Lawrence was stabbed to death at a bus stop in South London in an unprovoked, racist attack. The police were heavily criticized for their conduct of the investigation, and no one has ever been convicted for the crime. After years of campaigning by Stephen's parents, authorities announced a judicial inquiry in July 1997 to be led by Sir William Macpherson. *The Macpherson Report*, published in February 1999, found that the police investigation into Stephen's murder was "marred by a combination of professional incompetence, institutional racism and a failure of leadership by senior officers" (House of Commons Home Affairs Committee, n.d.). Since the release of the report, the term "institutional racism" gained wide acceptance.

The history of racism in the United States dates back to the country's origin. A prime example of the institutionalization of racism in the United States is the treatment of Native Americans during the 19th century. To open land for expansion to the western territories, President Andrew Jackson enacted the Indian Removal Act of 1830 (Library of Congress., n.d.). The Indian Removal Act mandated that Native Americans, mainly the Cherokee nation, were to leave from their lands located east of the Mississippi River. The forced march west, known as the Trail of Tears, resulted in many Native Americans suffering from exposure, disease, and starvation. It has been estimated that 60,000 of the 130,000 Cherokees died en route to their new destination (Studyworld.com, n.d.).

At the same time that the Native American were being subjected to genocidal racism, Africans were being kidnapped from their homeland and imported to the United States as slaves. The first slaves had arrived in Jamestown, Virginia, in 1619 on a Dutch ship. By the end of the Civil War, there were over 4 million slaves in America (History.com, n.d.).

The Reconstruction may be said to have begun with the passage of the 14th Amendment, which gave former slaves full citizenship, including the right to vote. The African American population steadily grew in numbers and began to establish a political and civil rights presence in urban centers in the country. The late 19th and early 20th centuries also saw the arrival of more and more immigrants from Europe. Because these racially disparate communities tended to coexist in the urban areas of the country, new racial and ethnic tensions emerged.

In the early 20th century, the playwright Israel Zangwill coined the phrase "melting pot" (Owen, 2005) to describe how immigrants from many different backgrounds came together in the United States. In Zangwill's 1908 Broadway production, feuding Russian Jewish and Cossack families immigrate to America, where they learn that hatred and intolerance have no place (Owen, 2005). The melting pot metaphor assumed that over time the distinct habits, customs, and traditions associated with particular groups would disappear as people assimilated into the larger culture. A uniquely American culture would emerge that would accommodate some elements of diverse immigrant cultures, such as holiday traditions and language phrases, in a new context (Owen, 2005). However, there were some who questioned whether the melting pot idea was the ideal approach to absorbing the many diverse ethnicities and cultures in the United States.

Even before the influx of European immigrants to the United States, scholars in Europe and America had recognized that issues of race and ethnicity play a considerable role in shaping societal norms and values. Furthermore, they came to understand that in large multiracial and multicultural (pluralistic) societies such as the United States, it is essential that governmental and civic leaders articulate, both in law and in policy, that dominance by any given race or ethnic group is unacceptable and unsustainable.

Mostly in response to the difficulties that the country had in absorbing mass immigration (along with existing African American, Hispanic, and Native American populations), a major philosophy for dealing with the conflicts related to racism and ethnocentrism emerged. It was referred to as "cultural pluralism" (Haas, 2011). As one of the early adherents to the concept of cultural pluralism, Randolph Bourne, stated, "To face the fact that our aliens are already strong enough to take a share in the direction of their own destiny, and that the strong cultural movements represented by the foreign press, schools, and colonies are a challenge to our facile attempts, is not, however, to admit the failure of Americanization. It is not to fear the failure of democracy. It is rather to urge us to an investigation of what Americanism may rightly mean. It is to ask ourselves whether our ideal has been broad or narrow—whether perhaps the time has not come to assert a higher ideal than the meltingpot" (Bourne, 1916). In his essay "Democracy versus the Melting Pot" (1915), Bourne's contemporary Horace Kallen called for a federal republic, a democracy of nationalities cooperating voluntarily and autonomously in the enterprise of self-realization through the perfection of men according to their kind" (Harvard University, n.d.).

Simultaneous to the advent of the cultural pluralism movement another phenomenon occurred that truly strained the idea of the assimilation as a solution to racial and cultural tensions in 20th century America. Between 1915 and 1970, more than 6 million African Americans moved out of the South to cities across the Northeast, Midwest, and West. This relocation, known as the Great Migration, resulted in massive demographic shifts across the United States. Between 1910 and 1930, cities such as New York, Chicago, Detroit, and Cleveland saw their African American populations grow by about 40 percent, and the number of African Americans employed in industrial jobs nearly doubled (Gross, 2010). The migration of black people meant that European immigrants and African Americans were living in close proximity to one another in the major industrial cities. Racial strife in major population centers worsened, with skin color being another variable that challenged the melting pot theory.

Black thinkers began to become attracted to ideas of multiculturalism and cultural identity as a response to the racism they encountered after the Great Migration. The Harlem Renaissance of the 1920s also reflected those principles, as seen by open expression of black pride and celebration of black culture. “Alain Leroy Locke (1886–1954), America’s first African-American Rhodes scholar and a former student of William James, furnished the guiding vision of the Renaissance and helped to achieve Bourne’s ‘beloved community.’ Finding beauty within him, through a rebirth of black art, the ‘new Negro’ would thereby achieve the moral dignity suited to a ‘collaborator and participant in American civilization.’ Langston Hughes, Zora Neale Hurston, Claude Mackay, Jean Toomer, and others awakened black pride” (Science.JRank.org, n.d.).

It took decades of civil disobedience, protests, legal challenges to racist laws and practices, violent upheavals, and a resurgence of immigration (with many more immigrants coming from non-European nations) to force the country to begin to accept that racial and ethnic minorities could retain their cultural “roots” while still embracing their American nationalities. Such events triggered a resurgence of cultural pluralism as a means for a society with a history of racism and intolerance to accommodate racial and ethnic differences.

As we moved into the 21st century the country found itself on the verge of dramatic changes in its racial and ethnic makeup—the United States will soon become a majority minority society. “Minorities, which means those of any race other than non-Hispanic, single-race whites, were about a third of the U.S. population, according to Census figures. However, it is projected that by 2042, those racial and ethnic groups are likely to comprise more than half the population, and by 2050, 54 percent of the population will be minorities” (U.S. Census Bureau, n.d.).

This fact has obvious socioeconomic and political implications for the country. More important, the idea of the United States becoming a majority minority country has huge sociological implications for which we need to be prepared. By 2054, the question of how to manage and adapt to pluralism and multiculturalism will need to have been answered. Generally, in democratic countries where there is a history of racism, dramatic demographic shifts that bring the oppressed minority to an equal or majority position with the oppressor result in tension, resentment, and sometimes violent resistance to the inevitable change. This is where strategies that prepare the country for change comes into play.

It is important to note that concepts and national policies that support multiculturalism and diversity *do not* represent a single theory in the fight against racism. History and the current presence of institutional racism (and person-to-person acts of racism) have taught us that antidiscrimination and antiracism laws have been effective in mitigating racism and are still needed to defend against overt racism. The civil rights and social justice community will have to continue to be vigilant in responding to race-driven laws and policies that repress the rights of people of color.

For example, the spread of voter suppression laws and policies at the state level since the 2010 presidential election is clearly racially driven. In response, there was and continues to be a nationally coordinated response to monitoring and challenging voter suppression laws and policies. A similar antiracism and civil rights community response to the “Stop and Frisk” policy in New York City was successful in having that policy greatly modified because it was inherently racist.

Immigration reform is another area where it is clear that cultural pluralism, in itself, is not adequate for addressing racist undertones of the opposition, by some Americans, to offering legal status for over 11 million undocumented immigrants, a vast a majority of whom are Hispanic but also include people of Asian, African, and Caribbean descent.

Racism is often discussed as a broad global issue. However, it is useful to look at the range of racial disparities within various systems as examples of institutional racism, which can often be intractable and pervasive. For example, the following systems have had to seriously reflect on and make policy changes that respond to institutional racism:

- **Education system.** There are significant disparities in the quality of education received by African American and Hispanic children as compared with white children.
- **Employment.** The overall national unemployment rate during 2013 was approximately
- 7.6 percent. During that same period, the unemployment rate for African Americans was 13.5 percent and for Hispanics it was 9.6 percent (U.S. Department of Labor, Bureau of Labor Statistics, 2014).
- **Housing.** Disparities in the housing market are exemplified by the disproportionate losses suffered by African Americans and Hispanics during the collapse of the housing market, which reached its peak in 2008. The so-called housing bubble, during which millions of Americans lost their homes to foreclosure largely due to unscrupulous and outright fraudulent mortgage financing practices, was seen as one of the causes of the worldwide economic depression 2008 to 2012. According to a report released by the Center on Responsible Lending, Though most of "affected borrowers have been white, African American and Latino borrowers are almost twice as likely to have been impacted by the crisis. Approximately one quarter of all Latino and African-American borrowers have lost their home to foreclosure or are seriously delinquent, compared to just under 12 percent for white borrowers. Asian borrowers have fared better as a whole than Latino and African-American borrowers, but they, too, have been disproportionately affected, especially in some metropolitan areas" (cited in Waldron, 2011).
- **Health and behavioral health.** Disparities are also evident in what are known as the social determinants of health—conditions in the environments in which people are born, live, learn, work, play, and worship (Healthy People.gov, 2014).
- **Criminal justice system.** The criminal justice system is another area where we see lingering evidence of institutional racism. Racial disparity in the criminal justice system exists when the proportion of a racial or ethnic group within the control of the system is greater than the proportion of such groups in the general population. The causes of such disparity are varied and can include differing levels of criminal activity, law enforcement emphasis on particular communities, legislative policies, and decision making by criminal justice practitioners who

exercise broad discretion in the justice process at one or more stages in the system (Sentencing Project, 2008). The following are indicators of racial disparities in the criminal justice system:

- African Americans make up 13 percent of the overall population, but 38 percent of all prison and jail inmates are African American compared with their 13 percent share of the overall population.
- Latinos constitute 15 percent of the overall population but 19 percent of the prison and jail population.
- According to one sobering statistic, 32 percent of all black men born in 2001 will have been to prison at some point in their life; compared with 17 percent Hispanic men and 6 percent white men (Sentencing Project, 2008).

The issue of racism in America has been a national concern since the country's inception. Organized protests against racist policies have existed from the antislavery abolitionist movement that began in the late 18th century through the Civil Rights Movement of the 1960s. It seems that to truly achieve a race-neutral country there has to be a change in how individuals adapt to and accept racial and ethnic differences. As we move deeper into the 21st century, the expected changes in America's demographics will almost certainly bring about a new dynamic in race relations. Whether or not that dynamic is conflict free is not clear. However, as was true in the past, social justice and civil rights advocates and political leaders have a role to play in helping to guide the nation in accommodating social change.

The social work profession has been on the cutting edge of leading the nation in responding to racism. Therefore, it would be appropriate for the profession to assert its ongoing leadership in working with other national leaders in developing policies and programs to significantly diminish if not eliminate racism in society, and within the social work profession. According to the NASW *Code of Ethics*, "Social workers . . . should advocate for changes in policy and legislation to improve social conditions in order to meet basic human needs and promote social justice. . . . Social workers should act to prevent and eliminate domination of, exploitation of, and discrimination against any person, group, or class" (NASW, 2008).

POLICY STATEMENT

As a matter of principle and in line with its historical values, NASW supports an inclusive, multicultural society in which racial, ethnic, class, sexual orientation, age, physical and mental ability, religion and spirituality, gender, and other cultural and social identities are valued and respected. NASW is a proponent of forward-thinking social policies that seek to foster diversity at all levels of social discourse, ranging from the workplace to where we live. NASW encourages government, national social justice and civil rights organizations, and faith-based organizations to become vocal about preparing the nation for demographic changes that are imminent by openly advocating for

- respect for cultural differences
- racial and ethnic inclusion
- embracing the value of accommodation when dealing with cultural differences.

From a policy perspective, NASW espouses the principles of cultural pluralism as described in the Issue Statement of this document. By itself, cultural pluralism is not a remedy for racism; it is a mechanism for multicultural societies to adapt to the convergence of various cultures into a functional whole without major conflicts. A central tenet of cultural pluralism is that cultural groups can coexist without losing their cultural identities.

NASW recognizes that there are those in America who have an opposing view of multi-culturalism as being an acceptable approach for easing racial conflict. Those voices espouse the viewpoint that the best way to bring about an end to racism is for ethnic groups to subordinate their ethnic and cultural identities and embrace an “American” identity. Their concern is that multiculturalism fosters racial disharmony because it leads to the disintegration of the value of a single national ethos (Etzioni, 2009). Although all viewpoints should be respected, we do not feel that the many decades of having cultural diversity policies in place in one form or another supports the idea of the continued incorporation of multicultural demographic planning.

Just as important, NASW believes that existing national and state-level civil rights laws, antidiscrimination policies, and all levels of equal protections against institutional racism are the most effective tools to protect against racism. We believe and will strongly advocate for constitutional protections for voters' rights and equal access to housing, employment, and education.

NASW believes that our nation can and should institute proactive strategies that will lead to a greatly reduced number of communities and individuals who hold on to racist or ethnocentric values that become engrained in what is commonly called "white privilege." Over the years, America made gains in acceptance of workplace diversity policies in government, industry, and in many communities.

This policy statement encourages and supports efforts by the civil rights community, social justice advocates, and individual social workers to monitor and respond to major incidents of racism and violation of national laws against racism:

- ending all forms of racial disparities in the criminal justice system
- ending all forms of racial disparities in the juvenile justice system
- ending racial disparities in the primary and secondary education system that lead to disproportionate and severe discipline for black and Hispanic children
- ending all forms of racial disparities in health care
- proactively advocating for an end to economic disparities, especially income disparities
- monitoring voter suppression and procedures that limit the access to voting by minorities
- supporting legislation that ends racial profiling of African Americans, Hispanics, immigrants, and profiling that is the result of Islamic phobia.

NASW supports and encourages its chapters and members to take a leadership role in joining national coalitions of civil and human rights organizations to combat racism and help to engrain a national ethos that respects cultural diversity while maintaining loyalty to America as a nation.

NASW believes that social workers have an ethical responsibility to commit to cultural competency in their workplace with fellow employees, with those under their supervision, and, most important, in their areas of practice. In addition, with regard to policy for responding to current incidents of institutional and other forms of racism, change can be achieved by working with national and state coalitions, along with other organizations with a civil rights and social justice agenda, to advocate for reforms in public policies and to enact legislation that will eliminate discrimination and disparities based on race and ethnicity.

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Reproductive Justice

ISSUE STATEMENT

Women’s reproductive issues are a matter of women’s health. However, women’s bodies have become battlegrounds on which ideological battles are waged. Rather than a simple matter of physical and emotional health, the fight over women’s reproductive capabilities represents a larger ideological struggle over the role and rights of women. For example, states have adopted 334 abortion restrictions since 2010, while adopting only 22 measures aimed at expanding access to reproductive health services or protect reproductive rights (Nash, Gold, Ansari-Thomas, Cappello, & Mohammed, 2016). It is vital that the social work profession keep abreast of the constantly changing policy landscape of reproductive issues and take an ethical and evidence-based position on behalf of our clients and communities.

Reproductive Justice: A New Framework

In the 1960s and 1970s the women’s rights movement made reproductive rights a cornerstone of organizing and advocacy. However, reproductive rights were often narrowly defined as the right to choose an abortion, often termed being “pro-choice.” Women of color critiqued this narrow focus and, in contrast, developed an intersectional analysis termed “reproductive justice” (Ross, 2007). Largely through the efforts of such groups as SisterSong Women of Color Reproductive Health Collective and the Asian Communities for Reproductive Justice (ACRJ), the reproductive justice lens is now the preferred lens for looking at women’s health and reproductive issues (Cook, 2007). *Reproductive justice* is “the complete physical, mental, spiritual, political, social, and economic well-being of women and girls, based on the full achievement and protection of women’s human rights" (Ross, 2007, p. 4). The lens is consistent and compatible with NASW's focus on social and economic justice for all.

This analysis seeks to join multiple social justice movements together to address structural inequalities across race, gender, generations, and class. The expanded agenda seeks to end the isolation of abortion and contraception from other related issues, such as immigration, incarceration, disability, spirituality, and the environment. Alzate (2009) presented 20 health concerns, other than abortion and contraception, including infertility, drug use during pregnancy, child sexual abuse, menopause, forced marriages, child birth, assisted reproductive technologies (ART), and lactation, to name a few, that fall under the larger umbrella of reproductive justice. This framework includes not only pregnancy prevention and termination, but also the right and support to have children, including health insurance, affordable and quality child care, a living wage, and paid family leave and sick leave.

In addition to the expansion of topical areas and structural injustices, the reproductive justice framework includes paying special attention to a range of populations, including sexual minorities, trans men and trans women, women of color, and incarcerated and immigrant women (Roth, 2007; Wellek & Yeung, 2007). This expanded focus includes three main frameworks: (1) reproductive health, which deals with service provision; (2) reproductive rights, addressing legal issues; and (3) reproductive justice, which focuses on movement building (Ross, 2007). The reproductive justice framework embraces activism and coalition building with diverse groups with interrelated agendas.

Furthermore, the reproductive justice movement highlights the unique concerns of women of color. For instance, black and Latina women have higher rates of abortion, often because of lower incomes and limited access to preventive health care, including birth control. Women of color have also been targets of coercive government policies that attempt to regulate their child-bearing through a range of policies including sterilization, family caps on public assistance, prosecution for using drugs while pregnant, and the criminalization of pregnant women (Roberts, 2015). Although it is beyond the scope of this policy statement to address the complete myriad of topics and structural inequities that fall under the reproductive justice umbrella, an attempt is made to expand the conversation.

Abortion

Brief History. Until the later years of the 19th century, abortion was legal before *quickening*, defined as when fetal movement could be felt, at approximately the fourth month of pregnancy (Reagan, 1998). Over time abortion began to be criminalized due to multiple factors including concern over the safety of women who were dying due to self-induced abortions; the medical profession's attempt to establish supremacy over midwives; and anti-immigration, anti-Catholicism, and anti-feminist movements. The criminalization of abortion did not stop abortion, but, rather, led to illegal abortions and more self-induced abortions often resulting in injury and death (Pollitt, 1997). Women used an assortment of methods to self-induce abortion including inserting knitting needles or crochet hooks into their uteruses or ingesting gunpowder and whiskey (Reagan, 1998). The estimated numbers of illegal abortions in the 1950s and 1960s ranged from 200,000 to 1.2 million a year (Gold, 2003).

In 1973 the Supreme Court decision in *Roe v. Wade* affirmed women's right to an abortion, attributed to the constitutional rights of privacy and liberty. Justice Blackmun created a three-tiered framework, tied to the three trimesters of pregnancy, which gave the state greater power to regulate abortion as the pregnancy advanced and fetal viability increased (Masci, Lupu, & Davis, 2013). Three years after the passage of *Roe v. Wade*, Congress passed the Hyde Amendment, which banned federal funding of abortion (Poggi, 2007). Because of the racialized nature of poverty, these prohibitions on abortion funding disproportionately affect low-income women of color. Poggi (2007) reported that as many as one in three low-income women who would have had an abortion if it were covered by Medicaid are instead obliged to continue the pregnancy. In 1979, the United Nations Commission on Human Rights stated that unimpeded access to family planning and reproductive health services, including abortion services, is a fundamental human right that contributes to the advancement of women worldwide.

A 1992 Supreme Court decision, *Planned Parenthood of Southeastern Pennsylvania v. Casey*, affirmed the *Roe v. Wade* decision, while also allowing states greater regulatory powers if abortion restrictions did not pose an "undue burden" on a woman's right to terminate her pregnancy.

After the Casey decision, antiabortion activists at the state level proposed and passed numerous restrictions on women and abortion providers, termed Targeted Regulation of Abortion Providers (TRAP) laws. The laws included mandatory sonograms, extended waiting periods, requiring doctors to have local admitting privileges, and requiring abortion clinics to meet the strict standards of ambulatory surgical centers (Guttmacher Institute, 2016b). In 2016 the Supreme Court decision in *Whole Women's Health v. Hellerstedt* reaffirmed women's constitutional protection for abortion rights while also finding that many of the TRAP laws constitute an undue burden on women (Liptak, 2016). The latest ruling sets a standard that abortion regulations must demonstrate evidence-based health and safety reasons to meet constitutional standards.

Statistics. Since the 1970s the overall trend of abortion has been a gradual decrease in number each year, often attributed to greater birth control education and access. However, despite a gradual decrease, in 2011 approximately 1.06 million abortions were performed (Guttmacher Institute, 2016a). Almost half of all pregnancies in the United States in 2011 were unintended, and about four in 10 of these resulted in abortion. Women of all races have abortions: 39 percent white, 28 percent African American, and 25 percent Latina. Women who seek abortions are disproportionately poor, with 49 percent in 2014 with incomes 100 percent less than the federal poverty level ($11,670 for a single adult with no children) (Guttmacher Institute, 2016a). Women provide multiple reasons for having an abortion, including concern or responsibility for another individual; unable to afford a child; having a baby would interfere with work, school, or the ability to care for others; did not want to be a single parent; and having problems with their partner.

Abortion Misconceptions. According to the Pew Research Center (Liptak, 2016), 56 percent of U.S. adults say abortion should be legal in all or most cases, compared with 41 percent who say it should be illegal. Support for abortion varies by age, party, and religious affiliation; young people, Democrats, and the religiously unaffiliated are more likely to support abortion rights.

The people and organizations that actively oppose abortion often resort to campaigns of misinformation (U.S. House of Representatives, 2006). For instance, they may claim that abortion increases a woman's chances for breast cancer, future infertility, and mental health problems. However, each of these claims is false as demonstrated by empirical studies (American Congress of Obstetricians and Gynecologists [ACOG], 2015; Biggs, Upadhyay, McCulloch, & Foster, 2017). In fact, the risk of death associated with childbirth is more than 12 times higher than that for an abortion (ACOG, 2012). Also, a recent longitudinal study of women's mental health five years after being denied or receiving an abortion found that there were no greater risks of adverse psychological outcomes after having an abortion; to the contrary, being denied an abortion was associated with greater risk of initially experiencing adverse psychological outcomes (Biggs et al., 2017).

One way misinformation is given is through so-called crisis pregnancy centers (CPCs). There are approximately 2,500 such centers in the United States (Belluck, 2013). CPCs are often religiously based and attempt to deter women from having abortions, often by giving misinformation. They often provide pregnancy tests and ultrasounds, but no further medical services, and they might not even have trained medical staff. CPCs may try to confuse women by geographically locating themselves close to an abortion provider and also pay for Internet service optimization services to bring the center's name up when people search for "abortion" online (Belluck, 2013). Some of the centers are state funded, and other governmental organizations have tried to regulate them, requiring them to post signs stating that they do not provide abortion or contraception and disclosing whether medical professionals are on-site (Belluck, 2013). CPCs attempt to impose their values on women, which goes against social work's principle of self-determination.

Stigma. *Abortion stigma* is defined as "a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to the ideals of womanhood" (Kumar, Hessini, & Mitchell, 2009, p. 628). In their review of the literature, Norris et al. (2011) found that abortion stigma can be transitory or episodic and that it increases adverse emotional outcomes, is worse when the abortion is categorized as undergone for "bad" reasons (for example, later gestational age or repeat abortion), and may increase if a woman has received misinformation about the physical and psychological risks of abortion. Even though one in three women in the United States has had an abortion (Guttmacher Institute, 2016a), the silence around the procedure also adds to the stigma.

Abortion stigma can also affect individuals who work in abortion provision, including social workers. The stigma is increased due to the harassment and violence at abortion clinics and may result in staff feeling stress, fears about disclosing one's work in social situations, and burnout (Norris et al., 2011). Abortion providers counter the stigma with positive beliefs, such as that their work is "valuable and it contributes to patients' well-being in a profound way" (Norris et al., 2011, p. S51).

Contraception

A Brief History. Abortion became necessary for some women because they did not have access to family planning methods to control their childbearing (Poggi, 2007). The modern history of family planning in the United States is often attributed to Margaret Sanger, a nurse and the founder of Planned Parenthood. In 1916 she opened the first birth control clinic to provide women with education and information, but was arrested under New York's obscenity laws (Centers for Disease Control and Prevention, 1999).

An often-untold story in social work is the support for birth control at Hull House in Chicago, a settlement house viewed as a vital part of the social work profession's founding and history. Two long-time Hull House residents, physicians Alice Hamilton and Rachelle Yarros, supported sex education and birth control education, provision, and activism. Yarros (cited in Haslett, 1997) described her predicament this way: "No matter what your ideas of the sacredness of human life and the criminality of performing abortions, your heart aches while you send a woman out of your office, knowing that she is surely going to a quack" (p. 266). Rather than seeing abortion as a single issue, Hamilton and Yarros connected birth control to poverty, classism, and the role and status of women and rejected the eugenics argument popular at that time—the racist idea that birth control should be offered to poor and immigrant women for the sake of white race preservation (Haslett, 1997).

In 1965 the Supreme Court decision in *Griswold v. Connecticut* legalized birth control for married couples by acknowledging the implied right to privacy in the U.S. Constitution; unmarried women gained the right in 1972. In 1960 the first birth control pill was approved by the Food and

Drug Administration (FDA). Today numerous forms of birth control for use by women exist, each with different advantages and disadvantages, including implants, intrauterine devices, injections, pills, patches, and rings.

Statistics, Legislation, and Public Funding. Three million pregnancies in the United States, almost half of all pregnancies each year, are unintended (Guttmacher Institute, 2016a). In 2014, 38 million women needed contraceptive care and of those, 20 million needed publicly funded services and supplies because they had income below 250 percent of the poverty level or were younger than 20 (Guttmacher Institute, 2016a). Public funding for birth control services totaled $2.37 billion in fiscal year 2010 (Guttmacher Institute, 2016a). Public funds for contraceptive care come from Medicaid (75 percent), state appropriations (12 percent), Title X (10 percent), and other state and federal sources (3 percent). One in four women who obtained birth control in the years 2006 to 2010 did so at a publicly funded center. There are great disparities in contraceptive use by women with low income. These women have an unplanned pregnancy rate five times higher than high-income women (Sonfield, 2013). In addition, transgender men who have sex with men may also be at risk for unintended pregnancy (National Center for Transgender Equality [NCTE], 2012).

The benefits of family planning are multiple and well documented (Frost & Lindberg, 2012; Sonfield, Hasstedt, Kavanaugh, & Anderson, 2013). Women state that planning their families allows them to take better care of themselves and their families, finish school, and obtain a job that enables them to support themselves and their families (Sonfield et al., 2013). The disadvantages of an unplanned pregnancy are also well documented and are associated with more conflict and less relationship satisfaction, physical and sexual abuse, depression, and anxiety (Sonfield, 2013).

The Patient Protection and Affordable Care Act (ACA, also widely known as “Obamacare”) was enacted by Congress in 2010 and included the requirement that most private plans include coverage of contraceptive methods and services. Earlier, the Equal Employment Opportunity Commission determined that health plans that covered other preventive services but excluded contraceptive coverage were guilty of sex discrimination (Sonfield, 2017). However, as soon as the ACA passed, some conservative lawmakers and employees objected to the mandatory contraception coverage. These employers asserted a “conscience clause” that would allow employers with religious or moral objections to birth control to not provide birth control to their employees in the name of religious freedom. Conservative lawmakers at the state and federal levels have also attempted, and at times been successful, in blocking Planned Parenthood clinics from receiving federal or state funds for birth control services. These conservative lawmakers claim that any provider affiliated in any way with abortion should not receive public dollars, whether they provide abortions or even refer clients for abortions (Hasstedt, 2016). State legislators have also been creative in finding ways to decrease contraceptive funding, including 15 states that tried to limit family planning providers’ eligibility for reimbursement under Medicaid (Hasstedt, 2016).

In fact, in January 2016 antiabortion lawmakers in Congress nearly forced a government shutdown over funding for Planned Parenthood. Contraception accounts for 34 percent of Planned Parenthood services, sexually transmitted infections (STIs) screening and treatment accounts for 42 percent, cancer screenings and prevention account for 10 percent, and abortions account for only 3 percent of Planned Parenthood services (Goldschmidt & Strickland, 2017). Planned Parenthood also serves 36 percent of all clients obtaining care from publicly funded family planning centers.

Emergency Contraception. Emergency contraception is birth control used after a sexual encounter in instances in which no birth control was used, the birth control failed, or a sexual assault occurred. Emergency contraception can be a woman’s own birth control pills in higher doses, or the specialized pill, termed “Plan B,” often called “the morning-after pill.” The pills are highly effective, especially if taken within 72 hours of unprotected sex (U.S. Department of Health and Human Services, Office of Population Affairs, 2014). After a protracted and highly politicized process, the FDA approved emergency contraception for sale over the counter to any person 17 years of age and older.

Male Contraception. In many instances responsibility for reproductive decisions and consequences is primarily borne by women. For instance, women often bear the brunt of obtaining, buying, and using birth control. Many of the most effective forms of birth control require women to take a pill, get an injection, or have an implant inserted. Numerous side effects can result, including mood swings, weight gain, blood clots, and irregular bleeding (American Sexual Health Association, 2013).

One way this unequal burden on pregnancy prevention can be shared is by developing additional methods of male birth control. A recent study assessed the safety and efficacy of an injectable combination hormonal contraceptive for men. Although the injection showed great promise in being a reversible and effective form of birth control, the study was ended early due to a high frequency of reports of mild to moderate mood disorders (Behre et al., 2016).

Birthing and Parenting

When viewed through the framework of reproductive rights, women's reproductive issues most often began and ended with pregnancy prevention or termination. However, the reproductive justice framework expands the conversation into affording women the right to have or not have children, and the necessity of aiding women and men who are parents so that they may raise their children in safe, healthy, and supportive environments.

The decision whether to have a child is often viewed as an emotional decision, but clearly it is also an economic one. For instance, the annual cost of raising a child from birth to age 17 by high-income parents is $372,210, by middle-income parents $233,610, and by low-income parents $174,690 (U.S. Department of Agriculture, 2017). Women's ability to economically support a family depends on many larger structural issues including, but not limited to, the gender wage gap; child care costs; health insurance coverage; early childhood education; the minimum wage; discrimination in the workplace, including pregnancy discrimination; the availability of family leave and paid sick days; and access to reproductive health care.

In the United States about one in three births happens by cesarean section (C-section), and that rate has risen dramatically over the past few decades. The U.S. C-section rate is higher than that in most industrialized nations and does not lead to better birth outcomes (Thielking, 2015). One study of maternal mortality conducted in 48 states found that it increased from 18.8 in 2000 to 23.8 in 2014, which represents an overall 26.6 percent increase (MacDorman, Declercq, Cabral, & Morton, 2016). In the United States, half of all households with children under the age of 18 years have a breadwinner mother (Institute for Women's Policy Research [IWPR], 2016a).

Correll and Benard's (2007) foundational research was the first to empirically document the often-suspected motherhood penalty for mothers in the workplace. Mothers were judged as significantly less competent and committed than women without children, were rated as less promotable, were less likely to be recommended for management, and were recommended for a starting salary that was $11,000 less than those salaries offered to women who were not mothers.

In 2015, women as a group working year-round and full-time earned only 80 cents on the dollar compared with men as a group (IWPR, 2016b). When analyzed by race and ethnicity, white women earned 75 cents for each dollar earned by a white man compared with 63 cents for black women, 84 cents for Asian American women, and 54 cents for Latinas. The U.S. Census reported that the poverty rate in 2015 varied by family type, with 5.4 percent of married couples, 14.9 percent of families headed by a man, and 28.2 percent of families headed by a woman living in poverty (Proctor, Semega, & Kollar, 2016).

ART, including egg donation, and pregnancy surrogacy can create new ethical dilemmas for women, families, and health providers. In some cases the risks of participation in some of these new technologies are not well described. For instance, older women should be informed of the probability of getting pregnant with the specific ART, and surrogates and egg donors should receive an explanation of the risks and rights inherent in their roles and protected from exploitation and commodification of their reproductive capacities.

Transgender individuals may face unique challenges to their fertility due to feminizing and masculizing hormone therapy or surgeries that may remove or alter their reproductive organs. The World Professional Association for Transgender Health (WPATH) Standards of Care (WPATH, 2012) recommended that mental health and health care professionals discuss reproductive options with clients before initiation of such medical treatments. Reproductive options can include sperm and egg freezing. In some cases fertility can be restored by stopping hormonal treatments, but that can depend on the patient's age and the duration of hormonal therapies (WPATH, 2012). The more recent use of hormonal blockers for prepubescent children may also affect fertility. Transgender and gender-nonconforming individuals often have been reluctant or prohibited from pursuing such options due to stigma, discrimination, insurance coverage restrictions, and lack of knowledge by medical professionals (National Women's Law Center, 2015).

Reproductive Coercion

Feminist activism in the reproductive rights arena proclaims the principle that women have the right to control their bodies and their reproductive decisions. However, in many cases that autonomy is usurped by others, from an intimate partner to the government that increasingly regulates access to reproductive services. Reproductive and sexual coercion involves "behavior intended to maintain power and control in a relationship related to reproductive health by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent" (Committee on Health Care for Underserved Women, 2013, p. 1). This behavior includes actions to pressure someone to get pregnant, continue a pregnancy, or terminate a pregnancy. Controlling behaviors include threats and physical violence, including homicide (Committee on Health Care for Underserved Women, 2013). Specific actions might include sabotaging contraceptive methods, forcing sex without a condom, or intentionally exposing a partner to an STI. A small qualitative study by Canadian social workers found that intimate partner violence influenced women's abortion decisions due to fear of the perpetrator and fear for the life of the baby (Cote & Lapierre, 2014).

Forced Sterilization. As mentioned earlier, reproductive coercion can occur as a result of an individual or government action. A very tragic but often untold chapter in American history is the story of how mostly poor women of color were sterilized, often by deceit or coercion (Krase, 2014). Instead of gaining access to reversible contraception, the United States promoted a policy of permanent sterilization in Puerto Rico. Some states set up Eugenics Boards that targeted poor, unwed, or mentally disabled women, children, and men for sterilization. This nationwide sterilization effort was institutionalized in U.S. laws and policy using government and private funds. Latinas in Puerto Rico, New York City, and California were targeted as well as black women in the South and Native American women in the West. The practice of forced sterilization is not just a tragic history lesson, but continues today. In 2013, investigative reporting revealed that female inmates in California had been illegally sterilized (Krase, 2014).

Sterilization also can affect the transgender population. Some policies require transgender people to undergo masculizing or feminizing surgeries before changing their gender markers on government documents. NCTE (2012) charges that such policies violate the reproductive rights of transgender individuals and can result in forced sterilization.

NASW Code of Ethics *and Reproductive Justice*

The NASW (2015) *Code of Ethics* states that "social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals" (p. 5). Self-determination related to reproductive health means that without government interference or reproductive coercion by an intimate partner, friend, family member, or professional, people should make their own decisions about sexual activity and reproduction. As social workers, we support the right of individuals to decide for themselves, without duress and according to their own personal beliefs and convictions, when they want to become parents, if they want to become parents, how many children they are willing and able to nurture and support, the opportune time for them to have children, and with whom they choose to parent. All social work services, ranging from abortion to adoption to contraception to parenting, should be provided safely and competently in a nonjudgmental atmosphere based on evidence-based practice rather than the imposition of another's personal beliefs. The right to parent should not be denied to individuals because of class, disability, race, gender or sexual identity, or any other category.

The ability to control one's own sexual and reproductive life leads to increased educational and career opportunities and the ability to care for oneself and others. All people deserve to make these decisions with dignity and autonomy and to have access to the services that support their decisions.

According to the NASW (2015) *Code of Ethics*, one of social workers' ethical responsibilities to clients is informed consent, which includes clear language to inform the client of the purposes, risks, and limits to services. Informed consent should be based on empirical evidence and the social work values of competence and integrity (NASW, 2015). These values require that social workers act honestly, responsibly, and "continually strive to increase their professional knowledge" (p. 4). Therefore, providing misinformation to dissuade women from having an abortion violates the social work code of ethics.

POLICY STATEMENT

NASW supports the following:

Public Awareness and Advocacy

- public health campaigns that attempt to destigmatize abortion and other reproductive services while providing evidence-based information so that each person has a solid foundation on which to base their decision
- coalitions that share the intersectional analysis of reproductive justice; for example, law enforcement killing of unarmed black men falls under the umbrella of reproductive justice because killing black youths violates the rights of mothers to raise their children in a healthy and humane environment (Roberts, 2015)
- a requirement that advertisements and notices seeking women to supply donor eggs state that long-term health risks of egg harvesting procedures are unknown

Availability and Access of Services

- increasing families' access to affordable, high-quality child care and early childhood education

- expanding Medicaid programs to cover those with incomes up to 138 percent of the federal poverty level
- increasing public expenditures for family planning services
- reproductive justice for incarcerated individuals, including access to abortion, quality prenatal care, and routine preventive health services; incarceration geographically close to their children to preserve relationships; prohibition of shackling during labor and delivery; diverting from jail or prison to mental health and addiction services where possible; and removing restrictions on people with felony convictions that make it difficult to obtain public housing, food stamps, Temporary Assistance for Needy Families, student loans, and jobs or to vote
- efforts to objectively educate individuals on the range of options available to them when facing an unplanned pregnancy, including abortion and adoption services, based on evidence and the beliefs of the client
- efforts to provide safe, competent, nonjudgmental, and confidential reproductive health services to trans women and trans men who may be in need of services that do not align with their current gender identification and expression, for example, transgender men who need annual pelvic exams or transgender women who require a prostate exam
- a full range of reproductive options available to trans men and trans women, including preventive health screenings, prenatal and pregnancy care, infertility assistance, STI screening and treatment, and contraceptive services
- training for medical social workers and other health professionals on transgender-appropriate care, nondiscrimination, and inclusivity
- school-based, age-appropriate, culturally informed sexuality and reproductive health education programs that include information about the roles of personal beliefs, culture, and values in individual and family decision making on these issues; prevention of STIs; range of reproductive health services and contraceptive methods; skills for making healthy personal choices about sexuality and reproduction; and information about sexual consent and violence prevention
- efforts to mandate insurance coverage for infertility treatments

- efforts to monitor the ethical dilemmas and health risks of current and future ART, including egg donation and surrogacy, which have the potential to increase the possibility of the commodification of reproduction and the potential exploitation of poor women, in the United States as well as internationally

Policy

- opposing the repeal of the ACA while continuing key requirements of the ACA for private health plans including coverage of contraceptive methods with no out-of-pocket costs and opposing any effort to exempt employers who would impose their religious beliefs on their covered employees
- opposing the repeal of *Roe v. Wade*
- repealing the harmful Hyde Amendment and other restrictions on insurance coverage of abortions
- resisting any restrictions to abortion access that do not meet the Supreme Court's *Whole Woman's Health v. Hellerstedt* decision that such restrictions offer evidence-based medical or safety benefits sufficient to justify any burdens
- opposing all efforts to deny federal and state funds, including Medicaid reimbursements, to Planned Parenthood and other providers associated with abortion
- increasing enforcement and oversight by state and federal agencies of the ACA birth control benefit
- the U.S. Department of Health and Human Services revising program guidelines for Title X family planning grants to prohibit discrimination on the basis of gender identity and sexual orientation and to address the cultural and clinical needs of transgender patients
- enacting the Pregnant Workers Fairness Act (2015–2016) and similar state legislation, which would require employers to make the same sorts of accommodations for pregnancy, childbirth, and related medical conditions that they do for disabilities

- passing the Reproductive Health Non-Discrimination Amendment Act of 2014, to ensure that employment discrimination based on reproductive health decisions is prohibited
- assisting working families by enacting the Schedules That Work Act (2015–2016) and similar state legislation to curb employers' abusive scheduling practices and give working people the right to request schedule predictability and flexibility
- passing the Healthy Families Act (2017–2018), which would establish a minimum, earned paid sick and safe days standard, and the FAMILY Act (2017–2018), which would establish a paid family and medical leave insurance program
- eliminating public policies that require surgeries that often result in sterilization, for people undergoing gender transitions to procure gender marker changes on government documents
- eliminating discretionary funding for abstinence-only-until-marriage programs
- passing the Real Education for Healthy Youth Act (2015–2016), legislation that would provide young people with the comprehensive sexuality education they need to lead sexually healthy lives
- passing the Military Access to Reproductive Care and Health for Military Women Act (2013–2014), which seeks to undo restrictions that prohibit women from obtaining an abortion in military facilities except in cases of rape, incest, and life endangerment, even though those women use their own funds
- opposing legislation that attempts to criminalize pregnancy by drug testing and prosecuting individuals for using drugs while pregnant

Professional Development and Continuing Education

- social work education that focuses on reproductive and sexual coercion (including birth control sabotage, pregnancy pressure and coercion) and harm-reduction strategies and safety planning

- inclusion of content on the reproductive justice paradigm in social work programs
- social work education efforts that address the evidence-based risks of pregnancy, birth control, and abortion

Research

- investigation to better understand the troubling recent increase in the U.S. maternal mortality rate to prevent maternal deaths and improve maternity care
- evaluation of the business case for paid family leave and sick days
- addressing racial disparities in reproductive health access including examining the structural issues that individuals of color face, such as less income and education, and limited access to preventive health care, including regular birth control, which can contribute to their higher rates of abortion
- development of a safe, effective, and reversible form of birth control for cisgender men to share the burden of pregnancy prevention
- investigation to better understand the risks of donor egg extraction, particularly with respect to the impact of drugs used for both suppression and stimulation of the ovaries.

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Role of Government, Social Policy, and Social Work

ISSUE STATEMENT

Since the colonial beginnings of this country, government has been involved in addressing social problems. As a reaction to the strong central authority of European monarchies from which they fled or against which they rebelled, the founders favored a theory of negative government, meaning the less government, the better. This preference for limited government responsibility for social services led Jansson (2012) to label the United States a “reluctant welfare state,” distinguishing it from the traditional European welfare states. Despite this obvious and strong preference for private and individual solutions, our government mitigates the fallout from an unregulated economy and protects disadvantaged populations. As far back as the early 1700s, Massachusetts’ colonists received aid from the general treasury to care for sick and displaced people (Trattner, 1999). Although government assistance has been present since our earliest beginnings, Americans have always struggled over how much government should be involved in helping cure the social ills of the nation.

An infamous instance of the hands-off approach is found in the “Pierce Veto.” In 1854 President Franklin Pierce vetoed legislation that would have designated federal lands to be used to establish psychiatric hospitals. Pierce did so because he feared that the federal government would become the “great almoner” to poor people (Pumphrey & Pumphrey, 1967). He did not want to set an “untenable precedent and draw the federal government into an inappropriate and unconstitutional relationship with the nation’s needy” (Block, 1996).

Trends and countertrends addressed the most extreme dimensions of poverty, inequality, and oppression. In the early years of the 20th century, the Progressive Era tempered the harshness of the free market economy and protected the most vulnerable people. The Roaring Twenties returned the country to a time of limited government involvement. When the Great Depression started in 1929, the Herbert Hoover administration refused to support government intervention to alleviate the serious hardships experienced by many Americans.

The laissez-faire approach was rejected by President Franklin Delano Roosevelt, whose reaction to the Great Depression brought forth the New Deal. The New Deal policies firmly established the responsibility of the federal government to ameliorate the inequalities inherent in a capitalistic system. During the subsequent 40 years, the presidential leadership of both parties further established and expanded rights of citizenship and new social, political, and economic benefits at the federal level.

Advances in science and technology, food production, public health, worker safety, and the environment have resulted in improvements in the quality of life undreamed of in the past. At the same time, dislocations and problems that have accompanied these changes have caused considerable misery and inequities for many people and communities. From Franklin D. Roosevelt to Jimmy Carter, the electorate tended to choose representatives who viewed government as a mediating structure that modified the vagaries and inequities found in the marketplace. This view was accompanied by the goal to create equality of opportunity to fulfill the vision of the United States of America as an open, pluralistic, caring, and inclusive society.

From 1935 to the late 1970s, federal government efforts moved in the direction of sharing the benefits of economic growth among its citizens, moderating the harshness of an unregulated economy, and protecting vulnerable people. During this period, government fulfilled this by

- regulation and oversight
- designing and funding programs created specifically to meet its policy goals
- stimulating the economy through industrial, taxation, and other fiscal policies
- redistributing the wealth of the society through the tax system.

Leadership by the federal government in promoting an equality-of-opportunity social agenda peaked in the Kennedy–Johnson era of the 1960s.

More socially progressive legislation was passed in the 1960s than at any other time in U.S. history and continued under the Nixon administration. President Nixon instituted several “new federalism” policies, such as block grants to the states (made without abdicating federal leadership) and Title XX support for a range of social programs. Nixon supported the federalization of categorical welfare entitlements, eventually enacted as Supplemental Security Income benefits (P.L. 92-603). Finally, he proposed the federal takeover of Aid to Families with Dependent Children and introduced national health insurance legislation that, if passed, would have extended Medicare and Medicaid–like health coverage to new categories of citizens.

Although the administrations of Presidents Ford and Carter did not really tamper with social programs and priorities, the stagflation of the 1970s led to an increase in calls for limits on both taxes and social spending at both the federal and state levels and a shift from universal to selective approaches to services. Concurrently, public hostility toward poor people and other marginalized groups was captured by the Republican Party’s appeals to the “silent majority” or those citizens who were unwilling participants in government intervention on behalf of marginalized groups.

The Reagan and Bush administrations in the 1980s even more vigorously promoted an ideology of individualism and privatization, challenged many established entitlements, and scaled down the government role in “interfering” with the marketplace and corporate profits. Supply-side economics and tax policies forced real cuts in social programs spending and a reversal of social program priorities, and efforts were made to deregulate businesses. The gap between rich and poor increased dramatically. Both administrations continued the concept of a safety net supplemented by private charity for meeting the needs of the truly needy. Although this safety net was selective, the administrations still considered government as the provider of last resort, and there was no attempt to remove federal protection for special groups, such as abused and neglected children.

Regressive “Reaganomics” interrupted progressive ideals of the federal government. Recent administrations have replaced fundamental values of the New Deal with their own agendas of privatization, personal responsibility, corporate welfare, and faith-based and profit-making social services.

The combination of severe cuts in funding of social programs to provide tax cuts for the wealthiest citizens, deregulation of legal rights and protections, and devolution of programs to states or private corporations with less funding and little or no regulation and standards with very short notice can cause great harm to our society and especially to its most vulnerable populations.

President Bill Clinton's victory in 1992 did not lead to a return to the philosophy on which the New Deal was based. Instead, Clinton, a neoliberal Democrat, announced that the "era of big government is over." Consequently, he signed the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (P.L. 104-193), which limited entitlement to public assistance for children and their families that the Roosevelt administration had established in 1935 with the passage of the Social Security Act. The Clinton administration restricted government provision and reduced record-setting deficits that had deepened during the Reagan–Bush years.

Both parties concurred that government should be reduced in size and scope. In the 1994 national elections, candidates supporting further limitations on government won the majority of congressional seats for the first time in 40 years. A majority of state governors was also elected on a platform of less government and lower taxes. These newly elected leaders sought to curtail the federal government in social program guarantees and funding, in protecting vulnerable populations, in restricting monitoring of business and investments, and in promoting affirmative action and other equity programs. At the same time they sought a greater social control role for government in shaping how families, and women in particular, may behave and in restricting who may come to this country and the rights they could exercise while in residence.

In the run-up to the 2000 elections, George W. Bush described himself as a "compassionate conservative." His social welfare policies were similar to those of his father's and Reagan's, with the further elaboration of privatizing social services programs, an emphasis on faith-based initiatives, and profit-making social services programs.

The George W. Bush administration saw problems as being individual in origin rather than social or environmental in nature, and too often the etiology of problems in society was characterized in moral, racial and cultural, or intellectual terms. The influence of social, economic, and political factors on community and family life was minimized or ignored. At the beginning of the 21st century, government was no longer regarded as an instrument of problem solving; instead, in some quarters, by some factions, it was portrayed as the problem or an exacerbating factor of the problem. Although state governments were given more responsibility and opportunities to address these issues with fewer resources, there were yet more requirements that states meet the needs of vulnerable and oppressed populations.

In the early years of the 21st century attacks on the role of the federal government have come to include negative opinions of recipients of services, views that are antithetical to social work values in several ways: There was a shift from blaming victims to punishing them. The category of “undeserving poor” has expanded to include almost everyone, even those formerly protected, such as children, veterans, elderly people, and people with mental and physical illnesses. Users of public resources are subject to greater social control measures. Consumers of both market and social services are granted fewer real protections and are simply admonished that “buyer beware.” Stereotypical views of personal characteristics or behaviors of certain groups by virtue of their racial, ethnic, or citizenship status (in the form of acts of racism, ageism, sexism, homophobia, transphobia, and xenophobia) are justified under the guise of returning to “a supposed” normalcy or “survival of the fittest.”

Consistent with this social agenda are economic tenets that include spending cuts and tax breaks for upper-income groups coupled with balanced budget legislation, shifts of minimum programs back to the states without any entitlement provisions, heavy deregulation of industry, the lifting of consumer and environmental protections, and mandates for personal responsibility legislation.

President Obama has tried to balance government involvement and individual responsibility. Through the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), he has demonstrated the need for government involvement in providing health care coverage.

What appears to be an increase in partisan politics during President Obama’s tenure may be indicative of racism seeping into and potentially affecting politics. According to research by Tesler and Sears (2010), "unusually large effects of race and racial attitudes on public evaluations of Barack Obama have spilled over into multiple facets of mass political decision making" (p. 1).

Results of national elections in the first decade of the 21st century reflect a seriously divided public opinion over the role of government. The rise of the Tea Party and the Occupy movement demonstrate the tension between keeping the government out of social and economic policy and promoting equity through government action.

Public policy is the dominant variable in determining the nature of social work practice, and it is profoundly affected by government policy. Although social agencies and social work professionals can help shape policies and practices, the nature of the service delivery system and the legitimacy of social work as a profession are established by public social policy. Changes in government policies affect clients, their eligibility, and their ability to obtain benefits and services. Restructuring and limiting government responsibility has profoundly altered the availability and the delivery of social work services and the role and status of social work as a profession.

Since the emergence of social work as a profession and the inception of NASW, two basic assumptions have been made: (1) The social ills of the nation and its citizens need public attention, resources, and solutions, and (2) government has a major role and responsibility to meet human needs. Moreover, there has been increasing recognition that major shifts in the structure and functions of society, including demographic, economic, health, and family factors, require universal social welfare benefits and services.

POLICY STATEMENT

It is the position of NASW that federal, state, and local governments must have a role in developing policies and programs that expand opportunities; address social and economic justice; improve the quality of life of all people in this country, with special emphasis on oppressed groups; and enhance the social conditions of the nation's communities. NASW reaffirms its commitment to the promotion of the positive role of federal, state, and local governments as guarantors of the social safety net and as the mechanisms by which people through their elected representatives can ensure equitable and accountable policies to address

- mitigating the effects of a free market economy
- entitlements to assist in the elimination of poverty
- improving access to universal comprehensive health care
- increasing access to mental health and substance abuse services
- standards for public services
- enabling citizen participation in the development and implementation of social programs
- taxation that is progressive and fair and promotes a reduction of poverty
- an income floor for working poor people through earned income tax credits and other mechanisms
- adequate federal minimum wage laws indexed to annual cost-of-living increases
- standards and laws for the protection of workers in the workplace
- standards and laws for the protection of vulnerable populations
- product safety standards
- access to legal services
- commitment to full employment
- adequate and affordable housing for everyone
- assurance of adequate public education and educational standards for all schools
- a justice system rooted in law and administered impartially
- laws that protect and maintain the fragile, natural environment
- ensuring the civil rights of citizens and noncitizen residents
- ensuring the right of all to marry
- nondiscrimination and affirmative action
- international initiatives based on collaborative and cooperative relationships with other nations.

The key to accomplishing these policy goals is a view of government as an embodiment of the people and by the people, rather than an entity above and apart from its citizens. This policy calls for a renewed commitment to civic responsibility by an informed community through participation in democratic forums. This policy can be achieved with civic and political participation by all, and with campaign finance reform that levels the political playing field. It demands open debate on a wide variety of policies and programs while maintaining the basic functions listed. As necessary, such a process would support the reform of government when it is consistent with the social work value base.

NASW reaffirms the essential role of government. The role of the federal government is to ensure uniform standards, adequate resources, equal protection under the law, monitoring and evaluating of outcomes, and provision of technical assistance to state and local governments. NASW also recognizes the role of state and local governments in social programs. A state government is often in a better position to understand the needs of the people in its state. As a part of a national community, states must work together to implement a federal policy that supports the well-being of the people of this nation. Thus, social programs are most effective when there is consistency in federal standards and guidelines, with adequate funding and accountability mechanisms for states and localities to administer programs in ways that are best adapted to meet the needs of people, examining the effectiveness, efficiency, and accountability of programs necessary to ensure the success of that role. Laws, regulations, and program guidelines need constant and thorough review. NASW can provide significant leadership in evaluating existing programs and in designing and recommending new ones that advance the goals of the social policy it has reaffirmed.

NASW believes that social workers can be effective at all levels of and in many roles in government. Social workers can fulfill roles as elected officials and leaders in government and as administrators in agencies. The recent reintroduction of block grants is an opportunity for social workers to support the collaborative efforts of government and the people. This policy asserts that government should actively and creatively guide, negotiate, and participate in cooperative efforts with nongovernmental organizations to provide programs that expand and support opportunities, address social and economic justice, and improve the quality of life for all people.

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Rural Social Work

ISSUE STATEMENT

Recent data suggest that rural areas are becoming increasingly diverse, with higher rates of immigration, especially of Hispanic people (Keating & Karklis, 2016). Rural communities typically experience slower employment and wage growth, lower household incomes, persistently high poverty, substandard housing, lack of Internet access, and limited access to health and behavioral health care (Rural Health Information Hub, 2018; White, 2015). Rural residents tend to be older and experience higher rates of chronic disease and substance abuse (Rural Health Information Hub, 2018). Given these challenges, social workers have an important role in supporting the health and well-being of rural residents.

Rural areas comprise 72 percent of the nation's land area (U.S. Department of Agriculture [USDA], 2017) and about 18 percent of the U.S. population (World Bank, 2018). Rural social work largely developed in the early 20th century and was influenced by local county welfare administrators, the country life movement, and the home services workers of the American Red Cross (Daley, 2015). Although rural social workers adapted their early methods from *Social Diagnosis* and the settlement house movement, rural social work was not immediately embraced by its urban counterparts.

The Rural Economy

Sustainable economic opportunities have increasingly been relocated away from rural America to larger cities or foreign markets. Many rural communities face the loss of traditional employment and the choice of embracing industries (such as extraction industries) that may pollute drinking water, affect drainage, cause soil erosion, or dispose of toxic chemicals into the local environment (Daley, 2015). Regional inequity is most evident in the South, with a rural poverty rate of 21.7 percent, nearly six percentage points higher than in the region's metropolitan areas. On average, southern states have the lowest median household income, with nine of the country's 15 poorest states located in the South. Nationwide, high-poverty regions are concentrated in rural southern and mountain states (New Mexico, Montana, and Idaho). Overall, rural poverty in the United States is more persistent than urban poverty with 84 percent of persistent poverty counties located in nonmetropolitan regions (USDA, 2017).

In addition, rural communities have higher rates of dependence on public transfers such as the Supplemental Nutrition Assistance Program (SNAP) (16 percent versus 13 percent for urban communities) and Medicaid-funded health care (21 percent versus 16 percent in urban communities) (Food Research and Action Center, 2017; Rural Health Information Hub, 2018). The past decade has continued a 30-year trend toward rising government transfer payments for rural areas predominantly when it comes to food and health care subsidies. Such funds now account for 22.7 percent of personal income, compared with 13.6 percent in metropolitan areas (USDA, 2017).

Rural Inequality

Approximately 60 million people reside in rural America, and 22 percent of them are minor children. Significant challenges are present for rural and remote populations specific to medical care, including behavioral health and substance use treatment, employment, education, housing, transportation, and access to technology. Rural Americans have higher rates of chronic illness, disability, injury, smoking, suicide, opioid use/issues, unemployment, poverty, and premature death. They tend to experience reduced health and wellness, limited job opportunities, lower socioeconomic status, less education, lower life expectancy, and geographic isolation. Rural residents tend to rely more heavily on federal subsidy programs combined with fewer medical providers present to support health and quality of life. They are less likely to have employer-provided health care and prescription drug coverage or to be covered by Medicaid (Rural Health Information Hub, 2018). Medicaid covers a larger share of nonelderly residents in rural areas, with a noticeable trend of high child enrollment (Wagnerman, 2017). Medicare payments to rural hospitals and providers are dramatically lower than those for equivalent services in urban areas, perhaps correlating with recent data finding that more than 60 rural hospitals have closed since 2010 and 673 are vulnerable to closure (Ellison, 2016).

An increased prevalence of mental illness, substance use and overdose, and reduced mental health also exists in rural areas. With limited access to intervention and treatment services necessary for recovery (Centers for Disease Control and Prevention, 2017), possible reasons for this lack of care include greater geographical distance to access providers, overall shortage of trained health care providers (only 10 percent of physicians practice in rural America), and increased stigma of receiving help (Rural Health Information Hub, 2018). Although efforts to augment health care services within rural areas with technology are encouraging, lack of access to broadband Internet technology (only 69 percent of residents have access) is disconcerting (National Telecommunications and Information Administration [NTIA], 2016). This profound technology gap between rural and urban residents continues to persist (NTIA, 2016), placing additional strain on these communities while supporting the value of and need for social workers as a result.

Access to Health Care Services

The availability, accessibility, and acceptability of health and behavioral health services is an issue of concern in rural areas with notable shortages of professionals present (MacKinney et al., 2014). As of January 1, 2018, there were 2,679 places with shortages in rural areas, compared with 1,899 in nonrural areas (Rural Health Information Hub, 2018). Apart from whether residents of rural areas have the health insurance coverage and resources to afford health care, they may struggle to find primary care providers, specialists, and hospitals in their area that provide quality health care services. Some groups, including veterans, disproportionately live in rural areas where accessing services may be more challenging. Five million (24 percent) veterans live in rural communities, and although they use both the Veterans Administration and private providers, access— specifically for specialty care—is often unavailable (U.S. Census Bureau, 2017).

The uneven geographic distribution of social workers in rural areas leads to inconsistency and gaps in care. Recent data sampling social workers (*N* = 691) who graduated from MSW programs in 2017 found that only 7.1 percent served rural areas (Salsberg, Quigley, Acquaviva, Wych, & Sliwa, 2018). Similarly, social workers with a BSW provide higher proportions of care in rural communities than in urban settings, creating a shortage of those with specialized skills and advanced professional education (Daley, 2015; Daley & Avant, 2014). Due to structural barriers (including lack of providers and long wait times for services), health and behavioral health services are often unavailable in rural communities (MacKinney et al., 2014). Rural communities may have fewer formal resources and are often taxed beyond their limits, understaffed, have limited services, and require long travel times (Beecher, Reedy, Loke, Walker, & Raske, 2016).

Technology

Using technology in the provision of health and behavioral health services is considered one solution to the challenges associated with providing and accessing rural health and behavioral health services. Telehealth or tele– mental health services, such as two-way video, can provide health or mental health services from off-site locations (Lambert, Gale, Hartley, Croll, & Hansen, 2015). Tele–mental health and telehealth services are considered feasible and comparable to services delivered in person for youths and adults (Gloff, LeNoue, Novins, & Myers, 2015; Lambert et al., 2015). Developing telehealth or tele–mental health services requires important planning and consideration of technology infrastructure, staffing, training, cultural factors, community readiness, and ethical issues (NASW, 2017). Despite the promise of telehealth and tele–mental health services, there are specific challenges with this service delivery model in rural communities. As with the challenges experienced in providing on-site mental health services in rural communities, tele–mental health services struggle with low reimbursement rates, difficulty in hiring and retaining providers, high rates of uninsured clients, and high no-show rates (Lambert et al., 2015). In addition, the digital divide affects rural access to telehealth and tele–mental health services. Rural areas have historically been the last to receive telecommunication investments and, as noted previously, have lower rates of Internet usage. The Obama administration stated that “modern technology is critical to the expansion of business, education, and health care opportunities in rural areas and the competitiveness of the nation’s small towns and rural communities” (White House, n.d.).

Diversity

Cultural and subcultural beliefs within rural areas may be sources of strength but are also where service breakdowns can occur, particularly among African American and Hispanic populations. Ethnic minorities in rural areas tend to have higher poverty rates, specifically for Hispanic, African American, and Native American populations (Daley, 2015). Also present are persistently high poverty rates for rural children, compared with children living in urban areas. This is thought to be correlated with the rate of female-headed households, which are known to be at an increased risk for much lower socioeconomic status (National Women’s Law Center, 2017).

For some rural counties ethnic minorities are, in fact, the numerical majority and often present with additional health disparities manifesting, for example, as chronic health conditions including diabetes, high blood pressure, malnutrition, and obesity (Daley, 2015). Lower education levels, correlated with overall reduced health, are more prevalent in rural areas and populations, with those who earned a bachelor’s or graduate degrees comprising just 10.5 percent of the population, compared with 29 percent among metropolitan populations (U.S. Census Bureau, n.d.). In addition, cultural values such as rugged individualism may stigmatize those who seek mental health services, resulting in reluctance to ask for help from health care specialists (Papadopoulos, Foster, & Caldwell, 2013). Unique needs of rural youths, aging populations, socially isolated families, and small pockets of cultural groups may not be effectively distinguished from survey data reported by the broader rural community (“The Conversation,” 2017). This may lead to a series of homogenous assumptions and misinformation about the significant needs, services, and strengths of those living in rural areas.

Social Work Practice in Rural Communities

In many communities, social workers may be the only helping professionals who develop, identify, and implement models of practice to reduce disparities across vast geographic areas. Especially in rural communities, social workers' obligation to apply professional skills and knowledge, to the best of their ability, for the betterment of society extends beyond the work environment. Practicing citizenship, advocating for positive change, and relying on the tools of democracy to empower marginalized populations are at the heart of good social work practice (NASW, 2017, standard 6).

Rural social workers may struggle with workforce challenges, often caring for increasing numbers of clients without sufficient numbers of allied professionals. Lack of social work supervision, high caseloads, low salaries, hiring of non–social workers to fill positions, and complicated ethical challenges are issues that rural social work professionals face (Daley, 2015).

Professional recruitment and retention issues are, in part, by-products of a social work education system that developed largely from urban roots, and most social workers receive little content on rural social work in their professional education. This may lead to a social work discipline unprepared to address the needs of rural communities. Knowledge of rural social work is important for all social workers, given patterns of migration and immigration to urban zones, specific economic opportunities, employment, conflict, and even natural disasters. The expansion of distance education programs has increased access to social work education for rural students; however, barriers for rural social workers continue to exist (Daley, 2015; Daley & Avant, 2014).

Rural social work practice requires a sophisticated understanding of values and ethics and highly developed skills in their application. In many respects social work in rural communities is similar to urban social work, but a refined focus on social relationships, nuanced cultural practices, and sheer geography are important (Daley, 2015; Mackie, Zammitt, & Alvarez, 2016). Rapport and connection are crucial given that the strength of community and interpersonal relationships directly correlate with the ability to create quality service delivery (Starks, Jones, Cashwell, & Stokes, 2016). Ethical issues, such as lack of anonymity due to low population, are present and worthy of additional training postgraduation (Daley, 2015; Davis, 2014).

Effective rural practice often involves locality-based community development that may make maintaining professional distance something that is considered inappropriate and may limit effectiveness. Protecting clients from any negative consequences of dual relationships in rural settings has less to do with setting clear boundaries and more to do with effectively managing professional relationships. A potential challenge for the helping relationship, many rural communities share close community ties, which may also be a grand strength in empowerment and change (Daley, 2015).

Similarly, recent work has highlighted the need for social work and religiously affiliated organizations to work closely in accessible service delivery (Moore et al., 2016; Yancey & Garland, 2014). Faith-based organizations may positively affect service delivery while concurrently may be less inclusive of those in non-dominant groups, such as people of color; women; or lesbian, gay, bisexual, trans, or questioning individuals. Residents of rural areas may be judgmental toward clients and services that reflect cultures and lifestyles different from community norms. Social workers not from the community may also find it challenging to establish effective working relationships due to the close-knit nature of the residents, which is an issue that requires further dialogue.

The overall understanding of rural people and cultures is a pressing issue of cultural competence in the social work profession. All social workers should have an awareness of the unique challenges associated with practice in rural communities. It is critical that the issues identified in this statement be addressed, not only in undergraduate and graduate social work curricula, but through ongoing educational training, research, and professional development.

POLICY STATEMENT

NASW supports

- recognizing the importance of rural populations to the nation's economy and cultural identity, and society as a whole
- legislation and policy initiatives that improve infrastructure, economic development, transportation, education, comprehensive strengths-based social services, and access to high-speed Internet, and also promoting environmentally sustainable practices
- advocacy efforts that address the unique needs of rural clients, particularly those who are at risk, vulnerable, or oppressed
- culturally competent strengths-based practice, research, advocacy, and education specific to rural diversity at all levels of study
- developing and applying ethical principles of social work practice with rural populations
- promoting workforce development and retention through incentives, training opportunities, mentorship, and supervision
- continuing education opportunities on a range of topics, including clinical and health practice, advocacy and organizing, administration and management, public welfare, ethics, and community-based services for rural people and communities.

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School Safety

ISSUE STATEMENT

Each school day, our nation's schools are entrusted to provide a safe and healthy learning environment for students and staff. Students need to feel safe, secure, and connected to educators and peers. In a healthy learning environment, students must have a sense of physical and psychological safety to achieve their full social, emotional, and academic potential (Readiness and Emergency Management for Schools Technical Assistance Center, n.d.). Factors that interfere with school safety include victimization, teacher injury, bullying and electronic bullying, poor school conditions, fights, presence of weapons, availability and student use of drugs and alcohol, student perceptions of personal safety at school, and criminal incidents (Musu, Zhang, Wang, Zhang, & Oudekerk, 2019). School safety is essential for all ages and at all levels of education, including preschool, K–12, community college, four-year college, and university.

Although rare, extreme cases of physical aggression and violence remain primary concerns for schools. School shootings have left deep scars in our nation and have gained increased attention and concern. Each shooting is a painful reminder of the complex challenge of keeping schools safe. According to data from the Comprehensive School Safety Initiative, school crime rates have decreased since the early 1990s (Poulin Carlton, 2017). At the same time, the Centers for Disease Control and Prevention's (2017) National Youth Risk Behavior Survey reports an increase in students who did not go to school because of safety concerns. Student perception of personal safety at school is critical, as the fear of victimization can affect the receptiveness and capacity for student learning (Bachman, Randolph, & Brown, 2011).

Instead of addressing school safety as a public health issue, fear and a focus on security have dominated our country's response (Barrett, Jennings,

& Lynch, 2012). Increasingly, schools are using law enforcement efforts and security measures to prevent crime, yet little research has been done on the effect on safety and school climate, including their unintended consequences (Addington, 2009). It is essential for efforts to promote school safety to include both prevention of violence and the promotion of a positive, welcoming school environment.

Advocating, preventing, and intervening to promote safe and healthy learning environments that make students feel secure and connected in school are critical aspects of school social work practice. The national school social work practice model (Frey et al., 2013), which is aligned with NASW's *Standards for School Social Work Services* and the *Code of Ethics* (NASW, 2012, 2017), delineates the type of services that might reasonably be expected from certified school social workers and is intended as a guide to inform key stakeholders (that is, school social workers, social workers who work in schools, educators, other school professionals, administrators, and policymakers) about professional school social work services. All three practice features of the model are associated with promoting safe and healthy learning environments: (1) provide evidence-based educational, behavioral, and mental health services; (2) promote school climate and culture conducive to learning; and (3) maximize access to school-based and community-based resources.

Although the national model clearly prioritizes school safety as a critical area of practice, the principles of risk, protection, and resiliency provide guidance to malleable factors that should be targeted for prevention and intervention efforts. As noted by Jenson and Fraser (2016), risk factors are individual, school, peer, family, and community influences that increase the likelihood a child will experience challenges, whether social or health-related. Conversely, protective factors are resources that help individuals prevail or succeed in the presence of high risk. When a child who is exposed to multiple risk factors succeeds, they are said to be resilient. Risk factors for school failure that are associated with school safety include (a) lack of family connectedness with the school or community, (b) negative school and classroom climate, (c) school violence, and (d) overreliance on physical security measures; relevant protective factors include (a) a positive and safe school environment, (b) positive student–teacher relationships, (c) school bonding, and (d) positive school climate (Frey, Mandlawitz, Perry, & Walker, 2015). Because individual factors such as learning-related social skills, disability, minority status, and special education status alone place students at risk for school failure (Frey et al., 2015), promoting school safety is particularly important for students with these characteristics. Together, the national school social work practice model and risk and protective factors associated with school failure highlight the need to prioritize prevention, rather than responding to problems after they occur, and attending to multiple levels of influence (that is, individual, school, peer, community).

School social workers and social workers who work with school systems and in communities can play a crucial role in reducing school safety–related risk factors and foster protective factors that reduce the prevalence of school failure. Social workers' efforts should aim to reduce risk factors and promote protective factors by adopting evidence-based approaches that focus on prevention, and also responding to particular incidents at multiple levels of influence. School social workers are uniquely trained to identify and implement interventions with fidelity; assist school communities to prevent, respond to, and recover from traumatic events; identify students and families at risk for school failure; and connect students and families to community resources.

POLICY STATEMENT

NASW supports the following:

- School social workers and other qualified school-based mental health service providers (Every Student Succeeds Act of 2015 [P.L. 114-95], Title IV, Part A, Subpart 11, Sec. 4102[6]) are needed to (a) assess students at risk, (b) support primary and secondary interventions to prevent violence and promote school safety, and (c) implement tertiary interventions (including mental health services) with high-risk students.
- Comprehensive approaches to school safety involve (a) schoolwide plans that adhere to safe schools legislation including primary prevention initiatives (for example, antibullying policies, bystander intervention, trauma-informed approaches, positive school climates); (b) evidence-based or evidence-informed strategies for early intervention; (c) crisis intervention, threat assessment, and risk management; (d) intervention

plans that reflect the diverse and unique cultural and linguistic needs of the students, families, faculty, and staff served by the school; and (e) quarterly or biannual review of the safe schools plans in collaboration with community resources and school stakeholders.

- Government funding for research is critical to improve our ability to prevent and reduce school violence and promote school safety.

NASW recommends that each school, in alignment with district and state policies, adheres to the following practices:

- Develop a comprehensive approach to school safety, in accordance with community partners (for example, law enforcement, health and mental health, juvenile justice, and child welfare agencies)
- Implement strategies to reduce the risk of students gaining access to firearms and weapons, including parental awareness of gun safety
- Monitor local data on school climate to inform decision making related to school safety
- Teach students prosocial and adaptive skills to ensure connectedness between school and students
- Minimize use of punitive strategies to address school safety, such as use of suspension and expulsion, reliance on enforcement efforts, and overreliance on security measures
- Establish a confidential and reliable referral process, including threat assessment and risk management strategies, to assist students who may pose a risk to self or others
- Provide ongoing training for teachers and school staff in the following areas: (a) equity, diversity, and cultural awareness and (b) evidence-based interventions and strategies to promote school safety.

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Sex Trade and Social Work Practice

ISSUE STATEMENT

Social work has focused on the care, outreach, and provision of services to sex workers and prostitutes since the earliest days of the profession. Since the 1800s, social workers have worked with those engaged in various aspects of the sex trade from childhood throughout the life span. The sex trade, which has been viewed as alternatively sacred and profane, depending on the historical context, has understandable roots influenced by culture, entwined with views on gender, sexuality, and sex as labor practice (Ringdal, 2007; Weiner, 2008). Sex workers have often been viewed as less deserving of essential rights because of perceived moral deficiency. This policy statement outlines current research and best practices to inform social workers in the 21st century on how best to serve this population with focus on personal empowerment, advocacy, and dignity.

Definitions

In this policy statement the term *sex work* refers to the exchange of sex or sexual stimulation for material gains such as money, food, housing, drugs, transportation, rent, and so on. *Sex trade* is used as an alternative term for sex work that acknowledges the various contexts through which people trade sex for something of value whether by choice, circumstance, or coercion (PROS Network & Tomppert, 2012). *Sex industry* is used as an inclusive term that references the range of sex trades and types of sex work, including, but not limited to, exotic dance, massage, telephone sex, pornography, escort, street work, Webcam work, and private modeling. Most types of sex work are stigmatized, and some aspects of it are criminalized.

Cultural Taboos and Gendered Notions about Sex

The United States encompasses vast differences in open-mindedness and practices in relation to sex and sexuality, with accepted norms constantly changing. However, sex and sexuality cannot escape their cultural connection (Caplan, 2013) with most people regarding sex and sexuality as off limits for discussion. This transfers to avoidance of conversations about sex in practice settings (Buehler, 2017). Social workers engaging with people involved in the sex trade are doing so within a cultural context that sees sex itself as a taboo (Crooks & Baur, 2017).

There also exists the cultural view that promotes sexual liberalism from cisgender men while expecting the reverse from cisgender women (McCave, Shepard, & Winter, 2014) (*cisgender* refers to a person whose internal sense of their gender identity is congruent with their sex assigned at birth). Although people engaged in sex trade come from significantly diverse backgrounds, the common assumption is that sex workers are exclusively cisgender women (Wahab & Abel, 2016). In this way, the experiences and social services needs of men and gender nonconforming individuals are often overlooked.

Criminalization

Historically, the United States has criminalized sex work, despite the potential for criminalization to endanger the individuals involved. Amnesty International (2016) and a report submitted to the United Nations Periodic Review of the United States both argue that the criminalization of sex work exposes people in the sex trade to a range of human rights abuses (Amnesty International, 2016; Best Practices Policy Project, Desiree Alliance, & Sex Workers Outreach Project New York City, 2015). Criminalization limits sex workers' access to health and safety and due process and justice, and it constrains access to housing, education, and governmental assistance. Criminalization also leads to disproportionate targeting, harassment, and incarceration of racialized and minoritized populations (Wahab & Panichelli, 2013). Street-based, gender nonconforming people, youths, migrants, and people of color in sex work experience a disproportionate burden of law enforcement abuse, including violence (Amnesty International, 2016).

Sex workers have historically complained about sexual assault perpetrated by law enforcement officers (Deerin et al., 2014; Shannon & Csete, 2010; Shannon et al., 2009) including degrading strip searches, excessive force, abusive language, and false arrests. The U.S. Department of Justice (DOJ) (2016) investigation supported claims of law enforcement abuse and misconduct, particularly for assaults involving women with additional vulnerabilities in the sex trade.

Of particular relevance to social work's commitment to social justice is the widespread and disproportionate profiling and targeting of transgender and cisgender women of color and undocumented people in the sex trade, through criminalization (Bernstein, 2007; Brooks, 2007; INCITE!, 2011; Stanley & Smith, 2011; Stern, 2012, DOJ, 2016). Targeting people for arrest to offer services is a grave form of coercion that violates numerous social work ethical standards across the NASW (2015) *Code of Ethics* (Standards 1 and 6), the Council on Social Work Education (2015) Educational Policy and Accreditation Standards (Policies 2.1.2 and 2.1.5), and the International Federation of Social Workers (2012) Ethical Principles (Principles 4.1 [1 and 2] and 4.2 [3–5]).

Violence, Harassment, and Exploitation

Although much research exists on the prevalence, determinants, and correlates of violence against women in the United States and globally, a dearth of similarly focused research exists on people in the sex trade (Deerin et al., 2014). Research around the world does, however, consistently report high levels of violence against street-based sex workers including sexual, physical, and emotional violence (Karandikar & Próspero, 2010).

The high rates of violence against people in the sex industry around the world lead some to argue that sex work is inherently dangerous, and others argue that it is the criminalization that has produced conditions that facilitate violence against people who trade sex (Bernstein, 2010; Lutnick & Cohan, 2009; Weitzer, 2010). Criminalization of sex work results in sex workers who are less likely to report violence and assaults out of fear of stigma, prosecution, or loss of income for admitting to engaging in an illegal activity (Best Practices Policy Project & Desiree Alliance, 2015; Shannon, 2010; Shannon & Csete, 2010). It also means that sex workers have minimal legal protections, sending the message to perpetrators that people engaged in sex work will not be protected by the wider legal system.

The emphasis on street-based sex workers in research creates a significant gap in our existing knowledge, because street-based sex work represents a small percentage of people engaged in the sex trade and who tend to experience more violence than those doing indoor sex work (O’Doherty, 2011; Weitzer, 2009). Although these studies inform us on the lives of some (mostly cis-female) street workers (O’Doherty, 2011), they tell us nothing about violence in the lives and employment of the lesbian, gay, bisexual, transgender, and queer (LGBTQ) populations and cis-male and female individuals who work in brothels, escort agencies, pornography, massage, and strip clubs.

Despite the lack of reliable research, there is evidence that some people who trade sex for material gains experience violence and exploitation in the context of trading sex, as well as in their personal and social lives (Karandikar & Próspero, 2010). Types of violence they experience include, but are not limited to, sexual assault; physical, verbal, and emotional violence; bullying; kidnapping (Weitzer, 2009); and structural violence (racism, classism, sexism, cissexism, heterosexism, and so on), including that of the wider legal system (Best Practices Policy Project & Desiree Alliance, 2015). Perpetrators of such violence include clients, law enforcement, strangers, intimate partners, managers, pimps, landlords, family, and club owners (Karandikar & Próspero, 2010; Weitzer, 2009).

Research, although inconclusive, suggests that although some studies demonstrate higher rates of childhood sexual abuse among street-based sex workers (Jeal & Salisbury, 2007; Perkins & Lovejoy, 2007), not all people engaged in sex work report experiences of childhood sexual abuse (Lutnick et al., 2015; Weitzer, 2009, 2010).

Youths

Whereas Geitz (2016) noted that the average age of entry into the sex trades ranges from 12 to 18 years, others have argued that the age of first entry varies depending on research eligibility criteria used (Lutnick, 2016). When considering research gathered from samples of young people and adults, we find that not all people start when they are young and not all youths continue to trade sex past 18 years of age (Martin, Hearst, & Widome, 2010).

Although there are many routes into the sex trade for youths, some include structural disadvantages including poverty and intersecting discrimination (race, gender, and sexual identity) (Weitzer, 2009). Youths in poverty may be particularly vulnerable to opportunities created by an underground economy (Swaner, Labriola, Rempel, Walker, & Spadafore, 2016). LGBTQ youths, in particular, may have run away from or been forced out of a nonsupportive family situation and consequently turn to exchange sex or survival sex out of necessity (Durso & Gates, 2012).

It is important to note that people under 18 years of age are considered minors (DOJ, 18 U.S.C. § 1591) and victims under the federal penal code (though many states have not changed their codes to reflect this). Subsequently, some minors arrested for sex work are afforded some protections under Safe Harbor laws, which allow for service provisions and expungement of related offenses. However, many youths are not served by Safe Harbor laws (Lutnick, 2016).

Health

Multiple factors create barriers of access to health and mental health care for people involved in the sex trade. Sex workers interviewed in New York City identified judgment and discrimination as key barriers, noting their impact on “the way we feel about our health and how we care for ourselves” (PERSIST Health Project, 2014, p. 3). They noted that sex work was illegal; therefore it “limited [their] ability to safely and voluntarily receive health and social services” (p. 5). They emphasized the need for providers who are nonjudgmental and affirming concerning sexual behaviors in general and sex work in particular.

Given these barriers, it is not surprising that the overall physical health of those involved in street-based sex trade is generally reported as poor (Lederer & Wetzel, 2014). There are a wide range of physical and emotional concerns. Some of the most prevalent include dietary issues, dental problems, sexually transmitted infections, and neurological concerns. Reported mental health concerns include depression, anxiety, and posttraumatic stress disorder (Lederer & Wetzel, 2014).

POLICY STATEMENT

NASW supports the following:

- the right of people in sex trade to be treated with dignity and respect
- vigorous enforcement of laws protecting people in the sex trade from violence, including from partners, customers, law enforcement, and the criminal justice system
- policies and services that promote access and remove barriers (like criminal records) to education, housing, health care services (including mental health and substance abuse treatment), and ability to secure employment
- the decriminalization of sex work
- joining forces with social movements fighting the range of oppressions including racism, classism, sexism, heterosexism, ableism, and ageism
- centering the most oppressed and marginalized people in the sex trade when creating services
- the idea that not all people engaged in the sex trade need or want services
- making culturally appropriate services accessible to all people in the sex trade
- making culturally appropriate services accessible to all youths, including LGBTQ and gender creative/nonconforming youths engaged in the sex trade.

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Social Services

BACKGROUND

Social services is defined in the *Social Work Dictionary* (Barker, 2003) as the activities of social workers and others

> in promoting the health and well-being of people and in helping people to become more self-sufficient; preventing dependency; strengthening family relationships; and restoring individuals, families, groups, or communities to successful *social functioning.* Specific kinds of social services include helping people [to] obtain adequate financial resources for their needs, evaluating the capabilities of people to care for children or other dependents, counseling and psychotherapy,.. . advocating for social causes, informing organizations of their obligations to individuals, facilitating health care provisions, and linking clients to resources. (p. 407)

Social services have been in existence for over 100 years in the United States. During the late 19th century and early 20th century, the Charity Organization Society, for example, assisted new immigrants with issues of poverty and employment. The settlement house movement, provided programs and services to assist individuals with citizenship issues, character building, leadership development, and problem solving (Brueggemann, 2006).

The New Deal era instituted many new social service programs. With the focus of providing relief and other forms of aid to people in need, the Works Progress Administration, the Civilian Conservation Corps, and the Civil Works Administration were among the most prominent of these new programs (Chapin, 2007). The Social Security Act of 1935, perhaps the best-known social service program in modern history, provided support for old-age benefits, financial assistance for older people and those who were blind, dependent children and children who were disabled, maternal and child welfare, public health, and unemployment compensation. The Old Age, Survivors, and Disability Insurance (OASDI) program, assisted surviving family members after a worker's death, and Aid to Families with Dependent Children (AFDC), provided cash assistance for children in need. The Social Security Act and the OASDI were foundational safety net programs (Chapin, 2007). In addition, following World War II, new social services emphasized support for returning veterans. The Servicemen's Readjustment Act, for example, provided loans to veterans for purchasing homes, starting businesses, or attending college (Chapin, 2007).

Challenges to racial segregation and other forms of discrimination in the 1960s and 1970s prompted several social policy initiatives. The passage of the Civil Rights Act of 1964 and the Voting Rights Act of 1965 was particularly effective in bringing awareness to the importance of equality and its relationship to the well-being of individuals, families, and communities. In addition, the Lyndon Johnson administration's War on Poverty led to the Economic Opportunity Act of 1964, establishing a number of programs to provide economic opportunities and empower those living in poverty. Medicare and Medicaid were later added to the Social Security Act to provide health assistance to older adults and poor people (Chapin, 2007).

During the last two decades of the 20th century and most of the first decade of the 21st century, a more politically conservative approach resulted in "New Federalism," devolution, and privatization of social services. As a result, there was a shift of responsibility from the federal government to the states, for the welfare of their citizens (Chapin, 2007). Overall support for low-income people was reduced. An example of this is the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, replacing AFDC with Temporary Assistance for Needy Families. Despite a conservative political environment, some progress was made, especially in social services to people with disabilities and their caregivers. These are examples of a system of laws that has evolved to ensure equal opportunity and access to and availability of services, as well as mandates for the operation of certain services.

Since the founding of the profession, social workers have been involved with and have enhanced social services. Settlement houses and charity organizations provided social workers with an opportunity to work with individuals and groups and to actively improve the delivery of social services within communities. The enhancement of social services paved the way for organizations to provide social services both equitably and effectively. Evidence-based practice has been a long-endorsed theory within the social work profession, and today that engagement is evident by the utilization of client-based outcomes as a means for appropriate treatment (Krysik & Finn, 2010; O'Hare, 2005).

A prominent and important contribution of the social work profession is the strengths-based perspective. Through this approach, social service planning incorporates existing strengths in organizations, communities, and individuals to enrich the environment and create new opportunities. As such, collaboration with consumer groups, organizations, and associations is emphasized. The focus is on current strengths, capacity building, enhancement of current programs, and prevention (Long, Tice, & Morrison, 2006).

ISSUE STATEMENT

A comprehensive social services system is needed to enhance the health, self-sufficiency, social functioning, and well-being of individuals, families, and communities. Yet there is no national social policy addressing the need, significance, and role of social services in the United States. In addition, there is a lack of acknowledgment of the role of social workers in the provision of social services. Social policies are continually influenced and bound by social, economic, and political forces on national, state, and local levels. As such, the approach to social services tends to be residual as opposed to institutional. The unique knowledge, skills, and abilities of professional social workers are inadequately recognized and used.

Although some social services are universal and proactive, many others are more residual and reactive. In addition, major events and political power can strongly influence the extent to which social services are supported and enhanced. The extent to which social services are institutionalized, and provided through government, also varies by era, administration, or both.

Too often, services are established and provided in a fragmented manner, resulting in individuals and families becoming compartmentalized by one specific challenge. Because resources are allocated by categories, decisions are made as to who is eligible for services, under what circumstances services are to be offered, and how long services will last, without adequate consideration of the social work values of self-determination and the strengths perspective.

Universal access to and diversity-inclusive services have been a long-standing concern for social workers. Social workers actively work to address these issues yet often find that both policy and funding pose significant barriers to eliminating unequal access and ensuring culturally competent and inclusive services (O’Hare, 2005).

POLICY STATEMENT

NASW advocates the following principles:

Access to Services

Services should be accessible, attainable, and offered in a way that encourages voluntary use. No criteria— including gender, marital status, sexual orientation, disability, religion, political views, race, and ethnic and national origin— shall be used to limit access. Eligibility for social services occurs when a reasonable request is made to a practitioner or social services agency that possesses the required skills to meet the request, subject to the willingness of the recipient to make a reasonable investment in the service. When services are imposed by courts, considered mandatory, or based on needs that may result in significant life changes for an individual or family, such services shall be available in a timely manner and according to best practice standards. Appropriate private administrative review and reasonable subsidy shall be available.

Comprehensive Services

The social services system must develop an organized, broad spectrum of public and private services to meet the short- and long-term service requests and needs of individuals, groups, and families. Consumers should be given alternatives, freedom to move from one service to another, and specific competence to fulfill defined needs in service systems that are supported by public funds. The social services system must include multiple types and levels of providers, as well as prominent roles for federal, state, and local governments, to meet various needs. The professional expertise of social workers, in collaboration with consumers, should be integrated into the decision-making process at all levels.

Informed Consent

Each consumer's decisions should be informed by self-determination regarding choice of services, protection of individuality, and ability to participate in policy matters, if not directly, then through selected or assigned advocates. Confidentiality is not absolute but dictates that sharing of information is done at all times in the best interests of those served.

Simplicity and Efficiency

Systems to establish accountability for social services should be designed to ensure simplicity of procedures and administration. Required documentation should be limited to what is essential. Technological advances should be appropriately used to enhance service delivery.

Establishment of Policies and Priorities

Establishment of policies and priorities for the social services system must include active participation of social work professionals. Policy design and standard setting must include consumers and the community at large, in addition to organizational representatives. Social workers should take the initiative in facilitating broad participation in priority setting and policy design.

Planning and Evaluation

The social services system should ensure maximum accountability. Funding sources, policy-making bodies, administrators, service personnel, and consumers should obtain regular and precise information about the operations, trends, problems, and results of the services delivered and recommend adjustments, wherever needed. Social services should incorporate evidence-based practices whenever possible.

Advocacy

Professional social workers value social justice, alleviating social ills and oppression at all levels of society. As such, they are uniquely qualified to provide advocacy at micro, mezzo, and macro levels of practice.

Financing of the social services system is the joint responsibility of all citizens and all levels of government. Public– private partnerships should be facilitated to enhance these services. Social workers are qualified to take the lead in educating funding communities, both public and private, about the nature and necessity of social services.

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Social Work in the Criminal Justice System

ISSUE STATEMENT

The American criminal justice system comprises three major institutions that process a case from inception, through trial, to punishment: law enforcement, the court system, and corrections. The criminal justice system also operates on three different levels: federal, state, and county. Except for certain common guidelines set by the U.S. Department of Justice (DOJ), the state criminal justice systems are fully autonomous from the federal system.

The United States has the highest incarceration rate in the world. As of 2014, there were 2.2 million individuals incarcerated in local, state, and federal correctional facilities in the United States (Sentencing Project, 2016) and twice as many on probation and parole (Sentencing Project, 2014). According to an April 2011 report by the Pew Center, the average national recidivism rate for released prisoners is 43.3 percent (Pew Center on the States, 2011). The U.S. prisons/jail population is disproportionately black and brown and predominantly male; 93 percent of people in prison are male. In the same year, one in every 13 black men ages 30 to 34 was in prison, compared with one in 36 Hispanic men and one in 90 white men in the same age group; and black men have a 32 percent chance of serving time in prison at some point in their lives (Pew Center on the States, 2011). It should be noted that in 2011, the rate of prison incarceration for black women was 2.5 times higher than the rate for white women (Sentencing Project, 2014).

These numbers represent a crisis, and activists have recently begun the push for major criminal justice reforms. Overincarceration has led to unsustainable costs to federal and state departments of corrections.

The current financial, social, and political contexts mark a historic opportunity for moving toward *decarceration*—significantly reducing the incarcerated population in the United States. There is a major role for social work to play if decarceration efforts are to be effective, sustainable, and socially just. One of the primary tasks in an era of decarceration is to identify what approaches should replace incarceration whenever possible—approaches that are more effective at addressing root causes of problem behaviors. Social work is well positioned to lead the charge for smart decarceration because of its social justice orientation, its focus on multiple levels and systems, and its expertise in intervention research and delivery.

National human rights organizations have also led the public outcry on the poor conditions in jails and prisons, especially concerns about the use of long-term segregation and isolation; the surge of incidents related to law enforcement use of excessive force, especially lethal force; and significant racial disparities in the arrests, convictions, and length of sentencing, especially in cases involving drug crimes.

Departments of corrections have embraced the concept of developing programs and services designed to assist returning citizens (reentrants) in gaining daily living and employment skills often lacking among the criminal justice system–involved individuals. The assumption is that such reentry programs will lead to reductions in recidivism. The first comprehensive reentry initiative was the Second Chance Act of 2007 (SCA) (P.L. 110-199). SCA funds are made available to state and local governments through competitive grants, and nearly every state receives this funding. To reinforce the importance of reentry policies, in 2013 the White House mandated that DOJ serve as the lead agency for the Federal Interagency Reentry Council, which includes the heads of nearly every federal department (DOJ, Office of Justice Programs [OJP], n.d.). The participating agencies of the Federal Inter-agency Reentry Council pool funds and other resources to strengthen the quality and effectiveness of reentry policies.

Collateral Consequences

Collateral consequences are “sanctions and disqualifications that can place an unanticipated burden on individuals trying to re-enter society and lead lives as productive citizens” (Berson, 2013, para. 1). Collateral consequences affect those convicted of felonies and misdemeanors, and those who have been charged with a crime but never convicted. Perhaps more important, collateral consequences tend to last indefinitely, long after an individual has been adjudicated for a criminal offense (Berson, 2013). The most common form of collateral consequence of being criminal justice system–involved is the limitation of employment opportunities because of a record of a past criminal arrest or conviction. Collateral consequences have potential life-altering implications.

Sentencing Reforms and Mandatory Minimum Sentencing

The two issues of sentencing reforms and mandatory minimum sentencing are linked. The strong advocacy for sentencing reforms sprang from data that showed substantial disparities in the length of sentences imposed for certain crimes as opposed to other similar offenses. These disparities are most often seen in convictions for drug-related crimes, which were subject to mandatory minimum sentence laws. Such laws limit the discretion of trial judges from looking at mitigating circumstances when sentencing those convicted of certain felonies (Attorneys.com, n.d.). In addition, statistics indicate that there are racial disparities in imposing mandatory minimum sentencing, with African American and Hispanic defendants more likely to be sent to prison under mandatory minimum sentencing guidelines.

Solitary Confinement

Based on recent data, over the course of a year nearly one in five U.S. prisoners spend time in solitary confinement, which is approximately 400,000 people each year (Ahalt & Williams, 2016). Solitary confinement is most commonly referred to as “segregation” or “isolation”; it can be applied as a disciplinary measure or administratively, to protect inmates or staff. The most pressing concern about the use of isolation in jails and prisons is the mental health implications. It is irrefutable that segregation, especially over the long term, can result in serious, potentially permanent mental health dysfunctions, including anxiety, depression, anger, cognitive disturbances, perceptual distortions, obsessive thoughts, paranoia, and psychosis (Metzner & Fellner, 2010).

Mental Health

The issue of mental health as a link to arrests, incarceration, and recidivism is critical. Encounters between law enforcement and people with mental illness can be dangerous to both parties. Far too often, the police respond with excessive use of force. Frequently, law enforcement personnel become default mental health crisis workers, a role they are not trained to perform. It has been estimated that nearly 50 percent of the nearly 500 police killings a year are of people with mental illness, most posing no immediate threat to the police or others (Lennard, 2012).

Incarcerating people with mental illness is often more challenging for the nation’s jails. Using 2006 data, 77 percent of convicted jail inmates were involved with alcohol or drugs at the time of the offense (Cornelius, 2011). Local and county jails have become the country’s de facto mental health institutions for people with severe mental illness. Also, because of episodic mental health crises, people with serious mental illness tend to have frequent rearrests for behavioral-related infractions and recidivate in and out of jail several times in a given year. Mental illness is also a matter for federal and state prisons, where mental illness is a significant concern.

Symptoms of posttraumatic stress disorder (PTSD) are frequently seen in criminal justice system–involved populations, specifically, the *postincarceration syndrome*, which is a set of symptoms that are present in many currently incarcerated and recently released prisoners that are caused by being subjected to prolonged incarceration in environments of punishment with few opportunities for education, job training, or rehabilitation. The symptoms are most severe in prisoners subjected to prolonged solitary confinement and severe institutional abuse (Liem & Kunst, 2013).

Substance Use–Related Crime Issues

The issue of substance use and the selling of illegal substances is also multifaceted. In 2014, 50 percent (95,800) of sentenced inmates in federal prisons were there for a drug-related charge (Drug War Facts.org, n.d.). In prisons overall, the vast majority are incarcerated for nonviolent drug offenses (Drug War Facts.org, n.d.). A key policy issue for discussion is the trend toward decriminalizing some drug-related activities, such as possession of small quantities of illicit drugs or prescription opioids, and to approach the problem from a public health perspective.

Drug-Related Parole and Probation Revocations

The intersection of recidivism and substance use can be found in community supervision policies of the parole and probation agencies. Substance use often adds to the incarceration rate from recidivism because of drug-related violations of conditions of probation. In many cases a condition of probation is to abstain from drug use. Probationers who test positive for illicit drugs, including marijuana, are subject to having their probation rescinded due to the “technical” drug use. Using 2009 data, drug dependent or abusing state prisoners (48 percent) were also more likely than other inmates to have been on probation or parole supervision at the time of their arrest (Office of National Drug Control Policy, 2011).

Health Care Needs

Increasing numbers of incarcerated individuals have special health needs, including those who have been exposed to hepatitis, tuberculosis, HIV, and other infectious diseases. The special health care needs of female incarcerated individuals, including care for those who are pregnant, must be considered. The health care needs of aging incarcerated individuals are increasingly important as this population continues to grow in the correctional system.

Law Enforcement

One of the most contentious criminal justice issues has been the relationship between law enforcement and the communities they serve, especially when dealing with black and brown communities. National attention on racial disparities in police encounters with people of color became acute after highly publicized incidents of lethal use of force in a number of communities of color. A precipitating factor that often leads to police use of force is racial profiling, which generally is associated with traffic stops or the police practice of "stop and frisk." Another factor is a misplaced perception of threat during police encounters. Some studies have indicated that perception of threat, such as a furtive movement, can result in police use of force on black suspects at a significantly higher rate that for white suspects (Najdowski, Bottoms, & Goff, 2015).

Bail Reform

Racial and socioeconomic disparities are also evident in inmate release from jail on bail, because low-income people are often unable to post bond. The result is that many of these individuals have to remain in jail until their trial date (which could be many months in the future), even when the alleged crime committed is a misdemeanor for which little or no jail time will be imposed. Some states, such as New Jersey, have passed jail reform legislation that addresses some of the problems with the bail system in that state (Drug Policy Alliance, n.d.).

Incarcerated Women

Women are the fastest growing segment of the criminal justice population with increases in arrests among women by approximately 1.5 percent from 2005 to 2009, outpacing that of men (Hall, Golder, Conley, & Sawning, 2013). African American women are three times more likely than white women to be incarcerated, whereas Hispanic women are 69 percent more likely than white women to be incarcerated (Ajinkya, 2012). There is a significant relationship between victimization, substance use, and mental health conditions among women involved in the correctional system. Attention to the intersecting impacts of these three facets is critical for effective treatment of this group of women (Hall et al., 2013). In addition, women face further discrimination after release from prison including accessing affordable housing, employment, education, and subsistence benefits. Many states impose bans on employment in certain industries such as nursing, child care, and home health care, the three fields in which many poor women and women of color happen to be disproportionately concentrated (Ajinkya, 2012).

Transgender People and the Criminal Justice System

Police interactions and detentions in jails and prisons can be traumatizing and are often dangerous for transgender people and those who are gender nonconforming. Transgender people are more likely to be stopped and questioned by police, engage in survival crimes such as sex work, and end up behind bars, resulting in daily humiliation and physical and sexual abuse. Many transgender people are placed in solitary confinement, supposedly for their own protection, for months or years (National Center for Transgender Equality, n.d.).

Consideration of Needs of Older People in Prisons

There is a critical need for effective and comprehensive reentry programs for older inmates returning to the community. Definitions of “older” inmates vary from state to state. The National Institute of Corrections considers prisoners over 50 to be “elderly” or “aging.” The rationale for using the relatively young age of 50 is that incarcerated individuals are more likely to have engaged in unhealthy behaviors during their lives and less likely to have received regular medical care. Once incarcerated, the stress of prison life tends to prematurely age people. Needs of older incarcerated adults have not been well studied. Longer sentences combined with the impacts of poverty prior to incarceration creates a need for intervention strategies within correctional institutions for chronic disease, mental health and other psychological problems in older adults, and identification of best practices (Freudenberg & Heller, 2016). The cost of providing health care for older adults who become vulnerable due to their health status remains a challenge in the provision of services with limited resources.

POLICY STATEMENT

NASW is an important and significant stakeholder in the effort to improve, through sensible reforms, the nation's criminal justice system. Social workers are employed in administrative and direct services positions throughout all components of the system. NASW seeks to lend its voice to the national dialogue about public safety and criminal justice reforms.

NASW recognizes the importance of providing quality social work interventions and helping to shape critical criminal justice standards and policies in the U.S. criminal justice system. NASW advocates for the provision of comprehensive biopsychosocial and evidence-based services by highly qualified social workers. As does the general public, NASW believes that public safety should be the ultimate goal of the criminal justice system. Increases in rehabilitative and clinical services to criminal justice system–involved populations can reduce the rates of rearrests and recidivism. NASW believes that an increase in reentry programs will reduce rearrests and recidivism.

NASW strongly advocates for and supports major reforms throughout the criminal justice system with an emphasis on eliminating racial, ethnic, and gender disparities. NASW also advocates for policy changes that eliminate all forms of inhumane treatment and uphold the human rights of all incarcerated individuals. Therefore, NASW supports the following services, policies and procedures, and legislative initiatives directed at bringing major improvements to the criminal justice system:

- ongoing advocacy to address racial disparities in every aspect of the U.S. criminal justice system, including, but not limited to, racial profiling in traffic stops, stop-and-frisk policies, and all other routine stops for so-called “suspicious behaviors”

- increased use of professional social workers to provide culturally competent treatment and service intervention, as well as administrative positions, for criminal justice system– involved individuals, especially providing behavioral health services
- social work policies and standards requiring clinical social workers to obtain trauma-informed credentials with an emphasis on incarceration-related PTSD and early childhood trauma
- continuation of legislation such as SCA, which funds reentry programs for returning citizens; expanded funding for reentry job programs such as the U.S. Department of Labor's Reintegration of Ex-Offenders program
- elimination of all barriers to employment for criminal justice system–involved citizens and support of "ban the box" policies to end the practice of requiring applicants to indicate past criminal arrests or conviction on employment applications
- safe alternatives to solitary segregation (Vera Institute of Justice, n.d.) that would eliminate long-term isolation of inmates regardless of the circumstances that required them to be segregated from the general prison population:
    - the policy of providing mental health treatment and monitoring for all inmates placed in isolation
    - creative therapeutic programs for people with mental illness as alternatives to segregation, to be developed by federal and state departments of corrections
    - a standard policy stating that social workers will not be required (by correctional officials at the federal, state, and local levels) to make a clinical determination about the emotional fitness of an inmate to withstand being placed in isolation
- all correctional jurisdictions ensuring that inmates in jails and prisons have access to quality health care and related ancillary health services, including
    - transitional planning that links returning citizens with chronic ailments such as HIV/AIDS, hepatitis C, cardiovascular disease, and diabetes to community-based health services

  - inclusion of correctional health services in Electronic Health Records systems to ensure that community health providers have access to health records of recently released individuals
  - health care policies that allow for pre-qualifying of returning citizens for health coverage through Medicaid Expansion (in states where such expansion exists)
- policies and program development that expand mental health services within local jails, state prisons, and the federal Bureau of Prisons facilities:
  - transitional planning that links people with severe mental illness to community-based mental health programs for treatment, case management, and medications
  - specialized transition planning for older individuals (50 years and older, including comprehensive records that document pre-existing medical or mental health problems; planning should also include linking (and following up on) older returnees with potentially life-threatening chronic ailments to community-based services
  - ensuring that all older inmates with serious health and mental health ailments are regularly assessed and referred for compassionate release as appropriate
- elimination of national drug sentencing guidelines that require mandatory minimum sentences for convictions for low-level drug-related crimes such as possession of small quantities of an illicit drug, as well as
  - national drug policies that recognize the wisdom of decriminalization of drug addictions and substance use
  - national drug policies that take a public health approach to the nation’s drug-use crisis, with an emphasis on prevention and treatment
  - expanded funding for drug treatment programs such as the currently pending Comprehensive Addiction and Recovery Act of 2016 (S. 524, 2015–2016)
- law enforcement policies that will end all racial profiling, particularly

    - mandatory data collection on all traffic stops by law enforcement at the federal, state, and local levels (the data must be disaggregated to reflect demographics such as race or ethnicity, gender, and age)
    - revised DOJ guidelines on avoiding racial profiling, including religious profiling based on the individual's traditional manner of dress or headwear
    - passage of the End Racial Profiling Act of 2015 (H.R. 1933, 2015–2016)
- national standards for law enforcement's policies and procedures regarding use of force, with a special emphasis on the use of lethal force, including
    - the use of body-worn cameras for law enforcement officers at all levels of government and jurisdictions
    - policies that require law enforcement agencies and departments to collect disaggregated data on all police encounters that involve force, especially those that result in injuries or deaths
    - policies that mandate training for law enforcement on recognizing signs of mental illness during police encounters
    - providing training to police officers on how to deescalate a police encounter involving people with obvious mental illness and other cognitive disorders
    - widespread use of special law enforcement units trained to respond to law enforcement calls involving mental illness
    - community policing policy and procedure recommendations as articulated in President Obama's *Task Force on 21st Century Policing* report (Davis, 2015)
- policies and legislation that eliminate mandatory minimum sentences, particularly
    - legislation that fully eliminates disparities in sentences between crack cocaine and powder cocaine
    - an end to racial disparities in sentencing for misdemeanors as well as felonies

  - passage of the Sentencing Reform and Corrections Act of 2015 (S. 2123, 2015–2016), which includes modifications of mandatory minimum laws to allow more discretion by judges

- policies and programs that address the special needs of criminal justice system–involved women, including

  - elimination of policies that require shackling incarcerated women during child birth
  - developing and instituting more alternatives to incarceration for female arrestees, especially for low-level drug-related crimes and nonviolent misdemeanors
  - developing reentry transition plans that take into account child welfare and family reunification issues

- standardized policies and procedures for criminal justice system–involved transgender individuals, including

  - regulations to implement the Prison Rape Elimination Act of 2003 (P.L. 108-79) and include specific provisions aimed at protecting transgender prisoners
  - stronger protections and accountability on transgender and gender nonconforming people's interactions with the criminal justice system and with local, state, and federal law enforcement officials and the public at large
  - providing training to law enforcement officers on how to demonstrate respect for human dignity during police encounters and arrests of transgender people
  - development of standardized policies on providing for the medical and psychological needs of incarcerated transgender people who have not fully completed gender reassignment procedures

- establishment of best practice standards for professional social work in criminal justice settings
- specialized training on the unique application of social work skills and values in a correctional environment for social workers practicing in criminal justice settings

- advocacy and social work leadership to establish national policy on criminal justice issues in collaboration with other organizations.

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Sovereignty, Rights, and the Well-Being of Indigenous Peoples Living in the United States

ISSUE STATEMENT

This policy statement focuses on Indigenous Peoples living within the U.S. borders, their sovereignty, rights, and well-being, with specific implications for social work at all levels of practice. For the purposes of this policy statement and aligning with the United Nations (UN), the term “Indigenous” is used to refer to all First Peoples. Indigenous Peoples are the descendants of those who inhabited a geographical region prior to the arrival of colonizing forces and establishment of colonial settler societies. Indigenous Peoples live in U.S. states, territories, and nation-within-nation states bound by treaties with the United States. Included are (a) Alaska Natives; (b) American Indians or Native Americans; (c) CHamoru living in the U.S. territories of Guam (Guahan) and the Commonwealth of the Northern Mariana Islands (CNMI); (d) Micronesians living in the Compact of Free Association (COFA) nations of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau; (e) Native Hawaiians or Kanaka Maoli or Kanaka ‘Oiwi; and (f) Taino Indians of Puerto Rico.

Sovereignty

The authority of a state to govern itself and the presence of a nation-to-nation treaty is sovereignty (National Congress of American Indians [NCAI], 2020a). Alaska Natives, American Indians (Native Americans), and Micronesians of the COFA nations are the only Indigenous Peoples who have a government-to-government or nation-to-nation treaty relationship with the U.S. federal government (Ka‘opua & Holden, 2010; NCAI, 2020b). Definitions of sovereignty vary across Indigenous groups. For example, Samoan Nationals from the Territory of American Samoa recognize U.S. plenary or absolute power, yet believe they enjoy autonomy within the homeland to practice *fa’a Samoa* (Samoan way), *fa’a matai* (traditional local governance), and village-based land tenure (Tofaeono et al., 2020). Settler societies have too often acted in ways that undermined and infringed upon Indigenous sovereignty (Weaver, 2015). Yet, Indigenous Peoples confer that sovereignty is an opportunity for decolonization—the repatriation of life and land, active self-governance, and restoration of tribal government.

Rights

Indigenous Peoples are accorded legal recognition as social, cultural, and political communities under international human rights law. In 2007 the UN adopted the Declaration on the Rights of Indigenous People, with attention to eliminating violations of human rights and creating a framework for laws that include meaningful discussion with Indigenous communities (UN, 2007). The declaration comprises 46 articles, five of which are especially relevant to this statement:

- Article 7: “be free from genocide and other acts of violence including the removal of their children by force”
- Article 11: “practice and revitalize their cultural traditions and customs”
- Article 14: “education that enables Indigenous children to develop a rich and positive sense of their own cultural identity”
- Article 19: “proper consultation by federal and state governments prior to adopting laws and policies that may affect them”
- Article 26: “the right to own, use and control their lands, waters, and other resources.”

The United States was one of the last nations to endorse the declaration.

Sense of Place

The connection between people and their surroundings is nurtured by access to ancestral lands; the opportunity to practice Indigenous traditions; and the sense of shared belonging to a particular place, community, or nation. In the neocolonial context, sense of place transcends usurpation of Indigenous sovereignty by settler power and fosters a positive cultural identity (Kanaʻiaupuni & Malone, 2006; NCAI, 2020a). The ability of Indigenous Peoples to have full management of their lands and natural resources is a right intrinsic and linked to the highest standard of health and preservation of Indigenous knowledge and practices (Oneha, 2001; UN, 2007).

Native Americans (First Nations Peoples)

Since the earliest contact with Europeans at the end of the 15th century, Native Americans were subjugated to the laws of colonization and denied tribal sovereignty, the basis of tribal government (Wilkins, 2009). The number of Native Americans, estimated at about 10 million in 1500, gradually decreased as their food sources disappeared and they fell victim to diseases such as measles, smallpox, and influenza. By 1800 the Native American population was about 600,000, and by 1900 it had been reduced to less than 250,000 (Hall, n.d.).

U.S. policies ranging from the Indian Removal Act in 1830, various treaties negotiated with individual tribes, the 1887 Indian General Allotment Act (also known as the Dawes Act), the Indian Reorganization Act of 1934 (P.L. 73-383), and the Termination Act of 1953 further stripped away much of the history, geography, political life, and traditions producing an abstract perception (Konkle, 2008) of the immensely significant cultural, family, and spiritual life that defines Native Americans. Each policy was designed to achieve progressive acculturation and final assimilation of the Native American into the White culture. Influenced in part by the Pan-Indian movement of the 1960s and 1970s, the passage of the Indian Child Welfare Act (ICWA) (P.L. 95-608) and the American Indian Religious Freedom Act (P.L. 94-341) in 1978, and later the Native American Graves Protection and Repatriation Act of 1990 (P.L. 101-601), were attempts to make some reparation for the mistreatment of Native Peoples over the previous 500 years. The estimated 5.2 million Native Americans today (Humes, Jones, & Ramirez, 2011) are still burdened with extensive unemployment and health and mental health disparities (Indian Health Service, 2007) and remain one of the poorest communities in their homeland as a direct result of these U.S. policies (Rodgers, 2008).

Reparation attempts, such as ICWA, have shown decreased numbers of children removed from their biological families and placements outside of their native culture (American Academy Adoption Attorneys, 2015). The Religious Freedom Act also brought positive results. In professional practice, Native American traditional healings that include the traditional Indigenous model of the medicine wheel are integrated and thus demonstrate cultural competence and humility (Flint, 2015). Overall, resilience among Native Americans echoes a circular perspective woven with internal and external meaning of families, communities, culture, environment, and spirituality.

Alaska Native Peoples

In the 1750s, exploitation of natural resources in Alaska first began by the Russians, then continued in the 1850s by the Americans. In 1867, Alaska was purchased by the United States from Russia. The Alaska Native Land Claims Settlement Act of 1971 (P.L. 92-203) established a capitalist structure through which U.S. and international corporations received access to oil deposits in the northern region. The act provided the title of 14 million acres to state-chartered Native corporations, required Native people to set up village and regional corporations, and transferred land ownership to corporations and not individual Alaska Native Peoples. Despite these significant improvements regarding legal and land rights, decisions on sovereignty and subsistence often set Alaska Native Peoples against state and federal authorities (Huhndorf & Huhndorf, 2011).

Discrimination and racism remain, despite gains made through the past four decades. Although 16 percent of Alaska’s population identifies as solely Alaska Native, 84 percent of the state’s population are primarily U.S. citizens, often from the lower 48 states (Thompson, 2008). Similar to Native Americans in other U.S. states, four generations of Alaska Native children were forced to attend mission and government-run boarding schools. The U.S. policy at that time was to remove their cultural identity and make these children a viable workforce for the populations coming into Alaska.

Taino

The Taino Peoples are the Indigenous people of the Caribbean, tracing their origins to South America. In the 15th century, Taino people migrated and broke into different groups throughout the Caribbean islands of Cuba, Hispaniola (the Dominican Republic and Haiti), Jamaica, Puerto Rico, the Bahamas, and northern Antilles. When Christopher Columbus arrived in 1492, the Taino people were a thriving society, with a rich inventive history and appreciation of language, a cultural identity, spiritual and religious beliefs, and harvesting of the land. With the arrival of the Spaniards, the Taino people were ravaged by warfare and were enslaved by these colonists, an experience shared by many other Indigenous Peoples (Collazo, 2018).

Despite a history of near extinction, over the past four decades there has been a regeneration and revitalization of Taino identity within the racially mixed and culturally blended Indigenous people of Cuban, Puerto Rican, and Dominican societies both on the islands and in the continental United States.

Kanaka Maoli (Native Hawaiians)

Kanaka Maoli are the aboriginal people of Hawaiʻi. The first foreigners to establish themselves in Hawaiʻi in 1778 were Western traders seeking commercial gain, then Christian missionaries seeking religious conversion. In the first 150 years of contact, Kanaka Maoli faced physical extinction from foreign diseases and cultural genocide from laws and practices that favored foreign interests. Laws were enacted that subverted the traditional system of land tenure from collective stewardship to private property, dispossessing Kanaka Maoli from their source of sustenance and well-being. In 1893, American industrialists and U.S. Marines overthrew the lawful Hawaiian government, gave lands to the United States without compensation, and dethroned and imprisoned Hawaiʻi's last ruling monarch, Queen Liliʻuokalani (Kaholokula, Nacapoy, & Dang, 2009; Kamauʻu, 1994). In 1898, Hawaiʻi was annexed as a U.S. territory. Denied stewardship over ancestral land, loss of language and cultural traditions followed, influencing the overwhelming socioeconomic problems and health disparities experienced by Kanaka Maoli in contemporary times (Kaʻopua, Braun, Browne, Mokuau, & Park, 2011).

Despite the devastating consequences of historical trauma, Kanaka Maoli possess cultural strengths that can inform policy, practice, and education, including *aloha ʻina*; strong *ʻohana* (family); prominent place of children; respect for *kupuna* (elders) and *kahuna* (experts); and a resilient, reciprocal, and interdependent worldview of spirit, people, and environment as core to wellness (Martin, Paglinawan, & Paglinawan, 2014). For future generations, Kanaka Maoli continue to engage deeply in culture revitalization of Indigenous language and knowledge, and the protection of sacred spaces such as Mauna Kea.

CHamorus

CHamorus of Guahan have experienced the longest history of colonization without recognition of sovereignty. In 1521, Magellan's arrival on Guahan marked CHamorus' first contact with the Western world. Over the next 200 years, as a result of the introduction of diseases and warfare, Guahan suffered a population collapse from 50,000 to 3,500 (Hattori, 2004). Guahan was a spoil of the Spanish-American War given to the United States in the Treaty of Paris in 1898. At the time, CHamorus were politically divided, with those living in the CNMI falling under the administration of the Germans. Hattori (2004) reported that on Guahan, language and health reform policies that were implemented adversely affected CHamorus' lives and culture. Japan occupied Guahan from 1941 to 1944, then the United States took control again, seizing 42 percent of the landmass that displaced the CHamoru people. The 1950 Guam Organic Act granted the CHamorus a limited form of U.S. citizenship. Their current political status as a commonwealth acknowledged U.S. sovereignty and CHamorus as political minorities in their homeland, comprising only 21.3

percent of the total population (U.S. Census Bureau, 2000). Decolonization efforts continue to be challenged, including historical disregard for Indigenous practices and elimination of Indigenous health practitioners, militarization, and environmental degradation and exposure without redress (Natividad & Lizama, 2014).

The resilience and endurance of CHamorus in perpetuating cultural values and practices have prevented a cultural extinction and are a source of revitalization of Indigenous culture. Cultural strengths include a healing process that connects Indigenous spirit to Indigenous identity; matrilineal descent, in which women are an integral part of the decision-making process; spirituality and connection to the land; language as part of one's identity; critical role of the family; and core values of reciprocity and respect. After 4,000 years as Indigenous people of Guahan, CHamorus are revaluing, rediscovering, and reconnecting to their Indigenous ways (Natividad & Lizama, 2014).

Peoples of Nations Affiliated with the United States through COFA

The island nations now known as Federated States of Micronesia, Republic of the Marshall Islands, and Republic of Palau—the Freely Associated States (FAS)—catapulted into U.S. view during World War II with value of the islands' location to U.S. defense (Hezel, 1995). In 1947, the United States became administrator of the Trust Territory of the Pacific Islands, committing to prepare Indigenous people for self-governance and improved health status. During this period, the United States executed nuclear testing of 84 bombs over Bikini and other atolls. Tests resulted in mass deaths, contamination of land and waters, radiation-related cancers, and birth defects (Ka‘opua, 2007; Keever, 2004). In exchange for exclusive military access, the United States promised to provide economic aid and access to health grants. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193), also referred to as the Welfare Reform Act, made FAS citizens ineligible for public assistance, and their access to Medicaid became uncertain. Western influence forced an identity shift and disregarded Indigenous healing and spiritual practice. As new immigrants, FAS citizens struggled with relocation trauma, isolation, economic stresses, and disproportionate health disparities (Hasugulayag, 2014; Howard & Kreif, 2014).

Strengths of these people were evident in their resilience and ability to preserve Indigenous cultural identity, healings, and medicines, and values such as the important role of women, customs, and traditions while adapting to new life and space. FAS Indigenous Peoples were the greatest ocean navigators in the Pacific, which facilitated seeking new opportunities. Their identity and very survival are deeply rooted in the land as well as core values of respect, cooperation, reciprocity, and collectivity (Hasugulayag, 2014; Howard & Kreif, 2014).

American Samoans

Dutch explorers made initial contact with Samoans in 1722. Business and military expansion by other Western powers followed, with social disruption of the Indigenous cultural order and warfare. In 1827, the U.S. Navy occupied and began to use Pago Pago (Tutuila Island) as a fueling station. The United States, Germany, and Britain came into conflict during the Second Samoan Civil War, which resulted in the 1899 Treaty of Berlin and established the colony of American Samoa in the eastern Samoan archipelago. In 1929, the colony was annexed as U.S. flag territory. Through the covenant agreement binding the United States and American Samoa, the latter is subject to U.S. federal laws and has a nonvoting representative in the U.S. Congress. Currently, there are about 68,000 American Samoa residents, 96 percent of Samoan heritage. Economic activity remains strongly linked to the United States. American Samoa is culturally rich but resource poor, with about 73 percent of the Indigenous population living at or below the U.S. federal poverty level (American Samoa Office of the Governor, 2007).

A long history of colonization and military presence have led to a complex and complicated struggle to reconcile between a collective Indigenous culture and individualistic contemporary Samoan culture. Migration to the United States was primarily for educational and career advancement, yet these Samoans disproportionately experience health and economic disparities, especially among new immigrants (Gabbard, 2014).

In spite of historical trauma, Samoans have preserved and perpetuated their traditional culture of *fa'a Samoa* in which respect, mutuality and reciprocity, spirituality, family, and community solidarity are at the core (Gabbard, 2014).

POLICY STATEMENT

NASW acknowledges the uniqueness and strengths of Indigenous Peoples and communities with distinct place-based histories, languages, cultural values, and practices that have historically sustained Indigenous Peoples and contributed positively to the world. NASW recognizes Indigenous Peoples' struggle for sovereignty and freedom from oppression, which has origins in past genocidal practices and ethnic cleansing resulting from policies of the U.S. government and others around the globe. NASW condemns oppressive acts that exploit Indigenous Peoples by administering powers of government.

NASW supports the following:

- The acknowledgment of sense of place often defined by ancestral lands, sacred spaces, peoples, Indigenous language, and identity for Indigenous Peoples as a social determinant of health through inclusion at the center of national conversations
- The development of social policies and practices that promote the health, land, and human rights of Indigenous Peoples living within U.S. boundaries and beyond
- The securing of resources for more effective policies on health care and education for the current generation of transnational, transcultural Indigenous Peoples
- The rights of Indigenous Peoples in their efforts to gain health; self-determination; and sustainment of physical, emotional, and spiritual health
- Education and training of all social workers on cultural competence, cultural safety, and cultural humility, specifically regarding value differences between the dominant culture and the cultures of Indigenous Peoples

- Advocacy for diverse ways of knowing and elimination of oppression, power, and control
- Education and training of all social workers on the various social determinants that influence the health and well-being of Indigenous Peoples
- The preservation of Indigenous traditional, spiritual, health, cultural, and linguistic practices
- Cultural and linguistic practices that integrate Indigenous and contemporary knowledge
- Funded efforts for decolonization and cultural revitalization among Indigenous Peoples in terms of language, ceremonies, practices, healings, and strategies
- National Institutes of Health vision on minority health and health disparities research to promote health equity among Indigenous Peoples.

In solidarity with Indigenous Peoples living within the U.S. borders, social workers must avoid complicity by proxy, understanding that neutrality de facto is a position of support for the status quo (Ka‘opua, Friedman, Duncombe, Mataira, & Bywater, 2019). We must unapologetically advocate for equitable access to health and other life-sustaining resources, social and distributive justice, human rights and sovereignty, and inclusion of Indigenous content in dominant curricula. Doing so advances social work’s signature principle of social justice for all and value of equitable partnerships.

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Substance Use Disorder Treatment

ISSUE STATEMENT

Substance Use

Millions of Americans are affected by substance use disorders (SUDs) every year. According to Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Survey on Drug Use and Health, 23.2 million people (9.4 percent of the U.S. population) age 12 or older needed treatment for an illicit drug or alcohol use problem in 2007 (SAMHSA, n.d.). These issues affect not only the person using substances, but the whole family system, and can have severe social, psychological, physical, and economic consequences. Issues relating to SUDs have a profound impact on society, as well. Abuse of tobacco, alcohol, and illicit drugs is costly to our nation, exacting over $600 billion annually in costs related to crime, work productivity, and health care (National Institutes of Health [NIH], National Institute on Drug Abuse [NIDA], 2012). SUDs are now widely regarded as complex diseases that require treatment, not punishment.

SUDs are often exhibited with co-occurring disorders—the use of more than one substance or presence of other psychiatric disorders. Data show that people diagnosed with mood or anxiety disorders are twice as likely to also suffer from a drug use disorder (abuse or dependence) compared with respondents in general (NIH, NIDA, 2012). A co-occurring disorder may also be a medical condition. Clients with SUDs may display polysubstance patterns, in which they experience physical or psychological effects from more than one substance. In the field of addiction treatment, there is recognition that addictive behaviors may be linked and that treatment for SUDs and other addictive behaviors (for example, gambling, overeating) may overlap (NASW, 2013).

Treatment

Scientific research since the mid-1970s shows that treatment can help patients addicted to drugs stop using, avoid relapse, and successfully recover their lives (NIH, NIDA, 2012). There is a growing emphasis in the professional fields working with clients with SUDs on using short-term and limited interventions. However, many clients who are dependent on substances require longer-term interventions that recognize that substance use can be a chronic disorder—one that includes relapse and may not go into remission for months or even years (NASW, 2013).

Consistent with a change in the DSM-5 (American Psychiatric Association, 2013), addiction is no longer viewed as an “either/or” phenomenon. That is, substance use is no longer dichotomized into separate categories of dependence and abuse; rather, it is viewed as existing along a continuum. This paradigm shift opens up the possibility for larger numbers of clients meeting the criteria of having SUDs and being eligible for treatment (NASW, 2013).

Related to this shift, harm reduction is increasingly emphasized today in federal funding and treatment services. The harm reduction approach is consistent with the social work value of self-determination and meeting the client where the client is. Harm reduction principles are applied in the interests of promoting public health—for example, to reduce homelessness or prevent the contraction of HIV/AIDS in populations affected by SUDs (NASW, 2013).

Barriers to Treatment

Most people with SUDs do not receive adequate treatment. In 2012, an estimated 20.6 million people (8.4 percent of the population age 12 or older) needed treatment for an illicit drug or alcohol use problem but did not receive it (SAMHSA, n.d.). This is due to a variety of reasons, including

- lack of available service provision (for example, shortage of inpatient beds)

- lack of financial resources, poverty, unavailable health care coverage, and managed care providers restricting the length of inpatient treatment stays
- unwillingness to engage in treatment— resistance to treatment is inherent in substance use
- social stigma and consequences of seeking treatment, as being diagnosed with SUDs can affect a person's social standing, including child custody and employment
- lack of understanding about substance use.

POLICY STATEMENT

NASW supports and advocates for policies that promote

- evidence-informed methods of prevention, treatment, and recovery
- increased access to affordable services, including treatment coverage, under health care reform requirements
- mandatory inclusion of behavioral health parity regarding health care coverage
- the elimination of stigmatizing language and labels and the promotion of respectful, supportive, strengths-based language regarding SUD issues
- the use of a holistic approach considering all treatment options to determine the best course of treatment for the individual, including, but not limited to, clinical intervention, medication therapy, harm-reduction approaches, and alternatives to incarceration
- access for individuals with SUDs and cooccurring mental, physical, and other disorders to receive treatment in an integrated, supportive manner
- comprehensive treatment in addressing compounding issues a person with SUDs may experience, such as health, employment, family, housing, legal, and other problems that may impede recovery
- comprehensive, ongoing training and development of social workers' knowledge and skills in culturally competent, evidence-informed methods of assessment, intervention, and evaluation of prevention and treatment approaches relating to SUDs

- the collaboration between social workers and other professionals and organizations to enhance the research base of effective treatment methods for best practices.

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Technology and Social Work

ISSUE STATEMENT

The evolution and proliferation of technology have expanded the ways in which social workers provide services to clients, administer agencies, advocate for social change, educate students and practitioners, and conduct research and evaluation. Accompanying these dramatic developments are a number of compelling issues for social workers to consider.

Although computer networks began in the early 1960s, mental health and other social work services emerged on the Internet in the early 1980s in the form of online self-help support groups. By the late 1990s, groups of clinicians were forming companies and e-clinics that offered online counseling services to the public using secure Web sites (Kanani & Regehr, 2003; Skinner & Zack, 2004). In social work, the earliest discussions of digital tools focused on practitioners' use of information technology and the ways in which social workers could use Internet resources, such as online chat rooms and Listservs joined by colleagues, professional networking sites, news groups, and e-mail (Grant & Grobman, 1998; Martinez & Clark, 2000; Schoech, 1999). Social work now includes a much wider range of digital options, including a large number of tools for the delivery of services to clients, community organizing, advocacy, agency administration, student and continuing education, and research (Chester & Glass, 2006; Kanani & Regehr, 2003; Lamendola, 2010; Menon & Miller-Cribbs, 2002; Reamer, 2013b, 2015, 2016; Wells, Mitchell, Finkelhor, & Becker-Blease, 2007; Zur, 2012).

Direct Practice

Contemporary social workers can provide clinical services using live online chat in real time, video conferencing, telephone counseling, online avatar counseling, digital social networking sites, e-mail, and text messaging (Lamendola, 2010; Reamer, 2015). Social workers' use of technology poses new challenges for practitioners in establishing therapeutic relationships, making appropriate assessments and referrals, monitoring and evaluating interventions, and providing crisis services.

A number of compelling ethical issues are emerging as social workers make increasing use of a wide range of digital and other electronic technology. Key issues include social work competence, client privacy and confidentiality, informed consent, conflicts of interest, boundaries and dual relationships, consultation and supervision, client referral, termination and interruption of services, and documentation.

Many social workers support enhancing clients' access to services using digital and other distance counseling tools and believe they can do so in a way that honors and adheres to prevailing ethical standards in social work (Dowling & Rickwood, 2013; Mattison, 2012). They argue that distance counseling services offer a number of compelling advantages. Some individuals who want clinical services live in remote geographic areas and would have great difficulty traveling to a social worker's office. Physically challenged clients can use distance counseling options without enduring the logistical challenges and discomfort involved in arranging transportation and traveling significant distances. Individuals with overwhelming anxiety and agoraphobia can access help from home that they might not seek otherwise. People who are profoundly concerned about protecting their privacy can receive counseling without risking exposure in a clinician's waiting room. The availability of counseling services, given the options people have to connect through social media with a clinician online or by smartphone 24 hours daily, also enhances social workers' ability to help people in crisis.

Management and Administration

Managerial uses of various technologies for administrative work—including fiscal planning, scheduling, billing, and human resources— have long been a part of organizations' practice. Such information is valuable for designing services and program planning. Although digital technology can be used to streamline an organization's administrative processes, social work administrators should also be aware of the implications of its use for clients, social workers, and other employees. Social workers often manage information systems related to client data. Information about clients and employees must be protected from those who do not require access to the client's information. Ethical and pragmatic decisions must be made about the collection, storage, retrieval, and protection of client and employee information. Furthermore, administrators should ensure that social workers have trainings and access to the technology they need to perform their work duties.

Social Action

Social workers have a rich heritage advocating for social change, engaging in policy practice, and improving the services provided to individuals, families, groups, organizations, and communities (Barsky, 2009). Social workers may use e-mail, texting, Web sites, online social networking, and other digital communications to mobilize and organize communities, communicate political messages, and advocate about policy issues. Given the potentially controversial nature of some social action activities, social workers should be trained to use technology in a responsible and ethical manner.

Education

Distance education has become an alternative or supplement to traditional face-to-face instruction. This has led to significant changes in how social work development curricula are constructed and delivered. Social workers and students can now access educational content using digital, video, and other technology, for example, virtual learning environments and course management systems, interactive bulletin boards, e-mail, Webinars, chat rooms, and podcasts. Social work educators are designing and implementing distance learning models that reflect students' diverse learning styles and cultural differences (Miller & King, 2003).

Faculty development and continued technological skills training benefit not only students, but also faculty members. Curriculum committees must provide guidance and supportive processes for faculty who are interested in teaching distance education courses (Council on Social Work Education [CSWE], 2015; Regan, 2005). Social work educators must continue to monitor and evaluate the quality of distance education, especially given the current lack of consensus about the appropriateness and effectiveness of remote learning in a profession that focuses explicitly on the critical importance of human relationships and interpersonal connection (Reamer, 2013a).

In addition, distance continuing education programs are now being offered by many social work professional organizations and universities. Distance education has been especially popular in rural communities where students and social workers have difficulty traveling long distances for in-person instruction. Collaborative higher education programs provide students in rural areas access to online courses with accredited social work programs in other states. According to Portugal (2006), “the proliferation of distance learning programs, coursework, and new technologies allows the lifelong learner the ability to continually advance his or her skills in a changing knowledge and digital economy, anywhere, and at any time” (para. beginning with “Distance education is developing”).

Research

The social work profession is strengthened when practitioners use the evidence from social work research to guide their choice of practice interventions and to evaluate their effectiveness. Social work researchers contribute to the knowledge base of the social work profession by developing, organizing, and implementing research founded on sound, ethical principles. Social workers may use online surveys or other digital technology to gather information for needs assessments, evaluations, or other research activities. When social workers use technology to conduct needs assessments or evaluations for communities or organizations, they may plan for the information to be shared with government officials, policymakers, program administrators, other decision makers, or the general public. For some purposes, such as legislative advocacy, social workers may invite community residents to share personal stories and identifying information. For other purposes, social workers may allow participants to share information on an anonymous basis or to ensure that any identifying information is removed before it is shared with others.

Although technology has enabled faster access to and use of data, social work researchers must safeguard the confidentiality of client records, follow strict guidelines to protect research participants, and understand the importance of gathering valid and reliable data. It is also important for social work researchers to use state-of-the-art technology to disseminate their findings widely and advocate for the advancement of ethical research in general, and for practitioners to use these findings to help guide their work to improve the quality of life for individuals, families, groups, organizations, and communities.

POLICY STATEMENT

Social workers' increasing use of technology has created new ethical challenges, especially related to issues of informed consent; privacy and confidentiality; boundaries, dual relationships, and conflicts of interest; social work competence; client records; collegial relationships; and social work education. These dramatic developments require new and unprecedented practice, regulatory, and ethical standards that contemporary social workers should consider with respect to social workers' use of digital technology to provide information to the public; design and deliver services; gather, manage, store, and access information about clients; communicate with and about clients; and educate social workers.

Social workers should consult relevant standards in the National Association of Social Workers (NASW) (2015) *Code of Ethics* for guidance related to their use of technology (especially related to practitioner competence; conflicts of interest; privacy and confidentiality; respect; dishonesty, fraud, and deception; misrepresentation; solicitations; private conduct; and acknowledging credit). They should also consult current regulatory standards pertaining to social workers' use of technology (Association of Social Work Boards [ASWB], 2015) and current practice standards promulgated by NASW and other prominent social work organizations such as ASWB, CSWE, and the Clinical Social Work Association.

NASW supports the following:

- use of technology in a manner that reflects the values, ethics, regulations, laws, and mission of the profession especially related to social work competence; conflicts of interest; privacy and confidentiality; respect; dishonesty, fraud, and deception; misrepresentation; solicitations; private conduct; and acknowledging credit
- efforts to maintain competency in technology through relevant continuing education, consultation, supervision, and training
- development of protocols, policies, and assessments to protect client confidentiality, including the use of encryption software; periodic assessment of the confidentiality policies and procedures used by business associates, server hosts, and platform owners to ensure compliance with social work standards; and assessment of the appropriateness of services provided using digital means, considering the possibility of confidentiality risks
- assessment of the appropriateness of providing services using digital means, considering relative risks and benefits for all populations including oppressed and vulnerable people
- evaluation of the effectiveness of digital services and their impact on the human connection that is essential in the clinical relationship
- advocacy efforts to enhance access to digital technology and resources for individuals, families, groups, and communities that have difficulty accessing them due to limited financial means, disabilities, literacy challenges, limited proficiency in English, lack of familiarity with digital technology, or other cultural factors
- development of social media policies to guide professionals, employees, and volunteers who work in their organizations
- planning, budgeting, and policy development for the use of technology in a manner that promotes their organizations' mission and goals in a cost-effective manner and that provides social workers with appropriate technology to deliver services to clients and fulfill other job responsibilities
- competence in the ethical use of the technology to provide undergraduate, graduate, and postgraduate classroom instruction; field

education; supervision; continuing education; and agency-based education

- development of ways to assess the extent to which education provided using technology enables students to master core and essential professional skills
- compliance with statutes and regulations that govern the provision of social work services.

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Transgender and Gender Nonconforming People

ISSUE STATEMENT

Gender identity is a person’s inherent sense of being a girl or woman, a boy or man, a blend of these, or an alternative gender; this term refers to a person’s internal identity acquired and defined in relation to social norms (National Academies of Science, Engineering, and Medicine, 2011). Transgender is a broad term used to describe those whose gender, gender identity, or gender expression is in some sense different from, or transgresses social norms for, their birth-assigned sex. Terms such as transgender not only are used as overarching descriptors of a population, but also function as identity categories. Transgender includes those who identify as being transgender, transsexual, cross-dressers, androgynous, bigender, agender, no gender, multigender, genderqueer, and a growing number of people who do not identify as belonging to any sex or gender category at all; others affirm their identity within the sex binary of male or female and do not identify with the transgender label. Moreover, although there are transgender-identified people with medically diagnosed intersex conditions, most people with intersex conditions do not self-identify as transgender (Intersex Society of North America, n.d.).

Transgender and gender nonconforming (TGNC) people experience gender identity as different from the sex assigned to them at birth. One’s gender identity is considered innate and therefore just as “biological” or “natal” as other components of sex, and although most people’s gender identity is congruent with their biological sex (also known as a cisgender identity), some experience their gender identity to be discordant (Lev, 2004). Although gender identity is usually established in childhood, individuals may become aware that their gender identity is not in full alignment with their biological sex during childhood, adolescence, or adulthood. The developmental pathway of gender identity, for some, includes a progression through multiple stages of awareness, exploration, expression, and identity integration (American Psychological Association, 2015).

In 2011, using state-level data, the Williams Institute estimated the number of transgender people in the United States at 300 per 100,000 (Gates, 2011). Although there continues to be an absence of systematic data collection as to the number of TGNC individuals in the United States, estimates have the TGNC population at up to 1,333 per 100,000 or approximately 4 million people in the United States (Meier & Labuski, 2013). Analyses of census and other administrative data indicate that the number of transgender people who identify as transgender has increased over time. A recent survey suggests that at least 1 percent of millennials identify as transgender (Jones & Cox, 2015).

Some transgender people experience a profound sense of mismatch between their physical body and their gender identity. The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association [APA], 2013) identifies this affective and cognitive distress as gender dysphoria (GD). This label replaced the diagnosis “gender identity disorder” in an effort to focus on the dysphoria as a clinical symptom rather than the person’s gender identity as the diagnosis or problem (APA, 2013). Even with this change, labeling transgender people with a psychiatric diagnosis continues to be problematic in that it pathologizes a normal variation in human development (Moleiro & Pinto, 2015). There have been many debates about whether the GD diagnosis is increasing stigma and negative public sentiment or facilitating access to medical treatment (Lev, 2013). At the same time, a diagnosis is needed for insurance to cover medically necessary treatment. Such treatments (including cross-gender hormone therapy, electrolysis, or surgical and other procedures, as clinically indicated) are often an integral part of aligning the physical body with the experienced sense of self (Joel et al., 2015). There has been a growing movement to create a medical diagnosis outside of the mental health category within the next version of the International Classification of Diseases (ICD)-11 (Drescher, Cohen-Kettenis, & Winter, 2012). Until such a diagnosis is created, the GD diagnosis will continue to serve a narrow purpose.

In an effort to reduce barriers to accessing medical treatment, an increasing number of providers of transgender medical care are using an informed consent model (Deutsch, 2016). This model strengthens the patient– medical provider relationship, removes the dual role of mental health provider as both a clinician and a gatekeeper, and clarifies the role of the mental health provider as a member of the interdisciplinary team. However, when present, insurance coverage can vary widely and insurers may continue to require mental health assessments before authorizing some surgical benefits.

Although the number of private insurance companies providing coverage for sex reassignment surgery is limited, an increasing number of large private sector employers have taken steps to actively remove exclusions on transgender health care from their employer-provided plans (Human Rights Campaign [HRC], 2016b; Thaler, 2007). Through persistent advocacy from the allied health professions, as well as many civil rights groups and transgender activists, federal agencies are implementing policies and regulations that promote equity among lesbian, gay, and bisexual (LGB) and TGNC people. In April 2016, the U.S. Department of Health and Human Services (HHS) issued a regulation regarding implementation of the Patient Protection and Affordable Care Act (ACA) Section 1557 prohibition against sex discrimination, which extends to gender identity; with transgender-specific exclusions now prohibited in nearly all health plans in the United States, equity in coverage of health services is required. The regulation extends to all Marketplace, Medicare, and Medicaid plans, as well as to TriCare and most self-insured health benefits plans. Medically necessary transition-related services for transgender people must be covered without exclusion, when similar medically necessary services are covered for others (Transgender Law Center, 2016; HHS, 2015). In 2011, the U.S. Department of Veterans Affairs, Veterans Health Administration (VA, VHA) released the Providing Health Care for Transgender and Intersex Veterans Directive (VHA Directive 2011-024), which established policy and developed guidance related to accessing transition-specific health care for transgender and inter-sex patients enrolled in the VHA; in 2013 the directive was reissued (VHA Directive 2013-003). VHA is currently working on updating the directive and may begin permitting access to gender confirmation surgeries (Shane, 2016; VA, VHA, 2016). On June 30, 2016, the U.S. Department of Defense (DOD) announced that, effective immediately, the U.S. military will have a policy allowing for open transgender service. And, beginning on October 3, 2016, transgender service members are eligible for access to transition-specific health care. In addition, a training program is being developed and all service members will be required to complete the trainings (DOD, 2016).

Barriers to care persist, and many TGNC people experience discrimination, ranging from subtle to severe, when accessing housing, health care, employment, education, public assistance, and other social services (Grant et al., 2011). Healthy People 2020 found significant health disparities for transgender people, including lack of insurance or coverage for transition-related care; lack of U.S. Food and Drug Administration approval for transgender hormonal therapies; major disparities in treatment, testing, and prevention, despite increasing data that transgender people are at risk for higher rates of HIV and other infectious diseases such as tuberculosis and hepatitis; violence and murder; suicide and mental health issues; lack of public health infrastructure, including trained providers and data collection; high levels of substance abuse and lack of treatment; and high levels of tobacco use and lack of treatment (HHS, Healthy People 2020, 2016).

A severe lack of competent health providers, including mental health and primary care providers, indicates that those with health care coverage have limited access to competent providers. Despite changes in the ACA, insurance administrators continue to limit the range of covered transition-related care. Currently, no population-based surveys collecting data on transgender or gender minority youths exist (Gender Identity in U.S. Surveillance [GenIUSS] Group, 2014). This gap affects the health and wellness of TGNC people. One startling example is data on TGNC people living with HIV/ AIDS in the United States. While recognizing the gaps in population measurement, the Centers for Disease Control and Prevention (CDC) has found a higher prevalence of HIV within the transgender community, with transgender women less likely to be on antiretroviral therapy or having achieved viral suppression. Racial and ethnic disparities exist within the transgender community as well, with black transgender women more likely to test HIV positive than other races or ethnicities. Furthermore, few health care providers receive adequate training or are knowledgeable about transgender people’s health issues and their unique needs (CDC, 2016).

Social determinants affecting the health of TGNC individuals are rooted in oppression and discrimination. Examples include legal discrimination in access to health insurance, employment, housing, marriage, adoption, and retirement benefits; lack of laws protecting against bullying in schools; lack of social programs targeted to and appropriate for LGB and TGNC youths, adults, and elders; and shortage of health care and behavioral health care providers who are knowledgeable and culturally competent in LGB and TGNC health (HHS, 2016). TGNC people continue to experience dismissal from jobs, eviction from housing, and denial of services, even by police officers and medical emergency professionals; inequities in educational settings and other forms of TGNC-related discrimination may contribute to the significant economic disparities of TGNC people (Movement Advancement Project, 2015). No federal laws currently protect individuals from discrimination on the basis of gender identity or gender expression; however, the U.S. Equal Employment Opportunity Commission (EEOC) interprets and enforces Title VII's prohibition of sex discrimination as forbidding any employment discrimination based on gender identity or sexual orientation, and this will be applied regardless of any contrary state or local laws. In addition, a number of federal agencies have issued clear guidance that such discrimination is considered sex discrimination (Office of Personnel Management, 2015; EEOC, 2016).

Despite increased public awareness, no individual or community faces more social judgment and stigma, verbal harassment, and physical violence than TGNC people, often in tandem with racial and ethnic discrimination (Jones & Cox, 2015; Juang, 2006; National Black Justice Coalition, 2016). Many transgender children and youths face harassment and violence in school environments, and those who do not feel safe or valued at school cannot reach their potential (D'Augelli, Grossman, & Starks, 2006; GenIUSS Group, 2014). Many jurisdictions, including states and school districts, have policies or guidance against bullying, with an increasing number having policies ensuring that TGNC children and youths are welcomed in school and school-sanctioned programs. In May 2016, the U.S. Department of Education and the U.S. Department of Justice (DOJ) released guidance clarifying that Title IX of the Education Amendments of 1972 states that schools receiving federal money may not discriminate based on a student's sex, including a student's transgender status. The guidance makes clear that both federal agencies treat a student's gender identity as the student’s sex for purposes of enforcing Title IX (DOJ, 2016). However, the backlash generated by such policies is an indicator of a continuing lack of understanding. There are also still too few support resources for TGNC children, their parents, or surrounding social institutions, leaving transgender youths particularly vulnerable to so-called “reparative therapy,” which evidence has discounted as both harmful and unethical (CSWE, 2016; NASW, 2015a, 2015b; Substance Abuse and Mental Health Services Administration, 2015). Restrooms, the most mundane of public and workplace amenities, often become sites of harassment and confrontation, with access often denied and increasingly used as a vehicle for codifying discrimination in state-level public access laws (HRC, 2016a; Transgender Law Center, 2005). Although the federal government, numerous local jurisdictions, and many employers across the country have policies ensuring access to restrooms and other facilities consistent with gender identity, these policies are a continuously contested patchwork of policy and law.

Few studies or resources exist regarding aging and the transgender population. Residential and care facilities pose familiar barriers such as sex segregation and lack of culturally competent caregivers at a time of life when transgender individuals may be unable to advocate for themselves; many older transgender people may also fear abuse and neglect, whether aging in place or in residential care facilities. Transgender people report higher rates of disability, general poor health, depression, anxiety, loneliness, and suicidal ideation, with the prospect of entering their later years with little to no social or community supports. Although gaps remain, there is a growing movement toward supportive residential and social programs that are affirming to LGB and TGNC individuals, couples, and families (Cook-Daniels, 1997; Services and Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders, 2016).

A host of institutional settings in the United States are hostile to transgender people, especially those that are segregated by sex, many of which require transgender individuals to have undergone genital surgery to be placed according to their gender identity. One in five transgender people in the United States have experienced discrimination when seeking a home, and more than one in 10 have been evicted from their homes, because of their gender identity. Many homeless shelters and other facilities have updated policies to welcome transgender individuals, but many still refuse to house clients according to gender identity, placing individuals at risk of sexual propositions, harassment, and assault. Sex-based dress codes affect youths in particular, who are often disciplined and ejected from the facilities for violating such policies (National Center for Transgender Equality, 2016).

Although many states still require proof of genital or other surgery before altering the sex marker on birth certificates or driver licenses, the Social Security Administration (SSA) issued a policy to replace the requirement of medical certification of sex reassignment surgery with the option of providing a passport or birth certificate with the accurate gender or a medical certification that the person has received appropriate clinical treatment (SSA, Program Operations Manual System, 2013; U.S. Department of State, Bureau of Consular Affairs, 2010).

Inaccurate identity documentation is a common barrier to employment, housing, and appropriate services from gender-segregated facilities. The increased vulnerability—to violence and harassment, to loss of social support and mounting despair—suggests that policies that prevent changing documentation to align with gender identity represent serious barriers to health and well-being.

Some jurisdictions have begun to implement policies that address the needs of transgender individuals, often as a result of protracted legal battles. However, those incarcerated in jails and prisons in most jurisdictions still face familiar barriers to accessing gender-appropriate facilities; access to ongoing hormone therapy and other transgender transition-related procedures, including surgery; as well as solitary confinement just because of who they are (Correctional Association of New York, 2015; Sylvia Rivera Law Project, 2007; Thaler, 2007). In recent years, these concerns have gained national attention. For example, regulations to implement the Prison Rape Elimination Act of 2003 (PREA) (P.L.108-79) include specific provisions aimed at protecting transgender prisoners.

Clients benefit from treatment with clinicians who have expertise in transgender and gender nonconformity concerns, with standards of care for treatment indicating the use of approaches responsive to a variety of identities and to individual clinical presentations. Mental and medical health providers are often unaware of co-occurring disorders, resulting in delays in treatment for transgender people (Tom Waddell Health Center, 2001; World Professional Association for Transgender Health [WPATH], 2011). Lack of appropriately trained service providers, including mental health providers, makes it hard to obtain culturally competent legal, medical, and advocacy services (Testa et al., 2012; Xavier, Honnold, & Bradford, 2007). Social workers are frontline providers of mental health and other services for many transgender individuals, yet most schools of social work have little to no content in their curricula on transgender concerns.

One step toward a trained and competent health workforce is the field guide issued by the Joint Commission (2014), designed for use by hospitals to create a more welcoming, safe, and inclusive environment that contributes to improved health care quality for LGB and transgender patients and their families.

POLICY STATEMENT

NASW asserts that discrimination and prejudice directed against any individuals on the basis of gender identity or gender expression, whether actual or perceived, are damaging to the social, emotional, psychological, physical, and economic well-being of the affected individuals, as well as society as a whole. NASW supports, promotes, and affirms the following.

Social Work Education and Professional Development

- policies in schools of social work that ensure inclusion and equity for all TGNC people, infusion of relevant practice examples and content across all areas of the curriculum, and equal opportunity for research and field practice of relevance to and for TGNC people
- development and provision of culturally competent training for all personnel and volunteers within private and public schools of social work
- culturally competent continuing education programs focused on micro, mezzo, and macro practice with TGNC children, youths, and adults and their families across the life course, including the role of social workers

in provision of transgender transition-related health care, ethical practice, and holistic assessment and effective interventions and community resources.

Antidiscrimination

- full human rights and the end to all public and private discrimination on the basis of gender identity and gender expression, whether actual or perceived, and regardless of assigned sex at birth, including denial of access to employment, housing, public accommodations, education, appropriate treatment in gender-segregated facilities matching self-identification, familial status, appropriate medical care and mental health care coverage and appropriate identity documents
- repeal of discriminatory legislation and regulations and the passage of legislation, regulations, and institutional policy to protect the rights, legal benefits, and privileges of people of all gender identities and expressions
- inclusion of nondiscrimination policy in all public and private agencies that train or employ social workers, to include “sexual orientation, gender identity or expression,” provision of a safe and affirmative work space and learning environment; use of respectful address (asserted name, pronouns); access to facilities, service, and programs in accordance with the client’s or staff member’s self-identified gender identity; transgender-inclusive health care access and health insurance options; use of transgender-inclusive language and communications
- development and funding of supportive and knowledgeable practice environments for clients and colleagues
- active outreach, recruitment, mentoring, and leadership development of TGNC people to the profession of social work
- condemnation of the teaching of social work students in CSWE-accredited programs to use reparative or conversion therapy approaches, and an end to the use of reparative or conversion therapies by professional social workers.

Public Awareness and Advocacy

- safe and secure educational environments, at all levels of education, in which children, youths, and adults may obtain an education free from discrimination, harassment, violence, and abuse and are afforded confidentiality and access to culturally competent staff and volunteers
- convening of, and participation in, coalitions with other professional associations and progressive organizations to lobby on behalf of the civil rights for all people of diverse gender expression and identity, with recognition of the transgender individuals who experience multiple intersections of oppression based on racism, poverty, heterosexism, cissexism, ageism, ableism, and mental and behavioral health status
- implementation of nondiscrimination and antibullying policies, with specific inclusion of TGNC youths and adults, in all educational, housing, health, and social welfare programs and institutions
- development of programs, training, and information that promote proactive efforts to eliminate psychological, social, and physical harm directed toward TGNC people
- development of evidence-driven programs within schools, child and youth services, child welfare, and older adult agencies that educate students, faculty, and staff about the range of gender diversity and the needs of TGNC people across the life span
- development and implementation of policies ensuring that transgender individuals placed in sex-segregated rooms or facilities are placed according to their self-identified gender identity, including in jails and prisons, foster care, group homes and residential treatment centers, homeless and domestic violence shelters, substance abuse and recovery programs, and elder care services and housing
- increased public and private funding for education, treatment services, and research on behalf of people of diverse gender expression and gender identity.

Health and Mental Health Services

- open availability of comprehensive health, psychological, and social support services for transgender people and their families that are respectful and inclusive, and provided by skilled, educated professionals who have been trained to work effectively with TGNC people
- the right of all individuals to have transgender inclusive, comprehensive health insurance including medically necessary transition-related services
- referral to licensed medical specialists in accordance with WPATH's internationally accepted standards of care
- development of transgender health programs using the informed consent model of care that include professional social work as an interdisciplinary component of transaffirmative integrated health care settings
- implementation of a national database and annual comprehensive reports on violence against TGNC people to include hate crimes, bullying, and youth violence and discrimination
- implementation and funding of programs to address the education, housing, employment, health, and mental health needs of adults and youths who are struggling with their gender identity and who are thus at high risk of suicide, vulnerable to violence or assault, at increased risk of HIV/AIDS, or otherwise at risk
- implementation of electronic confidential record systems that capture asserted names, pronouns, and options for capturing sex assigned at birth; legal or asserted sex; and asserted gender identities, including the mandate for federal, state, and local agencies to collect data about individuals' sex and gender
- implementation of a new, more appropriate medical diagnosis within the ICD-11 with subsequent elimination of the GD diagnosis from the DSM-5
- inclusion of TGNC individuals in health surveys and data collection, census data, and public health monitoring data at state and national levels through inclusion of questions on gender identity (independent of sexual orientation).

Legal and Political Action

- passage of federal regulation to simplify sex change policies to allow licensed mental health and medical providers to certify a sex change for the purpose of changing the gender marker on legal documentation
- implementation by federal policies enacted to comply with PREA
- passage of laws at the local, state, and federal levels that prohibit use of reparative or conversion therapies by professionally trained social workers or people using the title of social worker
- legal recognition of TGNC individuals, including identity documents that reflect the gender with which they identify in life and in death, regardless of assigned sex at birth or subsequent surgical or other medical interventions
- passage of federal laws that will prohibit discrimination against, protect the civil rights of, and preserve the well-being of TGNC individuals in education, public accommodations, housing, inheritance and pensions, employment, legal document identification, relationship and familial status, health and other types of insurance, child custody, property, and other areas.

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Voter Rights and Voter Participation

ISSUE STATEMENT

Voting is a fundamental right of Americans. From the beginning, there have been many challenges to ensuring that the right to vote was not only guaranteed, but fully enforced. The following are the key voter rights and voter participation policy issues that are important to the nation and to the social work profession.

Voting Rights

NASW reaffirms its commitment to unencumbered and guaranteed access to the ballot for all eligible voters. This can be achieved through enforcing federal and state voting statutes, reinforcing federal monitoring responsibilities (especially for national elections), using the federal and state courts to challenge voting irregularities, and advocating for policies that make voting more accessible and easier, not more difficult.

Voter Suppression

NASW reaffirms its opposition to voter suppression; the denial of voting rights is an injustice. Historically, the issue of voter suppression dates to the passage of the Fifteenth Amendment in 1870. At the end of the Reconstruction Period and through the Jim Crow period, African Americans—mostly in the southern states—were subjected to overt voter suppression that included violent voter intimidation, requiring poll taxes, applying literacy tests, and economic retribution against blacks who dared to vote. In more modern times, voter suppression has taken the form of gerrymandering tactics that severely dilute the votes of black citizens and other minorities; requiring voter identifications (IDs), which significantly reduces the number of eligible voters, especially minorities; and the practice of purging voter registration rolls of “ineligible” voters.

Disenfranchisement of Those Convicted of a Felony

In most of the United States, individuals convicted of a felony are barred from voting. Maine and Vermont are the only states that allow incarcerated individuals to vote. New Jersey has pending legislation that would allow incarcerated individuals to cast a ballot. The bill would allow prisoners to vote by mailin ballot in the district where they lived prior to being incarcerated (Levine, 2018).

Thirty states deny voting rights to felony probationers, and 34 states disenfranchise parolees. More problematic, 12 states continue to deny voting rights to some or all individuals who have successfully fulfilled their prison, parole, or probation sentences (Sentencing Project, 2016). In total, over 6.1 million Americans are forbidden from voting because of a conviction (Sentencing Project, 2016).

Although nearly every state bars incarcerated criminals from voting, only Florida and three others—Iowa, Kentucky, and Virginia— do not automatically restore voting rights at the completion of a criminal sentence (National Public Radio, 2018). As of this writing, Florida has a ballot measure that amends the state constitution, allowing convicted felons to vote. The amendment restores the voting rights after the individual completes all terms of the sentence including parole or probation—excluding those convicted of murder or sexual offenses.

Redistricting (Gerrymandering) as a Tool for Voter Suppression

Members of Congress, state legislators, and many county and municipal offices are elected by voters grouped into districts. District boundaries are regularly redrawn to ensure districts of the same number of people and to fulfill the constitutional guarantee that each voter has an equal voice (Brennan Center for Justice, n.d.).

Gerrymandering refers to the manipulation of district lines to protect or change political power. A gerrymander is a deliberate attempt to ensure an electoral advantage for a political party or a specific racial or ethnic group. Most voting rights advocates see the practice as being unfair because it attempts to redraw district lines to increase the probability of a particular political electoral outcome, rather than to ensure equal representation for all members of communities (Brennan Center for Justice, n.d.). In many districts, redistricting is used to create voting districts that are based on race or ethnicity. However, there is an ever-increasing trend toward attempting to gerrymander districts by drawing artificial lines in such a way as to "pack" racial minorities in one district and make an adjacent district overwhelmingly white. In an effort to prevent gerrymandering, the Voting Rights Act provides that jurisdictions have to meet three tests: (1) compactness or coherence of the minority group in question, (2) the political cohesion of that group, and (3) the likelihood of white voters tending to vote against that group's preferred candidates if given a majority (Estepa, 2017).

Voter ID Laws

Voter ID laws became a contentious issue during the 2008 and the 2016 presidential elections. Thirty-six states have now enacted some form of voter ID laws. Proponents state that such laws are needed to combat voter fraud. However, there is compelling evidence that voter ID laws are often used by politicians to disenfranchise voters. The policy issue concerning the proliferation of strict voter ID laws is that such laws disproportionately affect people of color, students, older adults, and people with disabilities, all of whom are less likely not to have the required IDs (Brennan Center for Justice, n.d.).

In the states with the most restrictive voter ID laws, the following serve as barriers to registering to vote and casting a ballot:

- Nearly 500,000 eligible voters do not have access to a vehicle and live more than 10 miles from the nearest state ID-issuing office open more than two days a week. Many of them live in rural areas with dwindling public transportation options.

- Around 1.2 million eligible black voters and 500,000 eligible Hispanic voters live more than 10 miles from their nearest ID-issuing office open more than two days a week. People of color are more likely to be disenfranchised by these laws as they are less likely to have photo ID than the general population.
- Many ID-issuing offices maintain limited business hours. For example, the office in Sauk City, Wisconsin, is open only on the fifth Wednesday of any month. But only four months in 2012—February, May, August, and October—had five Wednesdays. In other states—Alabama, Georgia, Mississippi, and Texas—many part-time ID-issuing offices are in the rural regions with the highest concentrations of people of color and people in poverty.
- The cost of obtaining required voter IDs can be a barrier to voter participation for low-income eligible voters.

Voting should be encouraged and supported, as a right and responsibility of citizenship. Voter ID laws are undemocratic and unjust.

Intentionally Limiting Access to Voting

Voter suppression can also include purposeful limiting access to casting a ballot by state and local officials. Recently, numerous states have reduced the number of voting machines in voting districts where large number of minorities reside and on college campuses (American Prospect, 2014). This practice creates long lines in certain precincts and districts, so that voters become discouraged and leave the lines before casting a ballot or simply do not get in line to vote.

Voter Fraud

The idea that there is massive voter fraud during elections in the United States is incorrect. The myth of widespread voter fraud has often been propagated by politicians and nongovernmental organizations to justify implementing strong voter ID laws (Public Integrity, 2016). A study of 2,068 alleged election-fraud cases in 50 states between 2000 and 2012 found the level of fraud infinitesimal compared with the 146 million voters registered over the 12-year period (NBC News, 2016). A similar result was found in a 2010 study of 12 states substantiating that voter fraud appears to be very rare (Demos, 2010).

Voter Participation and Registration

Voter participation can be defined in both aspirational and technical terms. More generally, *voter participation* refers to an aspiration of various advocacy groups for their constituents to fully participate in voting in local, state, and national elections. The technical view of *voter participation* is that it is synonymous with voter turnout. In this context, voter participation is quantitatively collected and analyzed by nationally recognized policy institutes or governmental entities such as the U.S. Census Bureau. The voter participation analysis is usually issued in the form of a report for public consumption.

When discussing voter participation, the issue of voter registration is of foremost importance. It is well known that the United States ranks 27th among developed countries in the percentage of eligible voters who participate in national elections (Pew Research Center, 2017). For example, during the 2016 elections, approximately, 55.7 percent of the U.S. voting-age population voted. This was much lower than voter participation for national elections in other developed democracies.

Voter participation is also greatly influenced by voter registration levels. Voter registration laws vary from state to state; for example, 15 states and the District of Columbia offer same-day voter registration, which allows any eligible voter to go to register and cast a ballot in the same day. Thirty-seven states and the District of Columbia allow online voter registration. Ten states and the District of Columbia have automatic voter registration laws, where eligible citizens are registered to vote automatically through their interactions with specific government agencies (for example, the Department of Motor Vehicles), unless they choose to decline (Brennan Center for Justice, 2018).

Another factor that influences voter participation is election type. For example, it has been documented that low voter turnout occurs more frequently during primary elections, off-year (nonpresidential year) elections for Congress, state legislators, and local elections. A 2013 study of 340 mayoral elections in 144 U.S. cities from 1996 to 2012 found that voter turnout in those cities averaged at 25.8 percent. In many cities, mayors have been elected with single-digit turnout (Political Research Quarterly, 2015).

Social Workers as Advocates for Voter Rights and Voter Participation

As a matter of policy, one of the social work profession's ethical principles is that we challenge social injustice. Social workers are expected to advocate for social change, particularly with and on behalf of vulnerable and oppressed people (NASW, 2017). This policy statement reflects NASW's promotion of proactive positions that support marginalized populations in becoming aware of their rights as eligible voters and U.S. citizens. In addition, social workers are well positioned due to their professional location within communities to serve as advocates and educators on voter registration, engagement, and participation for all citizens.

POLICY STATEMENT

NASW supports

- strong national policies that guard against efforts to disenfranchise any group of otherwise eligible voters; such protections can be achieved through legislation that mirrors the intent of the Voting Rights Act
- federal and state voter eligibility policies that allow incarcerated individuals to vote in local and federal elections
- immediate and full restoration of voting rights for formerly incarcerated individuals who have completed their sentences (in states where access to voting for incarcerated individuals is not available)

- the position that denial of the right to vote is an injustice, and a failure to recognize basic human rights of citizens; justice-involved individuals who are currently incarcerated or have completed their sentence should have a full and unconditional right to vote, regardless of the offense for which they were convicted
- proactive advocacy that leads to the elimination of state voting policies that overtly or covertly lead to voter suppression—including, but not limited to, strict voter ID laws; purging voter registration rolls; and failure by jurisdictions to provide sufficient polling places in highly populated neighborhoods, college campuses, and rural areas
- social action and legal challenges to all state redistricting policies that are tantamount to gerrymandering and result in purposefully engineered voting districts that heavily favor one political party over another
- promoting social work advocacy policies that urge social workers to inform members of marginalized and alienated communities of the power of the right to vote and encourage them to participate in elections at all levels
- social workers working to actively support full participation in elections, including engaging (as appropriate) constituents and communities in voter participation, serving at the polls on Election Day, and participating in the postelection accountability and monitoring activities
- policies and mobilization designed to increase voter participation during off-year state and local elections and mid-term nonpresidential national elections
- nonpartisan voter education programs by nongovernmental and public agencies that inform clients about the positions of candidates and how they are affected
- efforts to reform and modernize voter registration laws that make it easier for people to register and vote. This includes support for all voter participation policies at the federal and state level that seek to increase access to voting—including early voting, same-day registration, absentee voting, and online voting
- policies and initiatives that would declare national elections as a national holiday

- full implementation and enforcement of the National Voter Registration Act of 1993, the Help America Vote Act of 2002, and the Voting Rights Act of 1964
- policies that ensure there is a proactive Civil Rights Division in the Department of Justice to enforce voter rights laws and to monitor voting activities for abnormalities in voting procedures, equipment, access to polling places, and cases of voter intimidation
- policies that ensure voter privacy, accuracy of the vote count, and assurances that all votes are counted and recorded
- social workers working with coalitions and organizations dedicated to increasing voter participation, especially efforts to help people living in poverty, people of color, those with disabilities, those who experience homelessness, elderly people, single parents, and others who are traditionally oppressed and often do not participate in elections.

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Welfare Reform

ISSUE STATEMENT

The social work profession is keenly aware that poverty serves as an impediment to promoting the general welfare of society on both local and global levels. It is an impediment to the development of people, their communities, and their social environments.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P. L. 104-193), as amended, is the welfare reform law that established the Temporary Assistance for Needy Families (TANF) program. TANF is a block grant program designed to make dramatic reforms to the nation's welfare system by moving recipients into work and turning welfare into a program of temporary assistance. Low-income parents often have limited access to resources such as education and training opportunities linked to economic security as well as reliable housing, transportation, and quality full-day child care that would allow them to pursue job opportunities (Berrick, 2009; U.S. Department of Health and Human Services [HHS], 2015b).

TANF grant funding has not increased since the program's inception 20 years ago. A large share of poor families with children do not get any help from TANF, even when the parents are out of work and the family has no regular source of income (Floyd, 2016; HHS, 2016a). According to the Center on Budget and Policy Priorities (CBPP) (2017), "in 2015, for every 100 families in poverty, only 23 received cash assistance from TANF—down from 68 families when TANF was first enacted. This 'TANF-to-poverty ratio' (TPR) reached its lowest point in 2014 and remained there in 2015" (para. 1). Although there is significant state-to-state variation in the TPR, that is, some states provide a relatively better safety net than others, the overall trend has been toward less access to needed cash assistance for families in poverty.

TANF's early years were marked by unprecedented drops in the number of families receiving cash assistance—and unprecedented increases in the number of single mothers working, especially those with a high school education or less. Since then, TANF's record has been dismal. TANF provides basic assistance to few families in need and has responded only modestly to the significant increase in unemployment nationally during and after the Great Recession. Currently, just 32 percent of families that meet state eligibility requirements for TANF (such as income and asset rules) actually receive income assistance. When families do not receive income assistance, they also typically lose access to the employment services that TANF programs provide (CBPP, 2016). Research from the Urban Institute states that only one in four poor families eligible for TANF receive any cash assistance (Hahn, Adams, Spaulding, & Heller, 2016). Not only are fewer needy families receiving TANF cash benefits, but benefit levels for those who are on TANF are extremely low. In the median state in 2015, a family of three received $429 per month; in 14 states, such a family received less than $300. TANF benefits are below 50 percent of the federal poverty line in all 50 states and the District of Columbia and below 20 percent of the poverty line in 16 states (CBPP, 2016).

There has been discussion at the federal level to make TANF a more effective safety net and employment opportunity program for those who need help. The budget increases funding for TANF Family Assistance Grants by $8 billion over five years, to partially address its erosion in value since 1996, and requires states to spend at least 55 percent of all funding, including state maintenance-of-effort funding, on core benefits and services within TANF, defined as cash assistance, child care, and work activities. The required share of funding for core benefits and services would increase as total TANF funding increases, and would reach 60 percent by 2021 (HHS, 2016a).

Low-income families receiving cash assistance through TANF also need assistance with workforce development and child care. TANF time limits and work requirements, and the related demands for employment preparation and child care, situate TANF at the intersection of the workforce development and child care systems; however, the characteristics of TANF families accentuate the weaknesses in each system, making these families the most challenging for each system to serve. Program rules and realities, in combination with family characteristics, make it hard for TANF families to access intensive, high-quality services. TANF is positioned to meet the needs of both parents and children in mutually reinforcing ways, but both generations can succeed only if the supports are high quality and intensive enough to meet those needs (Hahn et al., 2016).

A new approach, referred to as two-generation or whole family approach, meets the needs of children and their parents together. Serving the whole family is important because the income, educational attainment, and well-being of parents play crucial roles in children's outcomes. Moreover, services for children such as high-quality child care also help parents balance the demands of work and parenting by lessening their stress and supporting child and family well-being. The logic of the two-generation approach posits that linking and aligning services for children and parents will bring greater and more sustainable outcomes for children, parents, and families than focusing on one generation. There is growing interest among government entities, foundations, researchers, and service providers to develop, implement, fund, and evaluate approaches that rely on this model (HHS, 2016b).

The two-generation, or whole family, approach meets the needs of children and families together. The Administration for Children and Families (ACF) (HHS, 2015a) included in its strategic plan a goal to "promote collaboration on two-generation approaches among state and tribal human service agencies, work-force agencies, educational institutions and local organizations that achieve positive outcomes for both parents and children" (p. 5). The Office of Family Assistance, which administers the TANF program within ACF, is strongly committed to this goal and believes that adoption of a two-generation approach within TANF programs could foster more strategic use of TANF funds and improve family economic security and well-being (HHS, 2016b).

Child Poverty

A continuing problem associated with the limitations on benefit receipt as a result of welfare reform and the general reduction in benefits in many states has been high rates of child poverty. According to the National Center for Children in Poverty (2016), "about 15 million children (21% of all children) live in families whose income is below the federal poverty threshold. Research has shown poverty can have a significant effect on a child’s ability to learn and contributes to deficits in overall social, behavioral and emotional functioning” (p. 1). In addressing the effects of poverty, social workers need to acknowledge that poverty imposes an enormous cost on society at large. The lost potential of children reared in poor households; the lower productivity and earnings of poor adults; and the poor health, increased crime, and broken neighborhoods all serve as counterproductive to moving individuals, families, and communities toward self-sufficiency (Krase, 2014).

It is now the responsibility of organizations such as NASW to engage in this policy-making process by advocating to change the stereotypes about poor people, offering a humane and effective approach to income assistance programs, and truly working toward the reduction of the number of families living in poverty—not merely reducing the number of families receiving assistance. A key strategy to achieve this reduction in poverty would be through the implementation of full employment policies designed to guarantee good jobs at living wages (Tomczak & Rofuth, 2015).

POLICY STATEMENT

NASW supports the following:

- restoration of a safety net that protects the most vulnerable individuals while supporting their efforts to become economically self-sufficient
- a universal social welfare system that does not stigmatize, categorize, or pathologize people
- entitlement of all people to be treated with dignity, respect, and well-being regardless of their economic status
- comprehensive child support for all single custodial parents
- treating health care as a basic human right
- meaningful employment training (both postsecondary education and skill building) for available employment opportunities
- higher education for people on welfare that will provide opportunities for economic security

- assistance in obtaining employment at a living wage, including partnerships with the private sector; healthy, safe working conditions; child care; and unemployment insurance
- an increase in Earned Income Tax Credit (EITC) participation in all states
- the need to address problems that contribute to poverty, such as substance abuse, domestic violence, mental illness, illiteracy, and others and provide adequate services to address these issues
- an economic system that ensures that every person has a job at a livable wage and safe and humane working conditions
- the recognition of the economic value of child rearing and caregiving
- policies on the administration of welfare benefits and programs that promote national standards and policies for the delivery of benefits and programs that serve as a safety net for all people
- collaborative public–private efforts to move welfare recipients into work experiences that offer a living wage, appropriate levels of training, adequate health benefits, and an intentional effort to provide opportunities for economic advancement
- policies that protect the entitlement status of Medicaid and the Supplemental Nutrition Assistance Program (SNAP, formerly known as food stamps) for all who meet eligibility criteria, including immigrants, refugees, and other noncitizens
- the integration and expansion of professional social work personnel into the provision of public and private social services for welfare recipients
- legislation and funding for research activities that track recipients who are dropped from welfare programs; data collection to document the subsequent policy impact on child development, employment, and increases in child abuse and termination of parental rights, as well as the long-term effects of welfare reform on poverty
- integration of welfare policies with housing, child welfare, economic, and mental health policies so that there is a holistic approach to reducing and eliminating poverty
- policies that allow people to receive benefits for as long as they need them and eliminate punitive measures such as full family sanctions and family caps

- the promotion of strategies that enable welfare recipients to build personal and financial assets, such as individual development accounts
- promotion of intensive work supports for low-income families with children, including child care subsidies, Medicaid, and expansion of the State Children’s Health Insurance Program, SNAP promotion, and EITC availability
- the promotion and support of intensive case management services to adolescent recipients of welfare, elimination of the living-arrangement rule, and relaxation of school attendance requirements as per individual circumstances.

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Women in the Social Work Profession

ISSUE STATEMENT

The history of social work is a “herstory” of female reformers, suffragists, and charity workers (Vandiver, 1980). A partial list of female social work pioneers includes such prestigious names as Grace Abbott, Jane Addams, Sophonisba Breckinridge, Dorothy I. Height, Florence Kelley, Julia Lathrop, Lillian Wald, Mary Ellen Richmond, Bertha C. Reynolds, and Frances Perkins. Other trailblazers in social work included many women of color doing both “racial uplift” and traditional social work tasks, such as Barbara Solomon, Victoria Warner, Mary Church Terrell, Ida B. Wells-Barnett, and Nannie Helen Burroughs (Carlton-LaNey, 1999; Peebles-Wilkins & Francis, 1990; Perkins, 1997; Vakalahi, Starks, & Hendricks, 2007). The latest chapter in women in social work history includes recognizing that same-sex intimate relationships were central to the lives of many female social work pioneers, to prevent the erasure of sexual identity from social work history (Fredriksen-Goldsen, Lindhorst, Kemp, & Walters, 2009).

Although women were prominent during the newly developing profession of social work, men often held managerial positions and directed the frontline, and predominately female, workforce. As early as 1880, women noted and protested this uneven representation (see Vandiver, 1980). Although social work frequently has been referred to as a “female-dominated profession,” that supposition has been challenged over the years (Meyer, 1982). For instance, McPhail (2004) contended that a more accurate characterization of social work is that it is a “female majority, male-dominated” profession.

Today, women continue to make important contributions to the social work profession and comprise the numerical majority of social workers. A 2004 national study of licensed social workers provided a helpful demographic portrait of women in social work (NASW, Center for Workforce Studies [CFWS], 2006a). Eighty-one percent of licensed social workers are female. The racial and ethnic breakdown of women in social work is not representative of either the U.S. national population or the clients they serve: 86 percent of female social workers are white, 8 percent are African American, 3 percent are Latinas, and 3 percent identify as “other.” The majority of female social workers have an MSW degree (83 percent), and 2 percent hold a doctoral degree. Thirty-eight percent have between one and five years of practice experience, 37 percent are employed in the private not-for-profit employment sector, and the largest primary practice area is mental health (33 percent). Female social workers on average remain with the same employer for eight years, plan to remain with their current job for the next two years, and cited salary as the most important factor that could influence a job change (CFWS, 2006a). Female social workers were found in many practice settings, with women comprising 90 percent of social workers in the field of aging, 79 percent in behavioral health, 83 percent in children and families, and 87 percent in health care venues (CFWS, 2005).

Women in social work, like their male counterparts, demonstrate a range of professional skills, including assisting people in overcoming some of life’s most difficult challenges, such as poverty, discrimination, abuse, and addiction (NASW, n.d.), acting in a variety of roles such as academics, clinical practitioners, activists, educators, legislators, and policy analysts; bringing knowledge, training, determination, professionalism, energy, and enthusiasm to the complex profession of social work; and epitomizing social work values as they work for social and economic justice. They make a difference in the lives of people every day.

However, women in social work face professional challenges. Social workers operate in a world that continues to reflect traditional male bias and power in its institutions, structures, and theoretical models. Dressel (1987) argued that “the numerical dominance of women in social work has not translated into authority, power, and pay equity or equality” (p. 297). Female social workers are not immune from the problems women in many other professions confront in the workplace, including pay inequities, the glass ceiling, sexual harassment, and a problem that has only recently received increased attention: the maternal wall. As a result, female social workers face an ironic situation: working in a profession largely composed of women, primarily serving women and their children, they are often second-class citizens. Although women in the social work profession have made much progress, inequities continue to exist.

Pay Inequities

Gender-based wage disparities in the social work profession have been documented since 1961, when the first labor force study was conducted by NASW (Becker, 1961), and have been reaffirmed in subsequent investigations (Gibelman & Schervish, 1997; Huber & Orlando, 1995; Koeske & Krowinski, 2004). A study conducted in 2004 that surveyed approximately 10 thousand social workers (Center for Health Work-force Studies and CFWS, 2006) found that the difference in annual salaries between men and women in a full-time social work job was $12,045, with men earning higher salaries. When the salaries were controlled by a number of individual factors (age, race, degree, practice area, and so on) the average salary gap dropped to approximately $7,052, a difference of approximately 14 percent. The 2009 Compensation & Benefits Study (CFWS, 2010), which compiled the responses of 22,000 social workers, found the median male salary was $64,000, compared with $53,000 for the median female salary. Another study found that the gender gap occurred across all practice areas (CFWS & Social Work Practice, 2011).

A recent study that examined the wage gap in the 20 most common occupations for women included social work, with women making up 79.7 percent of the social work workforce; their earnings were 83.6 percent of the earnings of men in the field (Hegewisch & Hudiburg, 2014). The authors concluded that women’s median earnings are lower than men’s in nearly all occupations, whether occupations predominantly staffed by men, or women, or with a more even mix. Reasons for this persistent wage gap are hypothesized to include gender schemas (unconscious stereotypical biases that create unequal outcomes), stereotype threat (poorer performance when people are cued to their stigmatized race or gender), and sexism (benevolent, hostile, or ambivalent) (Anastas, 2007).

Comparing salaries by industry and the proportion of women in the industry, Gibelman (2003) found that “the proportion of women in an occupational group has an inverse relationship to weekly salary levels; that is, as the proportion goes up, salaries go down” (p. 25). Although minor exceptions exist, Gibelman (2003) noted that the pattern is consistent and strong. An analysis of gender pay disparities in the broader nonprofit arena found that although the gender gap exists, it is in some instances narrower than the gender wage gap in the private industry labor market (Faulk, Edwards, Lewis, & McGinnis, 2012). However, rather than the narrower gender gap being a function of paying women more equitably, it occurred primarily because men accepted lower pay in traditionally nonprofit and female jobs. The authors suggest that such professions should offer higher and more competitive wages to continue to attract high-quality employees in the nonprofit sector, especially as women have more professional choices today and low wages often lead to lower morale and higher turnover.

Glass Ceilings and Glass Escalators

The U.S. Department of Labor defined the *glass ceiling* as “those artificial barriers based on attitudinal or organizational bias that prevent qualified individuals from advancing upward into management-level positions” (cited in Gibelman & Schervish, 1993, p. 443). In a study of NASW members, Gibelman and Schervish (1997) found evidence of a glass ceiling in social work, with 32.5 percent of men and 22.7 percent of women holding management positions after 10 years of experience. Zunz (1991) found that although female social workers seem to have equal access to education, training, and mentors, they move into management positions at a slower pace than men, often lacking self-confidence and finding it a riskier proposition than do men. Another study, based on interviews with female leaders in human services organizations, identified respondents’ greatest barriers to professional advancement as prejudice and discrimination based on race, ethnicity, gender, and heterosexism (Gardella & Haynes, 2004).

In a study of undergraduate directors at accredited BSW programs and deans or chairs of accredited MSW programs from 1985 to 1996, Di Palma and Topper (2001) found that the percentage of female directors of BSW programs increased significantly over the years, from 43.4 percent in 1985 to 57.2 percent in 1996. The number of female deans or chairs of MSW programs also increased during this same time period, from 29.3 percent in 1985 to 44.7 percent in 1996. The researchers attributed the gains to two factors: concerted efforts of the Council on Social Work Education's (CSWE's) Commission on the Role and Status of Women and an increase in the number of women in social work academia. This study is encouraging —as the title of the article suggests, the glass ceiling may be beginning to crack.

Researchers also have found that men in the profession take on administrative tasks and move into administrative positions more often and at a much faster rate than women, with significant differences appearing three to 10 years after receiving an MSW degree (Gibelman & Schervish, 1993; Lambert, 1994; Zunz, 1991). Koeske and Krowinski (2004) found that men were more likely to occupy administrative roles, whereas women were more likely to be in direct practice positions. In a study that examined the status of men in predominantly female professions (social work, library science, and teaching), Williams (1995) found that men in these professions often received preference in hiring, were closely mentored by other men in the profession, and were actively encouraged to move into leadership positions. In contrast to the glass ceiling facing women moving into traditionally "male professions," Williams described the opposite phenomenon, men moving quickly up the management ladder in the so-called women's professions, analogous to riding a "glass escalator."

Work–Life Integration

Although the glass ceiling phenomenon has received increased attention over the past couple of decades, less attention has been given to work–life integration in social work. In a study of work-related stressors, 8 percent of social workers reported being unable to balance professional and personal life (Arrington, 2008). The maternal wall and motherhood penalty are the two other barriers for women in the workplace. The maternal wall, which refers to the problems women face in juggling their roles as employed workers with that of mother and caregiver, affects female faculty, who are less likely to marry and have children and more likely to divorce than their male counterparts (Mason & Goulden, 2004). Correll, Benard, and Paik

(2007) found a motherhood penalty among women in the workforce: Mothers were judged significantly less competent and committed than women without children, and the recommended starting salary for mothers was $11,000 (7.4 percent) less than offered to non-mothers. In some cases, the pay gap between mothers and nonmothers may be larger than between men and women.

The problem of work–life integration has largely been invisible, often seen as part of a personal rather than political struggle for women based on their “choice” to have children or care for aging parents. However, this attitude is changing. According to Crittenden (2001), “What is needed is across-the-board recognition—in the workplace, in the family, in the law, and in social policy—that someone has to do the necessary work of raising children and sustaining families, and that the reward for such vital work should not be professional marginalization, a loss of status, and an increased risk of poverty” (p. 10). This unequal distribution of caregiving between women and men affects women in the social work profession as well as the largely female clientele they serve.

In a study of Australian social workers, Kalliath, Hughes, and Newcombe (2012) examined bidirectional conflicts of work and family—how work roles can interfere with family roles (WFC) and family roles can conflict with work roles (FWC). The study found that social workers experienced both WFC and FWC, and both were associated with increased psychological strain. Social workers described their work as emotionally draining and stressful, often because of organizational factors such as heavy workloads, high work expectations, scarce resources, and staff shortages. Their sample was 81 percent female, with an average age of 44 years and average work experience of 15.5 years.

Stressors for Women in Social Work

Multiple stressors exist for women in social work. Some stressors are similar to those experienced by other women in the work-force, and some are unique to social workers or professionals in similar roles. For example, when social workers assist survivors of childhood abuse, domestic violence, violent crime, natural disasters, war, and terrorism, they may experience secondary traumatic stress (STS), and in rarer cases, posttraumatic stress disorder (PTSD) (Bride, 2007). Two studies of social workers who worked with traumatized clients found reports of psychological distress and physiological reactions, with intrusive thoughts being the most commonly reported symptom (Bride, 2007; Choi, 2011).

More routine work-related stressors reported by social workers include difficult and challenging clients, lack of time, heavy workloads, and salary and overall compensation inadequate and not comparable to other colleagues in similar jobs (Arrington, 2008). Additional stressors included having more responsibilities than they could handle, needing to complete routine tasks with little intrinsic value, having few opportunities for advancement, being expected to work long hours, having too few resources, and conflicting or unclear job expectations.

In response to stress, female and male social workers reported similar levels of stress-related health concerns, such as irritability, aggression, impaired cognition and immune functions, and workplace injury. However, women were more likely than men to report feeling fatigue, and men were more likely than women to report cardiovascular problems (Arrington, 2008). The three leading stress management techniques used by social workers, starting with most commonly used, were exercise, meditation, and therapy. There were no gender differences between male and female social workers using the coping mechanism of exercise (72 percent), drinking alcohol (16 percent), or absenteeism (6 percent). However, women were more likely than men to use prescription medicine and practice yoga, whereas men were more likely than women to meditate.

Sexual harassment has been documented in social work at agencies and educational institutions (Risley-Curtiss & Hudson, 1998; Singer, 1989). Across the board men have been the most likely perpetrators of sexual harassment, and women have been the most common victims. Sexual harassment has been categorized as violence against women and as a form of economic coercion (Hill, 2003). Another serious issue for women in social work is client violence perpetrated against social workers. Newhill (1996) found gender to be a risk factor in client violence, and other studies have documented client threats or physical violence directed toward social workers (Spencer & Munch, 2003). A study of licensed social workers found that 44 percent reported facing personal safety issues on the job (Whitaker, Weismiller, & Clark, 2006), although of those who did, 70 percent noted that the safety risks were adequately addressed by their employers.

Women in Social Work Education

Women are the majority of students and faculty at social work institutions of education. For example, 88.9 percent of students awarded BSW degrees, 86.3 percent of students awarded MSW degrees, and 76.5 percent of students awarded PhD degrees in 2012 were women (CSWE, 2013). The graduates were taught primarily by female professors: 69.8 percent of full-time professors and 72.2 percent of part-time professors were female. Although the female professors were not identified by race, among all full-time faculty 68.1 percent were white, 14.8 percent African American, 5.7 percent Latino, 5.9 percent Asian American, and 1.8 percent Native American or Pacific Islander (CSWE, 2013). Therefore, although female faculty is well represented, women of color faculty are less so. A study by Sakamoto, Anastas, McPhail, and Colarossi (2008) assessed female faculty in social work education and found that gender differences remained, with women disadvantaged in terms of pay, rank, job duties, and tenure when compared with their male colleagues.

Curricular content on women had to be mandated for inclusion in social work education in 1977 (Bentley, Valentine, & Haskett, 1999), and evidence suggests that it still is not fully integrated in the social work curriculum (Figueira-McDonough, Netting, & Nichols-Casebolt, 1998). To more fully integrate gender in the curriculum, Nichols-Casebolt, Figueira-McDonough, and Netting (2000) suggested assessing both the school's resources and values to plan an effective change strategy that matches appropriate tactics with the school's culture. In addition, although the majority of social workers and social work clients are female, traditional male-model theories continue to be taught (that is, Freud, Erikson, and Piaget) instead of newer theories that take into account female growth and development and the structural issues that negatively affect women. In 2008, the *Journal of Social Work Education* published a special section on the role and status of women in social work education. This section discussed the disparities in promotion, rank, and salaries, related to gender, race, and sexual orientation (Bent-Goodley & Sarnoff, 2008). It also included an article by McPhail (2008), who presented ways in which topics on gender, including men and masculinity, can be incorporated into the social work curriculum.

Women of color in the profession who are educators often experience issues of marginalization, racism, and duality—classic themes in the literature on cultural diversity and oppression (Vakalahi et al., 2007). The complexities of intersectionality for these women cannot be dismissed (McCall, 2007; Vakalahi & Starks, 2010).

Men in the Profession

Although it might be ironic to talk about men in a policy statement titled “Women in the Social Work Profession,” men are an important part of the human family and this profession. In fact, for future policy statements it might be more helpful to title this section “Gender in the Social Work Profession.” As previously mentioned, men comprise about 20 percent of social workers, and the number seems to be decreasing as men age out of the profession (Schilling, Morrish, & Liu, 2008), although since they receive greater pay and benefit from the glass escalator effect; “in this sense, ‘under-represented’ does not mean ‘disadvantaged’” (Schilling et al., 2008, p. 113).

An interesting trend in the profession is that social workers nearing retirement age are substantially more likely than younger social workers to be men (CFWS, 2006b). Social work does not seem to be drawing young men into the profession and is becoming even more of a female-majority profession as older male social workers age out of the workforce. Men in social work also vary by race: 85 percent are white, 8 percent are African American, 5 percent are Latino, and 2 percent are “other” (CFWS, 2006b).

At different times in social work’s history men have often been strategically recruited to bring power and prestige to the profession, which was deemed to be lacking these characteristics as a female-majority occupation (Vandiver, 1980). However, there might be additional reasons to recruit men into the profession without diminishing the work and status of women. One study found that more than half (51 percent) of social workers reported that women make up 50 percent or less of the clients in their caseloads (CFWS, 2006a). Schilling and colleagues (2008) suggested that a more balanced gender representation in the profession “will help social work to serve a diverse client base, carry out its multifaceted missions, and prosper as a profession” (p. 113). However, such actions should be undertaken with caution. Fahlgren (2013) found that when a gender numerical balance is attempted in social work it can have unintended consequences, such as making men in social work a coveted commodity with increased value, rendering female social workers and femininity a problem or shortcoming, and granting men privileges, which reproduces a gendered hierarchy. Pease (2011) rejected the notion of bringing more men into social work to serve as role models, diversify the profession, or increase professional status and prestige. Instead, he argued that men entering social work should adopt a profeminist stance to better address male privilege and challenge gender inequity and patriarchy, both in the profession and the wider world (Pease, 2011).

Summary

It may seem ironic that a profession often termed “female-dominated” would need a policy statement on the status of women in the profession, but such a statement is necessary. Although some of the greatest social reformers have been women, the personal and structural sexism and discrimination that women face in the larger society exists in the profession as well. Rather than being an exception to the systemic discrimination women face in the world, the social work profession is a microcosm of that world.

This state of affairs may be invisible to many within and outside the social work profession for several reasons (McPhail, 2004). First, the fact that historically women have played an important role in the profession and are frequently (and naïvely) credited with founding the profession may cause some to overlook the subordinate status of women within this field. The fact that women comprise the numerical majority of social workers often conceals the power imbalance in the profession. In addition, the semantics of calling a profession femaledominated or a “women’s profession” can distract or disguise the second-class status of women in this field.

The information provided in this policy statement systematically makes the case that women do not dominate the profession and, in fact, often receive less than men in terms of salary, prestige, position, and time spent on women's issues in the social work curriculum. Although the profession has taken helpful and effective steps to document and address some of these inequities, such as NASW's affirmative action stance that places women in leadership positions in proportion to their numbers among the membership, much work remains to be done.

Some might describe the present time period "post-patriarchal" or "post-feminist." However, the research findings presented here challenge such a characterization. Although gains have been made and can be celebrated, social workers must continue to examine and document the status of women in the profession and seek new, innovative ways to support women. Such a stance is necessary, fair, and can be accomplished without blaming or denigrating men.

Some social workers might believe that the focus on women in the profession is misplaced and constitutes a distraction from work with clients. A helpful metaphor to address this potential concern is the preflight emergency instructions given by flight attendants to passengers who are traveling by plane with small children or those needing additional assistance. Passengers are advised to first put on their own oxygen mask before assisting others. Similarly, if female social workers do not advocate for and empower themselves by confronting sexism and discrimination in their professional lives, it is hard (and hypocritical) to teach those skills and strategies to female clients operating in the larger world. The health and well-being of social work clients should not come at the expense of female social workers.

Although women have made great strides, the successes have been uneven. For instance, although some structural barriers have fallen in the public realm, women struggle with inequality in the home, which affects their lives at work. In addition, although some institutions have changed to accommodate women in the workforce, the underlying institutional structures, theoretical models, and work requirements continue to be imbued with a subtle, and not so subtle, bias that privileges men. The mixed messages women receive and the multiple roles they are expected to play have profound consequences for both female social workers and their clients. In addition, the gains that have been achieved often benefit women differently based on their race, ethnicity, sexual identity, socioeconomic status, caregiving roles, and level of ability.

POLICY STATEMENT

NASW has actively responded to the issues that negatively affect women in the social work profession—in the workplace, in social work education, and in program development and design. According to the *Code of Ethics of the National Association of Social Workers* (NASW, 2008), social workers should act to prevent and eliminate discrimination in organizations and in society. In 1973 NASW adopted a policy to address sexism and sex discrimination in the profession and in society. An affirmative action plan was initiated to ensure that NASW leadership would reflect the racial and gender composition of the membership and that women and people of color would have equal employment opportunities at NASW.

In 1975 the National Committee on Women's Issues became a standing committee of NASW to encourage and monitor activities aimed at the elimination of sexism in the association, the profession, and society. The following year NASW's journal *Social Work* published a special issue on women; in 1977 the NASW Delegate Assembly adopted a policy statement on women's issues; in 1980 the first NASW Conference on Social Work Practice with Women was held. In 1987 the Delegate Assembly revised the policy statement on women's issues to express a commitment to increase women's leadership in professional organizations and social services agencies and to ensure equal pay for men and women with similar qualifications and responsibilities. The 1993 Delegate Assembly approved a resolution titled "NASW Personnel Policies on Sexual Harassment" that addressed the need for educational materials, personnel policies, and procedures to protect NASW employees and social workers from sexual harassment. The NASW *Standards for Social Work Personnel Practices* (NASW, 2003) addressed discriminatory hiring and personnel actions, comparable worth, and employer's support of the family responsibilities of care-givers. In 2004 NASW established the NASW CFWS to conduct studies on the current social work labor force, to enhance social work professional development through training, and to disseminate timely information and resources on evidence-based practice. The first purpose is especially helpful in documenting gender differences and issues with women in the social work profession. NASW has made progress in addressing these issues within the organization and the larger society; however, much work remains to be done.

Therefore, NASW supports the following:

- continued attention to and documentation of the status of women in the social work profession, both within and outside of social work academia, including disparities faced by sub-populations of women because of race, ethnicity, disability, and sexual identity, focusing on but not limited to pay inequities, leadership and tenure track positions, sexual harassment, gender inclusion in the curriculum, publication rates in professional journals, disparities in receipt of research funding, and the work– family conflict
- educating social work students about stereotype threat and unconscious bias, providing access to role models about what women in social work can achieve, changing employment systems to recognize the work of women, and encouraging mentors and supervisors to be optimistic about the full range of women's abilities (Anastas, 2007)
- encouraging higher and more competitive salaries for the nonprofit sectors (Faulk et al., 2012)
- creating enhanced efforts to ensure nondiscriminatory hiring and pay practices, better training and career counseling, improved family–work supports, and raising the minimum wage (Hegewisch & Hudiburg, 2014)
- recruiting and retaining social workers with a focus on targeting recruitment within diverse communities to keep pace with the demographic composition of the United States; recruiting social work candidates earlier in their careers; focusing on retaining social workers by addressing issues of safety and increased support; and improving agency environments and needs for professional growth, respect, and fair compensation (Whitaker et al., 2006)
- educating employers and employees on the motherhood penalty to raise awareness and overcome the bias

- identifying and overcoming barriers to the advancement of women in social work by addressing the oppressive cultures of the organizations in which they work while assisting female social workers in removing internal and external obstacles (for example, teaching female social work students job negotiation, confidence building, and assertiveness skills; establishing support and networking groups for women planning a managerial career; challenging internalized restrictive gender-role stereotypes; increasing financial management training for women, including financial statement analysis and budget development; educating social workers about pay inequities in the profession; teaching women about legal remedies such as filing a claim with the Equal Employment Opportunity Commission; using the accreditation process to hold schools accountable for inadequate attention to women's issues; continuing to develop mentoring programs for women starting early in their careers; and increasing union membership and the use of comparable worth policies as a way to increase women's salaries)
- adopting and teaching nonoppressive leadership styles to male and female social work administrators that more congruently fit both social work values and (some) women's preferred style of interactional leadership
- holding institutions and systems accountable for gender responsive initiatives and support to women in the profession; creating a multilevel approach within these systems that is transformative
- continuing use of affirmative action programs inside and outside NASW as an effective tool for the advancement of women and other marginalized groups, and countering the current backlash and premature curtailing of such programs across the nation; addressing issues specific to women of color and women who identify as gay, lesbian, transgender, bisexual, or another sexual identity
- expanding practices to benefit both women and men with work–life integration, which would include flexible work hours and location (telecommuting), paid family leave, eliminating workplace discrimination, reducing the paid work week, creating more part-time jobs and equalizing social security for spouses, extended tenure track time for adopting or having children, paid maternity and paternity leave, offering work-related social insurance programs to all workers (including

unwaged caregivers), universal preschool for all three- and four-year-olds, subsidized child care, child allowances, and health care coverage to all children and their primary caregivers

- creating organizational cultures that value employees' families, creating family-supportive policies that can be used without negative consequences, and providing job conditions and work structures that promote work and family well-being (Kalliath et al., 2012)
- educating social work students who will work with violence survivors in STS and PTSD, including coping strategies such as balancing trauma work with other work-related activities, using healthy coping mechanisms such as seeking emotional support, stress reduction methods, positively reframing the situation, emotionally separating from clients lives, and maintaining good boundaries (Choi, 2011); teaching the importance of self-care throughout one's social work career
- demonstrating the viability of an identity as a feminist social worker (Valentich, 2011); keeping feminist social work critique, scholarship, and activism alive while employing a postcolonial feminist perspective (Gray & Boddy, 2010); increasing the use of intersectional frameworks in social work education with regard to diversity issues, globalization, feminist practice, and social justice (Mehrotra, 2010)
- reducing social worker job-related stress by providing more time to complete day-to-day work tasks, decreasing workloads and caseloads, providing clear job expectations, offering more resources, and increasing compensation while training social workers in helpful coping strategies like exercise, meditation and relaxation techniques, and therapy (Arrington, 2008)
- policies and procedures designed to eliminate violence and sexual harassment at social work agencies and educational institutions and research to document the extent of these problems and the outcomes of educational and intervention efforts
- lobbying for federal and state legislation that supports women in the workforce in general and female social workers in particular, including these bills currently before Congress: the Paycheck Fairness Act (S. 84, introduced by senator and social worker Barbara Mikulski on January 23, 2013), the Healthy Families Act (H.R. 1286, introduced by Representative Rosa DeLauro on March 20, 2013), Family and Medical

Leave Inclusion Act (H.R. 1751m introduced by Representative Carolyn Maloney on April 25, 2013), Part-Time Worker Bill of Rights Act of 2013 (H.R. 675, by Representative Jan Schakowsky on February 13, 2013), Parental Bereavement Act of 2013 (S. 266, introduced by Senator Jon Tester on February 4, 2013), and the Family Friendly and Workplace Flexibility Act (S. 1626, introduced by Senator Mitch McConnell on October 30, 2013)

- working for the advancement of women in academia: setting goals and strategies and specific, objective, and quantifiable targets for the proportional representation of women at each academic rank and strengthening the function of accreditation review to enforce remedial measures (Petchers 1996); DiNitto, Aguilar, Franklin, and Jordan (1995) recommended greater value placed on qualitative research, teaching, and service; adequate representation of women on promotion and tenure committees and male faculty taking greater responsibility for organizational tasks
- cautiously and strategically increasing the number of men in social work who represent a profeminist view and are willing to address their male privilege and work to end gender inequity inside and outside of the social work profession
- renewing commitment to teaching the history, policy, and practice of feminism in social work and how that work continues today (Brown, Western, & Pascal, 2013; FredriksenGoldsen et al., 2009; Gray & Boddy, 2010; Gringeri & Roche, 2010; Gringeri, Wahab, & Anderson-Nathe, 2010; Kemp & Brandwein, 2010; Valentich, 2011), including using more theories and evidence-based practices that apply specifically to women and a gender lens (McPhail, 2008) as well as employing feminist policy analysis (McPhail, 2003)
- recommitting to using intersectional approaches to address how gender interacts with oppressions based on race, sexual identity, and class (Nagoshi & Brzuzy, 2010; Pulliam & Mott, 2010), while also examining the intersections of globalization and gender oppression (Finn, Perry, & Karandikar, 2013), which also draws on postcolonial and transnational interdisciplinary approaches (Mehrotra, 2010)
- conducting research that more fully examines the reasons for pay and position inequities in social work to better address them.

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Women’s Issues

ISSUE STATEMENT

Throughout history, with rare exceptions, women have been relegated to second-class status, their lives controlled, regulated, and limited by male-dominated systems, often termed the patriarchy. In the United States, Native American women suffered genocide and African American women endured slavery. In addition, women were denied the right to vote, attend school, own property, keep their wages, or obtain custody of their children. Although gains have been realized, largely because of the first, second, and now third waves of the women’s movement, much work remains to be done. There is a measure of water in the glass, although some might view it as half empty and others as half full. Documentation of the current status of women and girls through quantitative evidence builds a case for the social work profession to continue to monitor women’s issues and progress (or lack thereof), with a special focus on unique populations of women who are disparately affected by discrimination as a result of the intersecting oppressions of race or ethnicity, sexual orientation and gender identity, citizenship status, disability, socioeconomic status (SES), or religious affiliation. Although women constitute a slight majority of people in the United States, with 158.3 million women representing 51 percent of the population in 2011 (U.S. Census Bureau, 2013a), the following statistics illustrate the continued disparity between women and men:

- A gender gap in earnings exists between men and women. Median weekly earnings for women employed in full-time work were $37,800, compared with $49,400 earned by men, a 76.5 percent female-to-male earnings ratio (U.S. Census Bureau, 2013b). Women across all racial and ethnic groups earn less than their male counterparts and less than white men, who are the standard due to their higher wages (Institute for Women’s Policy Research [IWPR], 2014). For instance, Latina women earn only 61.2 percent of white men’s median weekly earnings, but 91.1 percent of the median weekly earnings of Latino men, because Latino men also have comparatively low earnings. African American women earn only 68.6 percent of white men’s earnings, but 91.3 percent of black men’s earnings, which are also fairly low. Asian women’s earnings are 92.6 percent of white men’s earnings, but only 73.3 percent of Asian men’s earnings.

- Women who are mothers face discrimination in the workforce, an outcome often termed the “motherhood penalty.” For instance, one study found that mothers were not only less likely to be hired, but they faced a lower salary than other applicants. Mothers were judged as less competent and committed than women without children, and the recommended starting salary was $11,000 less than that offered to nonmother applicants (Correll, Benard, & Paik, 2007).
- Women are more likely to live in poverty than men. Among women ages 18 to 64, the poverty rate was 3.5 times higher compared with men (National Women’s Law Center [NWLC], 2013). More than one in seven women is poor. Women of color are more likely to experience poverty compared with white, non-Hispanic women (10.3 percent). Over a quarter of black (25.1 percent) and Hispanic (24.8 percent) women and one out of three Native American (34.4 percent) women live below the poverty line (NWLC, 2013).
- Women are still not represented in elected government positions in proportion to their numbers in the population. For example, in 2014 women held 18.5 percent of the total seats in the U.S. Congress, including 20 Senate seats and 79 of the 435 (18.2 percent) seats in the U.S. House of Representatives (Center for American Women and Politics, 2014).
- Women are still hitting the glass ceiling, which prevents advancement into higher positions within the corporate and nonprofit worlds. For instance, Catalyst (2014) found that although 46.8 percent of U.S. women are in the labor force, only 14.6 percent are executive officers, only 16.9 percent are on company boards, only 8.1 percent are top earners, and only 4.8 percent are CEOs. The pattern for nonprofit organizations is the same, with fewer women in leadership positions and

those who are paid less than their male counterparts (Joslyn & Switzer, 2014).

- The status of women in the area of educational attainment shows substantial progress over the years. In 1978, for the first time, more women were enrolled in undergraduate education in both two- and four-year degree-granting institutions than men (31.4 million versus 30 million, respectively) (U.S. Department of Education, National Center for Education Statistics, 2004). That trend continues today, with women's undergraduate enrollment increasing at a faster pace than men's (U.S. Census Bureau, 2013a). Although the majority (55 percent) of college students are women, they remain under-represented in science, technology, engineering, and mathematics (STEM) fields. In 2008, women earned 43.9 percent of bachelor's degrees in mathematics, 20.2 percent of physics degrees, 17.7 percent of computer science degrees, and 17.5 percent of engineering degrees (American Association of University Women [AAUW], 2013a). Also, even though women graduate in greater numbers than men from college, women one year out of college working full-time were paid on average just 82 percent of what their male counterparts were paid (AAUW, 2013b).
- Violence against women remains a continuing problem that affects all women, regardless of race, sexual identity, SES, or other identifying characteristic. More than one out of four (28 percent) women experience physical violence, rape, or stalking (Black et al., 2011), with women of color at even higher risk (White House Council on Women and Girls, 2014). One out of five women on a college campus experiences a sexual assault (White House Council on Women and Girls, 2014). Women continue to represent the majority of people victimized through intimate partner violence (Black et al., 2011). Of those who are killed by an intimate partner, women are the majority, with African American women being at particular risk of homicide as a result of domestic violence (Bent-Goodley, 2011; Violence Policy Center, 2010).
- Although women's health issues have received increased attention in the past decades, women continue to face unique health risks. The Patient Protection and Affordable Care Act (ACA) of 2010 (P.L. 111-148) expanded women's access to coverage and broadened health benefits, although some of these benefits, such as access to contraceptives, are

being challenged in court by employers who claim religious exemptions. Heart disease kills more women than men each year, even though, on average, women develop the disease 10 years later than men (Society for Women’s Health Research, 2010). Women are two to three times more likely than men to suffer from depression. Female smoking is more likely to have a negative effect on cardiovascular health than male smoking. Women are two times more likely than men to contract a sexually transmitted disease. Women represent one out of four people with HIV, with the majority (84 percent) being infected through heterosexual contact (Centers for Disease Control and Prevention [CDC], Division of HIV/ AIDS Prevention, 2013). Women of color are disproportionately affected, with black women being 20 times and Latinas being four times more likely than white women to become infected (CDC, 2013). More than 17 million women lack health insurance, which is nearly one out of five women (U.S. Department of Health and Human Services [HHS], Office on Women’s Health, 2007).

- The trafficking in persons, also termed modern-day slavery, is gaining greater attention in the United States and globally as a serious human rights concern. According to the Congressional Research Service (Siskin & Wyler, 2013), the United States is a source, transit, and destination country for trafficking in persons. Trafficking occurs both across international borders and within the United States (the latter is termed internal or domestic trafficking), for both labor and sex work. As many as 17,500 people are estimated to be trafficked into the United States each year. Research indicates that most of the victims of sex trafficking into and within the United States are women and children.
- Almost half (49 percent) of all pregnancies among U.S. women are unintended (Finer & Zolna, 2011). The percentage of unintended pregnancies that end in abortion has decreased from 47 percent in 2001 to 43 percent in 2006 (Finer & Zolna, 2011). However, there continue to be concerted efforts to regulate and restrict legal abortion at the state and federal levels, including prohibiting federal funding of abortion unless the mother’s life is in danger; expanding definitions of personhood to include fetal life, which construes some forms of contraception as abortifacients; and adding numerous state regulations, such as mandated waiting periods, restriction of access to minors, and restrictions on the inclusion of abortion and family planning coverage in insurance plans

(Guttmacher Institute, 2014). Many women consider the right to control their bodies as fundamental to their rights as free citizens in a democratic nation. This statement exemplifies NASW's belief that women's rights are human rights and that women have the right to self-determination. The issue is also about health and safety, as risks to women are significantly reduced when abortion remains legal and accessible (IWPR, 2003).

- Globalization is also a women's issue, especially with a focus on gender oppression around the world. Finn, Perry, and Karandikar (2013) summarized the global condition of women by noting that girls are still less likely to go to schools than boys, women and children make up two-thirds of the world's 1 billion people living on less than a dollar a day, and the mass rape of women and girls is often used as an instrument of war. Women constitute a majority of the U.S. population and clients that social workers serve. Attention to women's issues is essential because of the disadvantages and discrimination women continue to face in many aspects of their lives. Although women in the more prosperous Western nations often fare better in life circumstances than women in many of the less wealthy nations of the world, economic, political, social, and cultural forces in most societies operate to the disadvantage of women and girls. These disadvantages affect education; health care, including reproductive and mental health; crime, especially as victims of violence; employment; and social welfare, especially income maintenance programs. These disadvantages affect the well-being of women and their families at all stages of the life cycle, from girlhood through old age.

The social work profession has a long-standing commitment to the elimination of all forms of discrimination against women. Many efforts have been made to address the disadvantages and discrimination women face. However, continuing efforts to develop social work practices, policies, and services that better meet the needs of women are essential for enhancing the health, development, and well-being of all women, especially our clients and others at risk.

The social work profession's continued leadership in the struggle for women's increased opportunities is essential. Social work is often mischaracterized as a "female-dominated profession," when the profession is more appropriately described as a "female majority, male-dominated profession” (McPhail, 2004). Although the majority of both social workers and social work clients are female, the underlying structures and functions of the profession are often based on male models and theories.

The social work profession values social justice and ending the oppression of all people as articulated in the *Code of Ethics of the National Association of Social Workers* (NASW, 2008), which incorporates an antidiscrimination clause that includes the category of sex. Furthermore, the code states that “social workers should act to prevent and eliminate domination of, exploitation of, and discrimination against any person, group, or class on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability” (NASW, 2008, p. 27). Part of operationalizing this mandate is continuing to monitor and document the status of women and seeking to develop and influence policy and practices that improve the status of women and girls in this society.

Because different groups of women experience their gender differently and often in interaction with other oppressions, a concept known as intersectionality (Crenshaw, 2003), special attention must be devoted to women of color, lesbians, bisexual women, trans women, women with disabilities, older women, immigrant women, and poor women. Crenshaw (2003) noted that these intersecting oppressions are not just additive, but interactive and multiplicative. The intersection is a metaphor where routes of power, such as gender, race, age, class, ability, and sexual identity, are the thoroughfares and traffic is the activity of discrimination.

Although women are gaining parity with men in selected areas, often achieving liberal feminist goals of incremental change, the goal of changing structures and institutions to make them more equitable for both women and men, rather than merely having women join fundamentally flawed institutions in equal numbers as men, has not been realized (Bent-Goodley & Sarnoff, 2008). Although women have gained some measure of equity in the public sphere, the private sphere remains largely unchanged. Therefore, social work needs to continue to monitor, assess, educate, and advocate for women’s issues in policy and practice.

POLICY STATEMENT

NASW recognizes the wide range of issues that affect women and is committed to advancing policies and practices to improve the status and well-being of all women. Often “women’s issues” are limited to reproductive rights and breast cancer; however, almost every issue is a women’s issue that requires an intersectional gender lens. For instance, raising the minimum wage is rarely viewed as a “women’s issue,” but consider these facts: About two-thirds of minimum wage workers are women. If the minimum wage were substantially raised, a mother with two children would earn enough to pull herself and her two children out of poverty. With this in mind, raising the minimum wage becomes a women’s issue (NWLC, 2014). Similarly, immigration is not really seen as a traditional women’s issue, but because women constitute 51 percent of the people migrating to the United States, approximately 60 percent of undocumented women are in the labor force, and 5,600 children are in foster care because both parents were deported, immigration is also a women’s issue (Miller, 2013).

Rather than focusing on specific issues, which are too numerous to be comprehensively or completely covered within this document, it is vital to develop a critical consciousness about gender (Brown, 2004) or use a gender lens, including a feminist or womanist policy analysis (Borum, 2012; McPhail, 2003), that enables the ramifications of gender to be made visible in every issue, policy, and practice, at all three levels—micro, mezzo, and macro.

Employment

NASW supports the following:

- advocating for legislative and administrative strategies that address pay equity, paid sick leave, workplace policy addressing violence, caregivers workplace discrimination, and comparable worth initiatives for increasing women’s wages in both the public and private sectors—including addressing the pay inequities within the profession of social work (Koeske & Krowinski, 2004)

- breaking the “glass ceiling” and the “Lucite ceiling” for women of color (the *glass ceiling* is the invisible barrier that keeps women from rising to the highest career positions; the Lucite ceiling refers to the fact that the glass ceiling is even harder for women of color to break through); removing the motherhood penalty that affects mothers in the paid labor force; and addressing the “glass escalator” phenomenon for men in social work (*the glass escalator* refers to the tendency for men in social work to quickly rise into administrative positions (Vakalahi, Starks, & Hendricks, 2007; Williams, 1995)
- reducing occupational segregation, which clusters women in low-paying, “pink-collar” occupations, that includes the profession of social work
- eliminating sexual harassment and violence in the workplace that is linked with women’s disadvantaged status at work and, more generally, in society (Hunt, Davidson, Fielden, & Hoel, 2007)
- empowering and improving the quality of experience of women who are employed in female-majority, low-wage occupations in the domestic, home care, child care, retail, and hospitality sectors, which in the post-recession economy are some of the fastest-growing fields, although even in those fields, women earn less (for example, women in the restaurant industry earn 83 cents to a man’s dollar; Jaffe, 2013)
- advocating for female-majority, low-wage workers’ increase in minimum wage and gaining the rights to protections that apply to other workers, such as the federal right to organize and bargain collectively, health and safety laws, workers’ compensation, rights to overtime pay, meal and rest breaks, and antidiscrimination laws (Theodore, Gutelius, & Burnham, 2013)
- recognizing and acknowledging the crucial economic value of the hidden work of women employed in such low-wage work as nannies, housecleaners, and caregivers (Theodore et al., 2013)
- supporting legislation that benefits women in low-wage, virtually unregulated, and often precarious work, for example, the nation’s first Domestic Workers’ Bill of Rights passed in 2010 in New York State, which sets minimum standards in the domestic work industry (Find-Law, 2013)

- recruitmenting, cultivating, and retaining qualified female candidates for executive and other leadership positions in business and governmental initiatives
- conceptualizing caregiving as work because 30 percent of adults, most of who are working women, annually serve as unpaid caregivers (National Alliance for Caregiving, 2009); these women should be valued socially, legally, and economically, not least because the estimated economic value of the long-term service support provided by unpaid family caregivers was $450 billion in 2009 (AARP Public Policy Institute, 2011), which is about 3.2 percent of the gross domestic product
- expanding practices to benefit both women and men with work–life integration, which could include flexible work hours and location (telecommuting), paid family leave, eliminating workplace discrimination, reducing the paid work week, creating more part-time jobs and equalizing social security for spouses, offering work-related social insurance programs to all workers (including unwaged caregivers), universal preschool for all three- and four-year-olds, subsidized child care, child allowances, and health care coverage to all children and their primary caregivers.

Public Assistance Programs

NASW supports the following:

- committing to the comprehensive funding of Temporary Assistance for Needy Families (TANF) that would address structural causes of poverty and provide temporary assistance, which would include creating stable jobs with living wages, with special attention to the inner cities; allowing education (including college) and training as alternatives to work requirements; subsidized child care and health insurance coverage while on TANF and continuing after leaving the program; transportation assistance; and addressing the multiple problems that often affect women and their children who receive assistance, such as mental and physical health issues, learning disabilities, domestic violence, and drug and alcohol abuse (Anderson, Halter, & Gryzlak, 2004; Taylor & Barusch, 2004)

- supporting full funding for the antihunger low-income programs such as Supplemental Nutrition Assistance Programs and the Women, Infants, and Children program (popularly known as SNAP and WIC, respectively)
- advocating for programs that provide enforcement, collection, and distribution of child support
- funding for initiatives for social security and Medicare reform to provide increased retirement security for women who are disproportionately poor as they age
- viewing housing as a women's issue because more women live in inadequate housing or in government-sponsored housing, and housing rights violations can affect women in gender-specific ways.

Education

NASW supports the following:

- providing adequate and equitable funding for nonsexist public education for all students, including vocational education, special education, and higher education for all women
- creating curriculums, within and outside of social work education, that include women's issues, history, and experiences within what is explicitly taught in the classroom and amplified through implicit experiences outside of the classroom (HHS, Health Resources and Services Administration, Office of Women's Health, 2013)
- increasing college assistance for low-income students through an increase in the number of Pell grants, expansion of education tax credits, strengthening community colleges, and keeping student loan interest rates low
- creating tangible support for female students and faculty entering STEM fields
- vigorous enforcement of Title IX and other civil rights laws, including affirmative action initiatives that address sexual harassment, sexual assault, and gender-based discrimination in education.

Health and Mental Health

NASW supports the following:

- continuing initiatives to reduce teenage pregnancy, because it has been demonstrated that early motherhood (whether intended or unintended) truncates the educational, vocational, and economic lives of young women
- developing adequate funding and increased research on health and mental health services and issues that address disparities in these areas for diverse populations of women, including adolescent women, poor women, women of color, lesbians, older women, and women with disabilities
- providing adequate health and mental health services regardless of financial status, race and ethnicity, age, or employment status, and supporting the ACA, which requires universal health care coverage for low-income women and their children as a first step
- developing practices and programs that empower women and girls, enabling them to resist gender stereotypes; become resilient to shame; critique sexist and misogynist media representations of women; develop positive self-esteem and body image; confront internal and external sexism, racism, and homophobia; and challenge sexual double standards so girls and women might develop the power and sense of confidence that fuels self-advocacy
- advocating for reproductive freedom and justice, which includes safe access to the full range of reproductive health services for all women, including access to abortion; over-the-counter emergency contraception; comprehensive sexual education; family planning services; education and screening for a variety of sexually transmitted diseases (STDs), including HIV, with special attention to groups of women at increased risk, such as women of color; freedom from forced sterilization; the right to be child-free; and offering drug-addicted pregnant women intervention and drug treatment rather than criminalization
- creating gender-sensitive and culturally competent programs that ensure access to care; culturally specific engagement, intervention, and evaluation strategies; and advocacy for policies and practices that

promote equity and competence for diverse groups of women and girls and critiquing theories, policies, interventions, and research that may have been normed on men and are less applicable to women's realities

- participating in both prevention and intervention efforts that address all forms of violence against women across the life span, including adequate health and mental health services, crime victim assistance, and other social services, as well as educating all social workers about violence, including screening for past and current violence in all psychosocial assessments (Bent-Goodley, 2011)
- seeking out, studying, developing, and disseminating theories of psychosocial development and models of service delivery in the social work curriculum that recognize, rather than pathologize, the unique developmental patterns of women, including critiques of the gender bias in the most current edition of *Diagnostic and Statistical manual of mental Disorders* (American Psychiatric Association, 2013)
- recognizing the diversity of women's experiences, situations, cultural and ethnic identifications, and sexual orientations and gender identities.

Global Women's Issues

NASW supports the following:

- ratification by the United States of the Convention to Eliminate All Forms of Discrimination against Women (United Nations Human Rights, Office of High Commissioner for Human Rights, n.d.), an international agreement that affirms principles of fundamental human rights and equality for women and girls. The United States is one of only seven countries—including Iran, Palau, South Sudan, Somalia, Sudan, and Tonga—that have not yet ratified the convention
- recognizing transnational feminisms and international programs that address women's rights as human rights, including having women in each country define their own needs and solutions, and develop programs that meet their needs, which could include critiques of neocolonialism, imperialism, international development, capitalism, and the construction of the "third world woman"

- investing in programs and supporting policies aimed at both eradicating trafficking in persons and providing services for individuals who have been trafficked (Alvarez & Alessi, 2012)
- creating policy changes and programs that support the education of girls, who often face barriers to education that boys do not; research indicates that educating girls can break cycles of poverty and reduce maternal mortality and the incidence of STDs (United Nations Population Fund, 2005)
- promoting international efforts for the participation of women in the prevention and resolution of conflicts, calling on parties involved in armed conflict to abide by international laws that protect the rights of civilian women and girls, and incorporating policies and procedures that protect women from gender-based crimes such as sexual assault (UN Women, 2013)
- calling on social work educators to include topics of globalization and gender oppression in their course work, which may include developing a critical consciousness about privileges from being in the Global North, decentering the United States' place on the world stage, and a focus on transnationalism, colonialism, decolonization, immigration policy, international social work and field placement, international aid and development, and indigenous knowledge (Sakamoto, 2013).

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Workplace Discrimination

ISSUE STATEMENT

Employment serves as a major vehicle for the distribution of income and most other essential material social benefits, such as health insurance, public and private retirement plans, and disability insurance, as well as many non-material benefits, such as status and prestige. Because of the inherent power associated with employment, it is essential that NASW continues to work to end discrimination in the workplace and to enhance access to gainful employment for all.

Discriminatory workplace policies and practices limit opportunities for job attainment, career mobility, and equal participation in organizational leadership. These forms of discrimination interact with wage discrimination to negatively affect lifetime earnings, benefits, occupations, and personal and household income.

Discrimination—unequal treatment of persons, for a reason that has nothing to do with legal rights or ability (Law.com, n.d.)—continues to be pervasive in modern American life. The social work profession has long been concerned with working to eliminate discrimination in all forms. This commitment is embodied in the *Code of Ethics of the National Association of Social Workers* (NASW, 2008) and informs the major policies that NASW supports. Discrimination based on age, race, ethnicity, gender, sexual orientation, gender identity, religion, national origin, immigrant status, disability, and other axes of difference has a significant and pernicious impact on the lives of the clients that the social work profession serves as well as on the members of the social work profession themselves.

Discrimination unduly affects a variety of employable citizens in the workplace. Discrimination can occur at every stage of the employment process, from interviewing, hiring, training, promotion, and compensation to retention and separation. The U.S. Equal Employment Opportunity

Commission (EEOC), created in 1964, enforces statutes that make it illegal to discriminate against employees or applicants for employment on the basis of race, color, religion, sex, national origin, disability, or age. It also provides federal protections from discrimination on other bases, including status as a parent, marital status, political affiliation, and conduct that does not adversely affect the performance of the employee.

Far too many people confront difficulty in their quests to realize their career goals and support themselves financially. In the first decade of the new millennium, there were nearly 150,000 charges of sexual harassment filed with the EEOC and the state and local Fair Employment Practices agencies across the country (EEOC, n.d.-c). In 2012, nearly 100,000 complaints of discrimination were filed with the EEOC (n.d.-b), and complainants received more than $365 million in monetary benefits (EEOC, n.d.-a). That same year, charges of discrimination based on race accounted for 33.7 percent of all complaints filed with the EEOC, followed by charges of discrimination based on gender (30.5 percent), disability (26.5 percent), and age (23 percent) (EEOC, n.d.-c). Complaints were also filed on the basis of national origin (10.9 percent), religion (3.8 percent), color (2.7 percent), and compensation (1.1 percent) (EEOC, n.d.-c). In addition, 208 cases were filed with the EEOC charging discrimination based on genetic information (EEOC, n.d.-c). New manifestations of discriminatory behavior based on appearance (Muhajan, 2007), body size (Judge & Cable, 2011; Puhl, Andreyeva, & Brownell, 2008), credit worthiness (“Credit History Discrimination,” 2013; Traub, 2012), criminal records (Natividad Rodriguez & Emsellem, 2011), and employment status (Krueger, Cramer, & Cho, 2014), are also being reported in the workplace. In addition, verbal slurs, graffiti, bullying, sexual harassment, and other forms of offensive conduct have become more pervasive in the workplace and are often rooted in prejudices against people based on differences (Sallee & Diaz, 2012; Workplace Bullying Institute, 2010).

Despite federal and state civil rights legislation, affirmative action programs, and other legislative and policy efforts to reduce these differences in the past several decades, workplace discrimination persists.

POLICY STATEMENT

Given the persistence and pervasiveness of workplace discrimination, NASW supports

- enforcement of all laws and regulations that forbid discrimination in the workplace, including adequate funding for the federal and state agencies charged with the enforcement of civil rights and antidiscrimination laws and regulations, such as the EEOC
- workers' efforts to organize as a means to promote progressive employment policies and address employment discrimination
- federal and state legislative measures that aim to eliminate discrimination in employment, training, compensation, and job-related benefits
- public and private affirmative action programs that aim to ensure that people from historically oppressed populations, including women, have access to employment, opportunities for advancement, nondiscriminatory working conditions, and fair compensation
- federal and state measures that promote and protect legal employment opportunities for immigrants and undocumented workers
- human and civil rights measures and legislation to protect all Americans, including lesbian, gay, bisexual, transgender, and intersex people from discrimination in the workplace
- adoption of federal and state measures that prohibit discrimination based on sexual orientation, gender identity, reproductive health behavior, and marital or family status
- compliance with Americans with Disabilities Act of 1990 (P.L. 101-336) regulations to ensure that people with disabilities have equal access to employment, promotion, and job satisfaction
- equal opportunities for all people to access and complete their education in nondiscriminatory and nonhostile environments to further full participation in the workforce
- maintenance and expansion of the social safety net and work supports (for example, child care subsidies, universal health care, paid parental or caregiver leave, and so on) that promote full access to and participation in the workforce
- adoption of federal and state measures that prohibit discrimination based on reproductive choices

- adoption of the Equal Rights Amendment
- reforming the process of criminal background checks to facilitate fairer access to employment opportunities.

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Youth Suicide

ISSUE STATEMENT

Individuals, families, and communities are seriously and permanently affected by the harmful effects of suicide. These effects are particularly tragic when young people take their own lives. Each year, nearly 5,000 young people lose their lives to suicide. For youths between the ages of 10 and 24, suicide is the third leading cause of death (Centers for Disease Control & Prevention [CDC], 2014). In 2011, the rate of youth suicide was 7.8 per 100,000 (Child Trends, 2014). When compared with girls of the same age, boys between the ages of 15 and 19 were four times more likely to die from suicide, whereas teenage girls were twice as likely to attempt suicide (Child Trends, 2014). Lesbian, gay, and bisexual (LGB) youths have a higher risk of suicidal behavior than heterosexual youths, and that risk may extend to transgender (T) youths (Suicide Prevention Resource Center [SPRC], 2008). Youths in foster care or in shelters may also be at an increased risk for suicidal behaviors (U.S. Department of Health and Human Services [HHS], Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012). A recent study estimated that 40 percent of youths in shelters were LGBT (Durso & Gates, 2012)

However, the number of deaths does not accurately represent the full scope of the problem. In addition to fatalities, approximately 157,000 young people receive medical care for self-inflicted injuries at hospital emergency rooms across the nation (CDC, 2014).

Just as in adult suicide, the causation of youth suicide is complex, multidetermined, and reflects an interaction of risk and protective factors (Berman, Jobes, & Silverman, 2005). Factors that can increase a young person’s risk of suicide include mood disorders, stressful life events, low levels of communication with parents, family history of suicide, previous suicide attempts, access to lethal methods, incarceration, exposure to the suicidal behavior of others, stigma, and discrimination, including public policies that limit schools from discussing LGBT issues (American Foundation for Suicide Prevention, n.d.; CDC, 2014; Child Trends, 2014; SPRC, 2008; Williams Institute, University of California School of Law, 2011). LGBT youths generally face more risk factors, more severe risk factors, and fewer protective factors than heterosexual youths (SPRC, 2008).

In addition to the assessment of suicide risk factors, it is critical to recognize the protective factors that mitigate risk. Protective factors for youths include family cohesion, religiosity, access to behavioral health services, skills in problem solving and conflict resolution, reduced access to firearms, safe schools, academic achievement, and self-esteem (American Association of Suicidology, n.d.; Gould, Greenberg, Velting, & Shaffer, 2003; NASW, 2008).

Youth suicide prevention strategies can occur in a number of settings and generally have one of two goals: identifying youths at risk for referral and reducing risk factors (Gould et al., 2003). Prevention strategies can be school-based and include suicide awareness curriculums, skills training, screening, gatekeeper training, peer helpers, and crisis intervention/postvention (Gould et al., 2003). Community-based prevention programs include crisis centers and hot lines, restriction of firearms, and media education (Gould et al., 2003).

Few professions have as ubiquitous a presence in systems that involve children, from the family and the school to child protective agencies and the juvenile justice system, as do social workers. The National Strategy for Suicide Prevention (HHS, Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012), therefore, recognizes that the training of community gatekeepers, including social workers, must be improved to provide proper assessment, treatment, and management of youths who are at risk for suicidal behavior. Social workers are in a unique position to address the stigma associated with mental illness, substance abuse, and suicide. This stigma not only inhibits help seeking, but also has contributed to inadequate funding for preventive services and to low reimbursements for treatment (International Association for Suicide Prevention, 2013). Transforming public attitudes requires broad-based support, and the systemic approach of social work can bring community linkage skills to this critical public education need. In fact, because the community is truly at the core of many youth suicide prevention and intervention initiatives, social work networking and community organization techniques can facilitate the coordination of interorganizational communication and service delivery related to youth suicide awareness and prevention.

Social work is also in a position to contribute to the increasing body of knowledge about prevention strategies, treatment interventions, and the enhancement of protective factors that mitigate risk, especially in school and community settings. As in all social problems, the profession plays a vital role in the development of public policy that is theoretically grounded in evidence-based research and is directed toward the development of comprehensive youth suicide prevention plans.

POLICY STATEMENT

NASW recognizes youth suicide as a major public health problem. NASW will address the social and mental health issues related to youth suicide, by supporting the following:

- undergraduate, graduate, and continuing professional education about the scope of youth suicide and the current evidence-based prevention and intervention strategies
- provision of a range of education, prevention, intervention, postvention, and advocacy at the community level for families and others affected by the suicide of children and youths
- evidence-based research into the unique risk factors of ethnically, sexually, and gender-diverse youths
- involvement of social workers in the development and implementation of youth suicide awareness and prevention (including continuing education programs for and consultation services to non–mental health staff) in schools, child welfare agencies (child protection teams), juvenile detention facilities, courts, and other settings where youths may be at elevated risk

- media education, including social media, for the general public and community gate-keepers (including clergy, police, hospital personnel, emergency personnel, and recreation staff) to minimize the risk of suicide contagion and encourage the dissemination of information on mental health resources for youth suicide prevention at the community level
- interdisciplinary strategies developed in collaboration with professional associations and community agencies to decrease the stigma associated with mental illness, substance abuse, and suicide
- educational and legislative measures that restrict access of youths to firearms
- family, school, and community-based programs that enhance protective factors for families and youths
- education and collaboration with school-based personnel to assess and refer at-risk students
- development and funding of multidisciplinary research projects aimed at extending the knowledge base about youth suicide and demonstrating which interventions have proven efficacy
- legislative efforts to provide grants to state and local governments and nonprofit organizations to help develop, coordinate, and expand early intervention and prevention strategies and community mental health services for at-risk youths evaluation of the effectiveness and efficacy of youth suicide prevention and early intervention activities
- social work involvement in the development of policies, procedures, and protocols that facilitate interdisciplinary collaboration with professional associations and community agencies in the provision of education, early identification, intervention, postvention, and advocacy
- advocacy on state and local levels, to ensure an appropriate continuum of care, from least restrictive to most restrictive, is available for youths at risk of suicide.

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NASW CODE OF ETHICS

NASW Code of Ethics

PREAMBLE

The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's dual focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living.

Social workers promote social justice and social change with and on behalf of clients. "Clients" is used inclusively to refer to individuals, families, groups, organizations, and communities. Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice. These activities may be in the form of direct practice, community organizing, supervision, consultation, administration, advocacy, social and political action, policy development and implementation, education, and research and evaluation. Social workers seek to enhance the capacity of people to address their own needs. Social workers also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals' needs and social problems.

The mission of the social work profession is rooted in a set of core values. These core values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective:

- service
- social justice

- dignity and worth of the person
- importance of human relationships
- integrity
- competence.

This constellation of core values reflects what is unique to the social work profession. Core values, and the principles that flow from them, must be balanced within the context and complexity of the human experience.

PURPOSE OF THE NASW CODE OF ETHICS

Professional ethics are at the core of social work. The profession has an obligation to articulate its basic values, ethical principles, and ethical standards. The *NASW Code of Ethics* sets forth these values, principles, and standards to guide social workers' conduct. The *Code* is relevant to all social workers and social work students, regardless of their professional functions, the settings in which they work, or the populations they serve.

The *NASW Code of Ethics* serves six purposes:

1. The *Code* identifies core values on which social work's mission is based.
2. The *Code* summarizes broad ethical principles that reflect the profession's core values and establishes a set of specific ethical standards that should be used to guide social work practice.
3. The *Code* is designed to help social workers identify relevant considerations when professional obligations conflict or ethical uncertainties arise.
4. The *Code* provides ethical standards to which the general public can hold the social work profession accountable.
5. The *Code* socializes practitioners new to the field to social work's mission, values, ethical principles, and ethical standards.
6. The *Code* articulates standards that the social work profession itself can use to assess whether social workers have engaged in unethical conduct. NASW has formal procedures to adjudicate ethics complaints filed against its members.* In subscribing to this *Code*, social workers are required to cooperate in its implementation, participate in NASW

adjudication proceedings, and abide by any NASW disciplinary rulings or sanctions based on it.

The *Code* offers a set of values, principles, and standards to guide decision making and conduct when ethical issues arise. It does not provide a set of rules that prescribe how social workers should act in all situations. Specific applications of the *Code* must take into account the context in which it is being considered and the possibility of conflicts among the *Code*'s values, principles, and standards. Ethical responsibilities flow from all human relationships, from the personal and familial to the social and professional.

Furthermore, the *NASW Code of Ethics* does not specify which values, principles, and standards are most important and ought to outweigh others in instances when they conflict. Reasonable differences of opinion can and do exist among social workers with respect to the ways in which values, ethical principles, and ethical standards should be rank ordered when they conflict. Ethical decision making in a given situation must apply the informed judgment of the individual social worker and should also consider how the issues would be judged in a peer review process where the ethical standards of the profession would be applied.

Ethical decision making is a process. In situations when conflicting obligations arise, social workers may be faced with complex ethical dilemmas that have no simple answers. Social workers should take into consideration all the values, principles, and standards in this *Code* that are relevant to any situation in which ethical judgment is warranted. Social workers' decisions and actions should be consistent with the spirit as well as the letter of this *Code*.

In addition to this *Code*, there are many other sources of information about ethical thinking that may be useful. Social workers should consider ethical theory and principles generally, social work theory and research, laws, regulations, agency policies, and other relevant codes of ethics, recognizing that among codes of ethics social workers should consider the *NASW Code of Ethics* as their primary source. Social workers also should be aware of the impact on ethical decision making of their clients' and their own personal values and cultural and religious beliefs and practices. They should be aware of any conflicts between personal and professional values and deal with them responsibly. For additional guidance social workers should consult the relevant literature on professional ethics and ethical decision making and seek appropriate consultation when faced with ethical dilemmas. This may involve consultation with an agency-based or social work organization’s ethics committee, a regulatory body, knowledgeable colleagues, supervisors, or legal counsel.

Instances may arise when social workers’ ethical obligations conflict with agency policies or relevant laws or regulations. When such conflicts occur, social workers must make a responsible effort to resolve the conflict in a manner that is consistent with the values, principles, and standards expressed in this *Code*. If a reasonable resolution of the conflict does not appear possible, social workers should seek proper consultation before making a decision.

The *NASW Code of Ethics* is to be used by NASW and by individuals, agencies, organizations, and bodies (such as licensing and regulatory boards, professional liability insurance providers, courts of law, agency boards of directors, government agencies, and other professional groups) that choose to adopt it or use it as a frame of reference. Violation of standards in this *Code* does not automatically imply legal liability or violation of the law. Such determination can only be made in the context of legal and judicial proceedings. Alleged violations of the *Code* would be subject to a peer review process. Such processes are generally separate from legal or administrative procedures and insulated from legal review or proceedings to allow the profession to counsel and discipline its own members.

A code of ethics cannot guarantee ethical behavior. Moreover, a code of ethics cannot resolve all ethical issues or disputes or capture the richness and complexity involved in striving to make responsible choices within a moral community. Rather, a code of ethics sets forth values, ethical principles, and ethical standards to which professionals aspire and by which their actions can be judged. Social workers’ ethical behavior should result from their personal commitment to engage in ethical practice. The *NASW Code of Ethics* reflects the commitment of all social workers to uphold the profession’s values and to act ethically. Principles and standards must be applied by individuals of good character who discern moral questions and, in good faith, seek to make reliable ethical judgments.

With growth in the use of communication technology in various aspects of social work practice, social workers need to be aware of the unique challenges that may arise in relation to the maintenance of confidentiality, informed consent, professional boundaries, professional competence, record keeping, and other ethical considerations. In general, all ethical standards in this *Code of Ethics* are applicable to interactions, relationships, or communications whether they occur in person or with the use of technology. For the purposes of this *Code*, technology-assisted social work services include any social work services that involve the use of computers, mobile or landline telephones, tablets, video technology, or other electronic or digital technologies; this includes the use of various electronic or digital platforms, such as the Internet, online social media, chat rooms, text messaging, e-mail, and emerging digital applications. Technology-assisted social work services encompass all aspects of social work practice, including psychotherapy; individual, family, or group counseling; community organization; administration; advocacy; mediation; education; supervision; research; evaluation; and other social work services. Social workers should keep apprised of emerging technological developments that may be used in social work practice and how various ethical standards apply to them.

ETHICAL PRINCIPLES

The following broad ethical principles are based on social work's core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. These principles set forth ideals to which all social workers should aspire.

Value: *Service*

Ethical Principle: *Social workers' primary goal is to help people in need and to address social problems*

Social workers elevate service to others above self-interest. Social workers draw on their knowledge, values, and skills to help people in need and to address social problems. Social workers are encouraged to volunteer some portion of their professional skills with no expectation of significant financial return (pro bono service).

Value: *Social Justice*

Ethical Principle: *Social workers challenge social injustice.*

Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice. These activities seek to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity. Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people.

Value: *Dignity and Worth of the Person*

Ethical Principle: *Social workers respect the inherent dignity and worth of the person.*

Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients' socially responsible self-determination. Social workers seek to enhance clients' capacity and opportunity to change and to address their own needs. Social workers are cognizant of their dual responsibility to clients and to the broader society. They seek to resolve conflicts between clients' interests and the broader society's interests in a socially responsible manner consistent with the values, ethical principles, and ethical standards of the profession.

Value: *Importance of Human Relationships*

Ethical Principle: *Social workers recognize the central importance of human relationships.*

Social workers understand that relationships between and among people are an important vehicle for change. Social workers engage people as partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities.

Value: *Integrity*

Ethical Principle: *Social workers behave in a trustworthy manner.*

Social workers are continually aware of the profession's mission, values, ethical principles, and ethical standards and practice in a manner consistent with them. Social workers act honestly and responsibly and promote ethical practices on the part of the organizations with which they are affiliated.

Value: *Competence*

Ethical Principle: *Social workers practice within their areas of competence and develop and enhance their professional expertise.*

Social workers continually strive to increase their professional knowledge and skills and to apply them in practice. Social workers should aspire to contribute to the knowledge base of the profession.

ETHICAL STANDARDS

The following ethical standards are relevant to the professional activities of all social workers. These standards concern (1) social workers' ethical responsibilities to clients, (2) social workers' ethical responsibilities to colleagues, (3) social workers' ethical responsibilities in practice settings, (4) social workers' ethical responsibilities as professionals, (5) social workers' ethical responsibilities to the social work profession, and (6) social workers' ethical responsibilities to the broader society.

Some of the standards that follow are enforceable guidelines for professional conduct, and some are aspirational. The extent to which each standard is enforceable is a matter of professional judgment to be exercised by those responsible for reviewing alleged violations of ethical standards.

1. SOCIAL WORKERS’ ETHICAL RESPONSIBILITIES TO CLIENTS

1.01 Commitment to Clients

Social workers’ primary responsibility is to promote the well-being of clients. In general, clients’ interests are primary. However, social workers’ responsibility to the larger society or specific legal obligations may, on limited occasions, supersede the loyalty owed clients, and clients should be so advised. (Examples include when a social worker is required by law to report that a client has abused a child or has threatened to harm self or others.)

1.02 Self-Determination

Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients’ right to self-determination when, in the social workers’ professional judgment, clients’ actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others.

1.03 informed Consent

(a) Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients’ right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions.

(b) In instances when clients are not literate or have difficulty understanding the primary language used in the practice setting, social workers should take steps to ensure clients’ comprehension. This may include providing clients with a detailed verbal explanation or arranging for a qualified interpreter or translator whenever possible.

(c) In instances when clients lack the capacity to provide informed consent, social workers should protect clients’ interests by seeking permission from an appropriate third party, informing clients consistent with their level of understanding. In such instances social workers should seek to ensure that the third party acts in a manner consistent with clients' wishes and interests. Social workers should take reasonable steps to enhance such clients' ability to give informed consent.

(d) In instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of clients' right to refuse service.

(e) Social workers should discuss with clients the social workers' policies concerning the use of technology in the provision of professional services.

(f) Social workers who use technology to provide social work services should obtain informed consent from the individuals using these services during the initial screening or interview and prior to initiating services. Social workers should assess clients' capacity to provide informed consent and, when using technology to communicate, verify the identity and location of clients.

(g) Social workers who use technology to provide social work services should assess the clients' suitability and capacity for electronic and remote services. Social workers should consider the clients' intellectual, emotional, and physical ability to use technology to receive services and ability to understand the potential benefits, risks, and limitations of such services. If clients do not wish to use services provided through technology, social workers should help them identify alternate methods of service.

(h) Social workers should obtain clients' informed consent before making audio or video recordings of clients or permitting observation of service provision by a third party.

(i) Social workers should obtain client consent before conducting an electronic search on the client. Exceptions may arise when the search is for purposes of protecting the client or others from serious, foreseeable, and imminent harm, or for other compelling professional reasons.

1.04 Competence

(a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.

(b) Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques.

(c) When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm.

(d) Social workers who use technology in the provision of social work services should ensure that they have the necessary knowledge and skills to provide such services in a competent manner. This includes an understanding of the special communication challenges when using technology and the ability to implement strategies to address these challenges.

(e) Social workers who use technology in providing social work services should comply with the laws governing technology and social work practice in the jurisdiction in which they are regulated and located and, as applicable, in the jurisdiction in which the client is located.

1.05 Cultural Awareness and Social diversity

(a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.

(b) Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups.

(c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical ability.

(d) Social workers who provide electronic social work services should be aware of cultural and socioeconomic differences among clients and how they may use electronic technology. Social workers should assess cultural, environmental, economic, mental or physical ability, linguistic, and other issues that may affect the delivery or use of these services.

1.06 Conflicts of Interest

(a) Social workers should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. Social workers should inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary and protects clients' interests to the greatest extent possible. In some cases, protecting clients' interests may require termination of the professional relationship with proper referral of the client.

(b) Social workers should not take unfair advantage of any professional relationship or exploit others to further their personal, religious, political, or business interests.

(c) Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries. (Dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively.)

(d) When social workers provide services to two or more people who have a relationship with each other (for example, couples, family members), social workers should clarify with all parties which individuals will be considered clients and the nature of social workers' professional obligations to the various individuals who are receiving services. Social workers who anticipate a conflict of interest among the individuals receiving services or who anticipate having to perform in potentially conflicting roles (for example, when a social worker is asked to testify in a child custody dispute or divorce proceedings involving clients) should clarify their role with the parties involved and take appropriate action to minimize any conflict of interest.

(e) Social workers should avoid communication with clients using technology (such as social networking sites, online chat, e-mail, text messages, telephone, and video) for personal or non-work-related purposes.

(f) Social workers should be aware that posting personal information on professional Web sites or other media might cause boundary confusion, inappropriate dual relationships, or harm to clients.

(g) Social workers should be aware that personal affiliations may increase the likelihood that clients may discover the social worker's presence on Web sites, social media, and other forms of technology. Social workers should be aware that involvement in electronic communication with groups based on race, ethnicity, language, sexual orientation, gender identity or expression, mental or physical ability, religion, immigration status, and other personal affiliations may affect their ability to work effectively with particular clients.

(h) Social workers should avoid accepting requests from or engaging in personal relationships with clients on social networking sites or other electronic media to prevent boundary confusion, inappropriate dual relationships, or harm to clients.

1.07 Privacy and Confidentiality

(a) Social workers should respect clients' right to privacy. Social workers should not solicit private information from or about clients except for compelling professional reasons. Once private information is shared, standards of confidentiality apply.

(b) Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client.

(c) Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or others. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed.

(d) If social workers plan to disclose confidential information, they should (when feasible and to the extent possible) inform clients about the disclosure and the potential consequences prior to disclosing the information. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent.

(e) Social workers should discuss with clients and other interested parties the nature of confidentiality and limitations of clients' right to confidentiality. Social workers should review with clients circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. This discussion should occur as soon as possible in the social worker–client relationship and as needed throughout the course of the relationship.

(f) When social workers provide counseling services to families, couples, or groups, social workers should seek agreement among the parties involved concerning each individual's right to confidentiality and obligation to preserve the confidentiality of information shared by others. This agreement should include consideration of whether confidential information may be exchanged in person or electronically, among clients or with others outside of formal counseling sessions. Social workers should inform participants in family, couples, or group counseling that social workers cannot guarantee that all participants will honor such agreements.

(g) Social workers should inform clients involved in family, couples, marital, or group counseling of the social worker's, employer's, and agency's policy concerning the social worker's disclosure of confidential information among the parties involved in the counseling.

(h) Social workers should not disclose confidential information to third-party payers unless clients have authorized such disclosure.

(i) Social workers should not discuss confidential information, electronically or in person, in any setting unless privacy can be ensured. Social workers should not discuss confidential information in public or semipublic areas such as hallways, waiting rooms, elevators, and restaurants.

(j) Social workers should protect the confidentiality of clients during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders social workers to disclose confidential or privileged information without a client's consent and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection.

(k) Social workers should protect the confidentiality of clients when responding to requests from members of the media.

(l) Social workers should protect the confidentiality of clients' written and electronic records and other sensitive information. Social workers should take reasonable steps to ensure that clients' records are stored in a secure location and that clients' records are not available to others who are not authorized to have access.

(m) Social workers should take reasonable steps to protect the confidentiality of electronic communications, including information provided to clients or third parties. Social workers should use applicable safeguards (such as encryption, firewalls, and passwords) when using electronic communications such as e-mail, online posts, online chat sessions, mobile communication, and text messages.

(n) Social workers should develop and disclose policies and procedures for notifying clients of any breach of confidential information in a timely manner.

(o) In the event of unauthorized access to client records or information, including any unauthorized access to the social worker's electronic communication or storage systems, social workers should inform clients of such disclosures, consistent with applicable laws and professional standards.

(p) Social workers should develop and inform clients about their policies, consistent with prevailing social work ethical standards, on the use of electronic technology, including Internet-based search engines, to gather information about clients.

(q) Social workers should avoid searching or gathering client information electronically unless there are compelling professional reasons, and when appropriate, with the client's informed consent.

(r) Social workers should avoid posting any identifying or confidential information about clients on professional Web sites or other forms of social media.

(s) Social workers should transfer or dispose of clients' records in a manner that protects clients' confidentiality and is consistent with applicable laws governing records and social work licensure.

(t) Social workers should take reasonable precautions to protect client confidentiality in the event of the social worker's termination of practice, incapacitation, or death.

(u) Social workers should not disclose identifying information when discussing clients for teaching or training purposes unless the client has consented to disclosure of confidential information.

(v) Social workers should not disclose identifying information when discussing clients with consultants unless the client has consented to disclosure of confidential information or there is a compelling need for such disclosure.

(w) Social workers should protect the confidentiality of deceased clients consistent with the preceding standards.

1.08 Access to Records

(a) Social workers should provide clients with reasonable access to records concerning the client. Social workers who are concerned that clients' access to their records could cause serious misunderstanding or harm to the client should provide assistance in interpreting the records and consultation with the client regarding the records. Social workers should limit clients' access to their records, or portions of their records, only in exceptional circumstances when there is compelling evidence that such access would cause serious harm to the client. Both clients' requests and the rationale for withholding some or all of the record should be documented in clients' files.

(b) Social workers should develop and inform clients about their policies, consistent with prevailing social work ethical standards, on the use of technology to provide clients with access to their records.

(c) When providing clients with access to their records, social workers should take steps to protect the confidentiality of other individuals identified or discussed in such records.

1.09 Sexual Relationships

(a) Social workers should under no circumstances engage in sexual activities, inappropriate sexual communications through the use of technology or in person, or sexual contact with current clients, whether such contact is consensual or forced.

(b) Social workers should not engage in sexual activities or sexual contact with clients' relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to the client. Sexual activity or sexual contact with clients' relatives or other individuals with whom clients maintain a personal relationship has the potential to be harmful to the client and may make it difficult for the social worker and client to maintain appropriate professional boundaries. Social workers—not their clients, their clients' relatives, or other individuals with whom the client maintains a personal relationship—assume the full burden for setting clear, appropriate, and culturally sensitive boundaries.

(c) Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client. If social workers engage in conduct contrary to this prohibition or claim that an exception to this prohibition is warranted because of extraordinary circumstances, it is social workers—not their clients—who assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally.

(d) Social workers should not provide clinical services to individuals with whom they have had a prior sexual relationship. Providing clinical services to a former sexual partner has the potential to be harmful to the individual and is likely to make it difficult for the social worker and individual to maintain appropriate professional boundaries.

1.10 Physical Contact

Social workers should not engage in physical contact with clients when there is a possibility of psychological harm to the client as a result of the contact (such as cradling or caressing clients). Social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact.

1.11 Sexual Harassment

Social workers should not sexually harass clients. Sexual harassment includes sexual advances; sexual solicitation; requests for sexual favors; and other verbal, written, electronic, or physical contact of a sexual nature.

1.12 Derogatory Language

Social workers should not use derogatory language in their written, verbal, or electronic communications to or about clients. Social workers should use accurate and respectful language in all communications to and about clients.

1.13 Payment for Services

(a) When setting fees, social workers should ensure that the fees are fair, reasonable, and commensurate with the services performed. Consideration should be given to clients' ability to pay.

(b) Social workers should avoid accepting goods or services from clients as payment for professional services. Bartering arrangements, particularly involving services, create the potential for conflicts of interest, exploitation, and inappropriate boundaries in social workers' relationships with clients. Social workers should explore and may participate in bartering only in very limited circumstances when it can be demonstrated that such arrangements are an accepted practice among professionals in the local community, considered to be essential for the provision of services, negotiated without coercion, and entered into at the client's initiative and with the client's informed consent. Social workers who accept goods or services from clients as payment for professional services assume the full burden of demonstrating that this arrangement will not be detrimental to the client or the professional relationship.

(c) Social workers should not solicit a private fee or other remuneration for providing services to clients who are entitled to such available services through the social workers' employer or agency.

1.14 Clients Who Lack Decision-Making Capacity

When social workers act on behalf of clients who lack the capacity to make informed decisions, social workers should take reasonable steps to safeguard the interests and rights of those clients.

1.15 Interruption of Services

Social workers should make reasonable efforts to ensure continuity of services in the event that services are interrupted by factors such as unavailability, disruptions in electronic communication, relocation, illness, mental or physical ability, or death.

1.16 Referral for Services

(a) Social workers should refer clients to other professionals when the other professionals' specialized knowledge or expertise is needed to serve clients fully or when social workers believe that they are not being effective or making reasonable progress with clients and that other services are required.

(b) Social workers who refer clients to other professionals should take appropriate steps to facilitate an orderly transfer of responsibility. Social workers who refer clients to other professionals should disclose, with clients' consent, all pertinent information to the new service providers.

(c) Social workers are prohibited from giving or receiving payment for a referral when no professional service is provided by the referring social worker.

1.17 Termination of Services

(a) Social workers should terminate services to clients and professional relationships with them when such services and relationships are no longer required or no longer serve the clients' needs or interests.

(b) Social workers should take reasonable steps to avoid abandoning clients who are still in need of services. Social workers should withdraw services precipitously only under unusual circumstances, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects. Social workers should assist in making appropriate arrangements for continuation of services when necessary.

(c) Social workers in fee-for-service settings may terminate services to clients who are not paying an overdue balance if the financial contractual arrangements have been made clear to the client, if the client does not pose an imminent danger to self or others, and if the clinical and other consequences of the current nonpayment have been addressed and discussed with the client.

(d) Social workers should not terminate services to pursue a social, financial, or sexual relationship with a client.

(e) Social workers who anticipate the termination or interruption of services to clients should notify clients promptly and seek the transfer, referral, or continuation of services in relation to the clients' needs and preferences.

(f) Social workers who are leaving an employment setting should inform clients of appropriate options for the continuation of services and of the benefits and risks of the options.

2. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO COLLEAGUES

2.01 Respect

(a) Social workers should treat colleagues with respect and should represent accurately and fairly the qualifications, views, and obligations of colleagues.

(b) Social workers should avoid unwarranted negative criticism of colleagues in verbal, written, and electronic communications with clients or with other professionals. Unwarranted negative criticism may include demeaning comments that refer to colleagues' level of competence or to individuals' attributes such as race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical ability.

(c) Social workers should cooperate with social work colleagues and with colleagues of other professions when such cooperation serves the well-being of clients.

2.02 Confidentiality

Social workers should respect confidential information shared by colleagues in the course of their professional relationships and transactions. Social workers should ensure that such colleagues understand social workers' obligation to respect confidentiality and any exceptions related to it.

2.03 Interdisciplinary Collaboration

(a) Social workers who are members of an interdisciplinary team should participate in and contribute to decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of the social work profession. Professional and ethical obligations of the interdisciplinary team as a whole and of its individual members should be clearly established.

(b) Social workers for whom a team decision raises ethical concerns should attempt to resolve the disagreement through appropriate channels. If the disagreement cannot be resolved, social workers should pursue other avenues to address their concerns consistent with client well-being.

2.04 Disputes Involving Colleagues

(a) Social workers should not take advantage of a dispute between a colleague and an employer to obtain a position or otherwise advance the social workers' own interests.

(b) Social workers should not exploit clients in disputes with colleagues or engage clients in any inappropriate discussion of conflicts between social workers and their colleagues.

2.05 Consultation

(a) Social workers should seek the advice and counsel of colleagues whenever such consultation is in the best interests of clients.

(b) Social workers should keep themselves informed about colleagues' areas of expertise and competencies. Social workers should seek consultation only from colleagues who have demonstrated knowledge, expertise, and competence related to the subject of the consultation.

(c) When consulting with colleagues about clients, social workers should disclose the least amount of information necessary to achieve the purposes of the consultation.

2.06 Sexual Relationships

(a) Social workers who function as supervisors or educators should not engage in sexual activities or contact (including verbal, written, electronic, or physical contact) with supervisees, students, trainees, or other colleagues over whom they exercise professional authority.

(b) Social workers should avoid engaging in sexual relationships with colleagues when there is potential for a conflict of interest. Social workers who become involved in, or anticipate becoming involved in, a sexual relationship with a colleague have a duty to transfer professional responsibilities, when necessary, to avoid a conflict of interest.

2.07 Sexual Harassment

Social workers should not sexually harass supervisees, students, trainees, or colleagues. Sexual harassment includes sexual advances; sexual solicitation; requests for sexual favors; and other verbal, written, electronic, or physical contact of a sexual nature.

2.08 Impairment of Colleagues

(a) Social workers who have direct knowledge of a social work colleague's impairment that is due to personal problems, psychosocial distress, substance abuse, or mental health difficulties and that interferes with practice effectiveness should consult with that colleague when feasible and assist the colleague in taking remedial action.

(b) Social workers who believe that a social work colleague's impairment interferes with practice effectiveness and that the colleague has not taken adequate steps to address the impairment should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.

2.09 Incompetence of Colleagues

(a) Social workers who have direct knowledge of a social work colleague's incompetence should consult with that colleague when feasible and assist the colleague in taking remedial action.

(b) Social workers who believe that a social work colleague is incompetent and has not taken adequate steps to address the incompetence should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.

2.10 Unethical Conduct of Colleagues

(a) Social workers should take adequate measures to discourage, prevent, expose, and correct the unethical conduct of colleagues, including unethical conduct using technology.

(b) Social workers should be knowledgeable about established policies and procedures for handling concerns about colleagues' unethical behavior. Social workers should be familiar with national, state, and local procedures for handling ethics complaints. These include policies and procedures created by NASW, licensing and regulatory bodies, employers, agencies, and other professional organizations.

(c) Social workers who believe that a colleague has acted unethically should seek resolution by discussing their concerns with the colleague when feasible and when such discussion is likely to be productive.

(d) When necessary, social workers who believe that a colleague has acted unethically should take action through appropriate formal channels (such as contacting a state licensing board or regulatory body, the NASW National Ethics Committee, or other professional ethics committees).

(e) Social workers should defend and assist colleagues who are unjustly charged with unethical conduct.

3. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES IN PRACTICE SETTINGS

3.01 Supervision and Consultation

(a) Social workers who provide supervision or consultation (whether in-person or remotely) should have the necessary knowledge and skill to supervise or consult appropriately and should do so only within their areas of knowledge and competence.

(b) Social workers who provide supervision or consultation are responsible for setting clear, appropriate, and culturally sensitive boundaries.

(c) Social workers should not engage in any dual or multiple relationships with supervisees in which there is a risk of exploitation of or potential harm to the supervisee, including dual relationships that may arise while using social networking sites or other electronic media.

(d) Social workers who provide supervision should evaluate supervisees' performance in a manner that is fair and respectful.

3.02 Education and Training

(a) Social workers who function as educators, field instructors for students, or trainers should provide instruction only within their areas of knowledge and competence and should provide instruction based on the most current information and knowledge available in the profession.

(b) Social workers who function as educators or field instructors for students should evaluate students' performance in a manner that is fair and respectful.

(c) Social workers who function as educators or field instructors for students should take reasonable steps to ensure that clients are routinely informed when services are being provided by students.

(d) Social workers who function as educators or field instructors for students should not engage in any dual or multiple relationships with students in which there is a risk of exploitation or potential harm to the student, including dual relationships that may arise while using social networking sites or other electronic media. Social work educators and field instructors are responsible for setting clear, appropriate, and culturally sensitive boundaries.

3.03 Performance Evaluation

Social workers who have responsibility for evaluating the performance of others should fulfill such responsibility in a fair and considerate manner and on the basis of clearly stated criteria.

3.04 Client Records

(a) Social workers should take reasonable steps to ensure that documentation in electronic and paper records is accurate and reflects the services provided.

(b) Social workers should include sufficient and timely documentation in records to facilitate the delivery of services and to ensure continuity of services provided to clients in the future.

(c) Social workers' documentation should protect clients' privacy to the extent that is possible and appropriate and should include only information that is directly relevant to the delivery of services.

(d) Social workers should store records following the termination of services to ensure reasonable future access. Records should be maintained for the number of years required by relevant laws, agency policies, and contracts.

3.05 Billing

Social workers should establish and maintain billing practices that accurately reflect the nature and extent of services provided and that identify who provided the service in the practice setting.

3.06 Client Transfer

(a) When an individual who is receiving services from another agency or colleague contacts a social worker for services, the social worker should carefully consider the client's needs before agreeing to provide services. To minimize possible confusion and conflict, social workers should discuss with potential clients the nature of the clients' current relationship with other service providers and the implications, including possible benefits or risks, of entering into a relationship with a new service provider.

(b) If a new client has been served by another agency or colleague, social workers should discuss with the client whether consultation with the previous service provider is in the client's best interest.

3.07 Administration

(a) Social work administrators should advocate within and outside their agencies for adequate resources to meet clients' needs.

(b) Social workers should advocate for resource allocation procedures that are open and fair. When not all clients' needs can be met, an allocation procedure should be developed that is nondiscriminatory and based on appropriate and consistently applied principles.

(c) Social workers who are administrators should take reasonable steps to ensure that adequate agency or organizational resources are available to provide appropriate staff supervision.

(d) Social work administrators should take reasonable steps to ensure that the working environment for which they are responsible is consistent with and encourages compliance with the *NASW Code of Ethics*. Social work administrators should take reasonable steps to eliminate any conditions in their organizations that violate, interfere with, or discourage compliance with the *Code*.

3.08 Continuing Education and Staff Development

Social work administrators and supervisors should take reasonable steps to provide or arrange for continuing education and staff development for all staff for whom they are responsible. Continuing education and staff development should address current knowledge and emerging developments related to social work practice and ethics.

3.09 Commitments to Employers

(a) Social workers generally should adhere to commitments made to employers and employing organizations.

(b) Social workers should work to improve employing agencies' policies and procedures and the efficiency and effectiveness of their services.

(c) Social workers should take reasonable steps to ensure that employers are aware of social workers' ethical obligations as set forth in the *NASW Code of Ethics* and of the implications of those obligations for social work practice.

(d) Social workers should not allow an employing organization's policies, procedures, regulations, or administrative orders to interfere with their ethical practice of social work. Social workers should take reasonable steps to ensure that their employing organizations' practices are consistent with the *NASW Code of Ethics*.

(e) Social workers should act to prevent and eliminate discrimination in the employing organization's work assignments and in its employment policies and practices.

(f) Social workers should accept employment or arrange student field placements only in organizations that exercise fair personnel practices.

(g) Social workers should be diligent stewards of the resources of their employing organizations, wisely conserving funds where appropriate and never misappropriating funds or using them for unintended purposes.

3.10 Labor–Management Disputes

(a) Social workers may engage in organized action, including the formation of and participation in labor unions, to improve services to clients and working conditions.

(b) The actions of social workers who are involved in labor-management disputes, job actions, or labor strikes should be guided by the profession’s values, ethical principles, and ethical standards. Reasonable differences of opinion exist among social workers concerning their primary obligation as professionals during an actual or threatened labor strike or job action. Social workers should carefully examine relevant issues and their possible impact on clients before deciding on a course of action.

4. SOCIAL WORKERS’ ETHICAL RESPONSIBILITIES AS PROFESSIONALS

4.01 Competence

(a) Social workers should accept responsibility or employment only on the basis of existing competence or the intention to acquire the necessary competence.

(b) Social workers should strive to become and remain proficient in professional practice and the performance of professional functions. Social workers should critically examine and keep current with emerging knowledge relevant to social work. Social workers should routinely review the professional literature and participate in continuing education relevant to social work practice and social work ethics.

(c) Social workers should base practice on recognized knowledge, including empirically based knowledge, relevant to social work and social work ethics.

4.02 Discrimination

Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical ability.

4.03 Private Conduct

Social workers should not permit their private conduct to interfere with their ability to fulfill their professional responsibilities.

4.04 Dishonesty, Fraud, and Deception

Social workers should not participate in, condone, or be associated with dishonesty, fraud, or deception.

4.05 Impairment

(a) Social workers should not allow their own personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgment and performance or to jeopardize the best interests of people for whom they have a professional responsibility.

(b) Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties interfere with their professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others.

4.06 Misrepresentation

(a) Social workers should make clear distinctions between statements made and actions engaged in as a private individual and as a representative of the social work profession, a professional social work organization, or the social worker’s employing agency.

(b) Social workers who speak on behalf of professional social work organizations should accurately represent the official and authorized positions of these organizations.

(c) Social workers should ensure that their representations to clients, agencies, and the public of professional qualifications, credentials, education, competence, affiliations, services provided, or results to be achieved are accurate. Social workers should claim only those relevant professional credentials they actually possess and take steps to correct any inaccuracies or misrepresentations of their credentials by others.

4.07 Solicitations

(a) Social workers should not engage in uninvited solicitation of potential clients who, because of their circumstances, are vulnerable to undue influence, manipulation, or coercion.

(b) Social workers should not engage in solicitation of testimonial endorsements (including solicitation of consent to use a client's prior statement as a testimonial endorsement) from current clients or from other people who, because of their particular circumstances, are vulnerable to undue influence.

4.08 Acknowledging Credit

(a) Social workers should take responsibility and credit, including authorship credit, only for work they have actually performed and to which they have contributed.

(b) Social workers should honestly acknowledge the work of and the contributions made by others.

5. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO THE SOCIAL WORK PROFESSION

5.01 Integrity of the Profession

(a) Social workers should work toward the maintenance and promotion of high standards of practice.

(b) Social workers should uphold and advance the values, ethics, knowledge, and mission of the profession. Social workers should protect, enhance, and improve the integrity of the profession through appropriate study and research, active discussion, and responsible criticism of the profession.

(c) Social workers should contribute time and professional expertise to activities that promote respect for the value, integrity, and competence of the social work profession. These activities may include teaching, research, consultation, service, legislative testimony, presentations in the community, and participation in their professional organizations.

(d) Social workers should contribute to the knowledge base of social work and share with colleagues their knowledge related to practice, research, and ethics. Social workers should seek to contribute to the profession's literature and to share their knowledge at professional meetings and conferences.

(e) Social workers should act to prevent the unauthorized and unqualified practice of social work.

5.02 Evaluation and Research

(a) Social workers should monitor and evaluate policies, the implementation of programs, and practice interventions.

(b) Social workers should promote and facilitate evaluation and research to contribute to the development of knowledge.

(c) Social workers should critically examine and keep current with emerging knowledge relevant to social work and fully use evaluation and research evidence in their professional practice.

(d) Social workers engaged in evaluation or research should carefully consider possible consequences and should follow guidelines developed for the protection of evaluation and research participants. Appropriate institutional review boards should be consulted.

(e) Social workers engaged in evaluation or research should obtain voluntary and written informed consent from participants, when appropriate, without any implied or actual deprivation or penalty for refusal to participate; without undue inducement to participate; and with due regard for participants' well-being, privacy, and dignity. Informed consent should include information about the nature, extent, and duration of the participation requested and disclosure of the risks and benefits of participation in the research.

(f) When using electronic technology to facilitate evaluation or research, social workers should ensure that participants provide informed consent for the use of such technology. Social workers should assess whether participants are able to use the technology and, when appropriate, offer reasonable alternatives to participate in the evaluation or research.

(g) When evaluation or research participants are incapable of giving informed consent, social workers should provide an appropriate explanation to the participants, obtain the participants’ assent to the extent they are able, and obtain written consent from an appropriate proxy.

(h) Social workers should never design or conduct evaluation or research that does not use consent procedures, such as certain forms of naturalistic observation and archival research, unless rigorous and responsible review of the research has found it to be justified because of its prospective scientific, educational, or applied value and unless equally effective alternative procedures that do not involve waiver of consent are not feasible.

(i) Social workers should inform participants of their right to withdraw from evaluation and research at any time without penalty.

(j) Social workers should take appropriate steps to ensure that participants in evaluation and research have access to appropriate supportive services.

(k) Social workers engaged in evaluation or research should protect participants from unwarranted physical or mental distress, harm, danger, or deprivation.

(l) Social workers engaged in the evaluation of services should discuss collected information only for professional purposes and only with people professionally concerned with this information.

(m) Social workers engaged in evaluation or research should ensure the anonymity or confidentiality of participants and of the data obtained from them. Social workers should inform participants of any limits of confidentiality, the measures that will be taken to ensure confidentiality, and when any records containing research data will be destroyed.

(n) Social workers who report evaluation and research results should protect participants’ confidentiality by omitting identifying information unless proper consent has been obtained authorizing disclosure.

(o) Social workers should report evaluation and research findings accurately. They should not fabricate or falsify results and should take steps to correct any errors later found in published data using standard publication methods.

(p) Social workers engaged in evaluation or research should be alert to and avoid conflicts of interest and dual relationships with participants, should inform participants when a real or potential conflict of interest arises, and should take steps to resolve the issue in a manner that makes participants' interests primary.

(q) Social workers should educate themselves, their students, and their colleagues about responsible research practices.

6. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO THE BROADER SOCIETY

6.01 Social Welfare

Social workers should promote the general welfare of society, from local to global levels, and the development of people, their communities, and their environments. Social workers should advocate for living conditions conducive to the fulfillment of basic human needs and should promote social, economic, political, and cultural values and institutions that are compatible with the realization of social justice.

6.02 Public Participation

Social workers should facilitate informed participation by the public in shaping social policies and institutions.

6.03 Public Emergencies

Social workers should provide appropriate professional services in public emergencies to the greatest extent possible.

6.04 Social and Political Action

(a) Social workers should engage in social and political action that seeks to ensure that all people have equal access to the resources, employment, services, and opportunities they require to meet their basic human needs and to develop fully. Social workers should be aware of the impact of the political arena on practice and should advocate for changes in policy and legislation to improve social conditions to meet basic human needs and promote social justice.

(b) Social workers should act to expand choice and opportunity for all people, with special regard for vulnerable, disadvantaged, oppressed, and exploited people and groups.

(c) Social workers should promote conditions that encourage respect for cultural and social diversity within the United States and globally. Social workers should promote policies and practices that demonstrate respect for difference, support the expansion of cultural knowledge and resources, advocate for programs and institutions that demonstrate cultural competence, and promote policies that safeguard the rights of and confirm equity and social justice for all people.

(d) Social workers should act to prevent and eliminate domination of, exploitation of, and discrimination against any person, group, or class on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical ability.

Notes

*For information on NASW adjudication procedures, see *NASW Procedures for Professional Review: Revised*.