Poverty and Mental Health In New York City

Excerpt from NASW-NYC’s Poverty Toolkit

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Excerpted from
Worse Than You Think: The Dimensions of Poverty in NYC, What Social Workers See

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Close to two decades ago the World Health Organization identified poverty as the world’s most “ruthless killer” and the “greatest cause” of suffering on earth (see World Health Organization, 1995). Scholars from the behavioral and social science disciplines have noted the negative reverberating effects of poverty on the human condition and its impact on the physical and psychosocial well-being of individuals across the life span (Alesina & Glaeser, 2004; Evans & English, 2002; Iceland, 2006). Poverty contributes to—and in many cases is the direct cause of—many individual, community and societal ills. Murali and Oyebode (2004), for example, have observed that poverty is “intrinsically alienating and distressing” and it is correlated with the “development and maintenance of emotional, behavioral and psychiatric problems” (p. 216). As a multidimensional social problem, poverty aggravates and impedes the achievement of life goals, compromises healthy life transitions, impairs adaptive functioning in individuals, families and communities and taxes psychological mechanisms within the human organism that are vital for optimal well-being. Addressing and managing mental health problems within urban cities that are affected by poverty, homelessness, inadequate housing, unemployment and poor nutrition is a major challenge for political officials, advocates, service and treatment providers and other stakeholders. This brief will highlight the relationship between poverty and mental health and it will draw attention to recommendations that may be adopted at a local level to improve mental health outcomes among poverty-affected individuals in New York City.

Poverty in New York City: A Snapshot

In its report, Concentrated Poverty in New York City: An Analysis of the Changing Geographic Patterns of Poverty, the Citizens’ Committee for Children (see Wolf, 2012), noted that the number of people living below the federal poverty level in New York City grew by more than 120,000 to over 1.6 million in 2010. In 2010, one in three of the City’s children lived in poverty up from one in four in 2008. The report underscores four important findings that carry implications for understanding the relationship between poverty and mental health. The findings are: 1) citywide, concentrated poverty has declined in the past decade, but a large number of New Yorkers still live in extreme poverty; 2) concentrated poverty continues to be a serious problem for many New York City neighborhoods; 3) concentrated poverty disproportionately impacts Black and Latino communities; and 4) the full impact of the most recent recession on the City’s concentrated poverty remains to be seen. In the report concentrated poverty refers to the prevalence of poor people living in extreme poverty neighborhoods. Extreme poverty neighborhoods were defined as neighborhoods with more than 40 percent of the population living below the federal poverty level. Bedford Stuyvesant was identified as example of an extreme poverty neighborhood in Brooklyn, New York.
Poverty and Mental Health: A Cyclical Relationship

Research has shown that the relationship between poverty and mental health is cyclical or bidirectional in nature (see Leon & Walt, 2001; Saraceno & Barbui, 1997). Within this cyclical relationship, poverty increases the risk of mental illness and suffering from mental illness increases the probability that an individual may experience poverty. In describing the nature of this complex relationship, Murali and Oyubode (2004) note: “Money is not a guarantor of mental health, nor does its absence necessarily lead to mental illness. However, it is generally conceded that poverty can be both a determinant and a consequence of poor mental health” p. (217). In addition to the sufficient evidence that exists in support of the cyclical relationship between poverty and mental health, several studies have also demonstrated that poverty is indeed a causal factor leading to mental illness (see Hudson, 2005). Rank (2011) has identified three significant elements of poverty that research has shown to increase susceptibility to mental health problems. The three elements are: 1) lack of resources such as food, clothing and shelter; 2) psychosocial stress; and 3) poor environmental/community conditions within high poverty neighborhoods that may include elevated crime rates and inadequate housing.

The relationship between poverty and mental health is exemplified in the following research-supported associations.

- Low socio-economic status has been linked to the onset of specific mental health disorders including depression and an increased risk for suicide, psychosis, alcohol and substance
abuse, schizophrenia and negative emotional outcomes in children as a result of maternal depression (Murali & Oyebode, 2004). Evidence indicates that depression is 1.5 to 2 times more prevalent among low-income groups of a given population (Funk, Drew & Freeman, 2010). Common mental health disorders such as depression and anxiety are twice as frequent among individuals who experience persistent poverty as compared to individuals with significant financial resources (see Patel, 2001).

- Living in high poverty neighborhoods and poor and overcrowded housing conditions are significant risk factors for psychopathology and repeated psychiatric hospitalizations (see Hudson, 2005; Leventhal, 2003). For instance, in a study aimed at studying the effects of a housing program in New York City that assisted poor families living in impoverished neighborhoods to relocate to a low poverty neighborhood, Leventhal (2003) found that parents “displayed superior mental health, as evidenced by their reporting of fewer distress and depressive symptoms…” (p. 1580). Children in these families also reported less problems with symptoms of anxiety and depression. Improved neighborhood and housing conditions positively impacts mental health outcomes.

- Unemployment and underemployment increases an individual’s vulnerability for psychological distress and the acute onset of common mental health disorders. Research studies (see Fitch, Hamilton, Bassett & Davey, 2011; Wilson, 1997) have shown a connection between poverty and negative mental health outcomes. Economic pressure, personal debt and insufficient financial resources decrease an individual’s sense of self-efficacy and increase susceptibility to mental health disorders.

- From a pediatric perspective, poverty or low socio-economic status has been associated with depression, conduct disorder and attention-deficit hyperactivity in children and adolescents (see González, 2005; Murali and Oyebode, 2004). Duncan and colleagues (1994) have documented the strong association that exists between economic deprivation and deficits in children’s cognitive skills and capacity for educational achievement. Poverty negatively impacts the socio-emotional development of children and impairs parents’ ability to meet their psychosocial needs. In describing the effects of child health inequality, Hernandez, Montana and Clarke (2010) identified poverty as a detrimental factor that may result in pediatric depression and seriously impact the healthy development of the brain. It is important to note that length of exposure to poverty has been linked to children’s symptoms of psychological distress including unhappiness, anxiety and observed inability to master appropriate levels of independence (McLeod & Shanahan, 1993).

**Recommendations**

The relationship between poverty and mental health is complex and multidimensional in nature. Officials at the World Health Organization (see Funk, et al., 2010) have strategically noted that mental health issues cannot be examined in isolation from other critical areas of social living such as education, employment, housing, sustainable communities and neighborhoods, adequate health care and access to life-sustaining services. Individuals who meet diagnostic criteria for either a common mental
health diagnosis or severe and persistent mental illness are vulnerable and may face significant barriers in negotiating daily living. Systemic, community-centered interventions aimed at interrupting the poverty-mental health relationship (see Anakwenze & Zuberi, 2013) are needed to increase psychosocial well-being among vulnerable and at-risk populations. The following recommendations drawn from the World Health Organization (see Funk et al., 2010) and mental health scholars (see Anakwenze & Zuberi, 2013; González, 2005; González and González-Ramos, 2005; Strike, Goering & Wasylenski, 2002) may be useful in addressing the devastating effects of the poverty-mental health relationship.

- Cities, communities, systems of care and human service organizations ought to adopt health promotion and population health approaches for identifying and responding to mental health problems in high poverty neighborhoods. For example, universal, selective and indicated mental health prevention initiatives have been found to be effective in reducing the risk for psychopathology (Institute of Medicine, 1994). Informed by a population health approach (see Strike, et al., 2002), mental health prevention initiatives may address the factors that compromise optimal psychological well-being such as insufficient income, lack of employment, poor education and high crime neighborhoods. Within a population health approach these factors ought to be viewed as determinants of health and targets of mental health intervention. The interventions must emerge from the coordinated efforts of treatment facilities and representatives of public and private sector agencies. Psychological treatment of emotionally compromised individuals must occur in tandem with structural and social change.

- Community mental health care coalitions are vital in interrupting the poverty-mental health relationship—and they should be created throughout selected New York City communities. These coalitions ought to include consumers of services, treatment providers, advocates and representatives from local and state and—if possible—federal agencies that have resources to ameliorate the social conditions that sustain the cyclical and bidirectional processes of poverty and mental health. The World Health Organization (Funk, et al., 2010) strongly advocates for coalition initiatives that incorporate mental health into broader health policies, programs and community/neighborhood partnerships. It is the Organization’s position, for instance, that mental health issues should be taken into account within social services, housing development, employment and income generating opportunities and education. Mental health professionals—which include a strong cadre of social work practitioners—should play an active role in providing leadership, training and direction to community mental health care coalitions.

- Representatives from local and national poverty centers or institutes and mental health organizations should partner with clergy and religious leaders in creating a common agenda that aids in interrupting the poverty-mental health relationship. Scholars (see González and González-Ramos, 2005) have noted that the clergy plays an important role in enhancing the emotional and social well-being of many individuals and families including marginalized populations in high poverty communities. This type of partnership may be instrumental in reducing barriers to mental health care access and in assisting impoverished communities and human service organizations to overcome mistrust and develop care alliances with each other (Anakwenze & Zuberi, 2013).
Evidence-based approaches ought to be adopted as empirical guides for addressing the reverberating effects of poverty and mental health. Evidence-based approaches or evidence-informed strategies that target both symptoms of psychiatric disorders and the structural components that sustain poverty are equally important in disrupting the maladaptive processes of poverty and mental health. Strike et al. (2002), for example, support the use of a community report card as an evidence-informed tool that can help community leaders, elected officials, directors and providers from mental health care organizations and advocates to systematically identify problem or population-specific psychosocial issues that require resolution. Homelessness, suicide and pediatric health are examples of problems and population-specific issues. A community report card is a document which presents views on how a community is doing. The topics that are included in the report card—such as crime rates, incidence and prevalence of adolescent pregnancy, specific health problems—may vary by community and can change over time. Selected issues or indicators represent important measures of a community’s well-being, and become target of social intervention and systemic change. Evidence should guide the selection of issues and indicators and the interpretation of possible relationships between and among identified domains of concern. On a clinical level, the family associate engagement strategy (see Anakwenze & Zuberi, 2013) is an evidence-based intervention aimed to provide outreach and support to low-income families with children in need of mental health care.

Conclusion

Research has demonstrated that poverty has a detrimental effect on psychosocial functioning across the life span. The reverberating impact of poverty affects both physical and psychological health. Poverty and mental health are associated, and the nature of the relationship is both cyclical and bidirectional. Researchers and mental health scholars have stressed the importance and value of interrupting the poverty-mental health relationship, given that such a union produces significant human suffering. This brief has summarized the nature of the poverty-mental health relationship. It has presented a snapshot of poverty in New York City and it has provided examples of the research-informed associations between poverty and mental health. The noted recommendations are aimed at decreasing the reinforcing, maladaptive cycle that characterizes poverty and mental health in urban communities.

For References see page 46 of NASW-NYC’s Poverty Toolkit
Brief Updates on Chapter Activities

*Robert Schachter, DSW, LMSW*

**Continuing Education**

NASW-NYC received 72 proposals for its planned April 8 conference which will offer 6 CEUs. Over 20 workshops will cover a broad spectrum of social work practice, and we are in the final stages of securing a well-known and inspiring individual to deliver keynote remarks. We expect to announce this speaker before the end of the year.

We are also planning to launch up to 25 stand-alone workshops beginning as early in 2015 as possible. The State Education Department requires us to submit topics and speakers for approval, and the approval might not be ready until after the New Year.

These two program activities—the conference and the stand-alone workshops—are requiring a major investment of time and resources, but we are committed to getting this going as soon as possible. Once we launch the CE program, NASW-NYC will look into providing online educational experiences as well as webinars, probably in the fall of 2015.

**Poverty Toolkit**

Please review the toolkit which features the magnitude of poverty through 17 briefs. This newsletter features one brief, by Dr. Manny Gonzalez, on the relationship between poverty and mental health. Go to www.naswnyc.org to access the toolkit.

**Equitable Salaries Campaign**

NASW-NYC is completing a letter to go to employers in the not-for-profit human services sector drawing out the findings that this sector is the lowest paying of all the sectors employing social workers. Staff also met with a key member of the City Council about this issue. There will be more activities in the months ahead to keep salaries in front of city leaders. We also expect that National NASW will be taking up social work salaries as a cause, following the NYC Chapter’s lead.

**Policy Roundtable on Licensing**

NASW-NYC worked with the Latino Social Work Task Force to hold a policy roundtable on the issue of agency exemptions ending in 2016 and on the question of whether the licensing exam is culturally biased or not. Both agency representatives and leaders in the profession, including many deans of the schools of social work participated. The goal was to have a conversation among stakeholders who have different perspectives on the impact of licensing in New York City.

The testing organization, ASWB, was in attendance, and the dialogue with a very diverse group of social workers and employers was a first for them. The Task Force focused on how ASWB assures that the test is fair.

NASW-NYC and the Latino Task Force will be following up with all of the participants to attempt to increase understanding of the varying perspectives, to close the gap on our differences, and to assure more social workers obtain the license.

The Asian American Federation of NY, the Hispanic Federation, Black Agency Execs, Inc., the Deans Association of Schools of Social Work, the Coalition of Behavioral Health Agencies, and the Council of Family Child Caring Agencies all co-sponsored. The leaders of the Office of the Professions were there as were ABSW and major labor unions.
What We are Reading  
I recently shared with a group of social workers that the Chapter is looking at issues through a racial equity lens. I looked at their blank faces and asked whether they were wondering what this has to do with social work. It was definitely the case.

Given the disproportionate number of people of color coming for services across most service systems, we now recognize as never before that to understand critical elements of people’s lives, we need to understand the larger dimensions of racism.

I therefore strongly recommend reading *The New Jim Crow: Mass Incarceration in the Age of Colorblindness* by Michelle Alexander. This is a compelling examination of our country through the lens of slavery, reconstruction, the formation of the Jim Crow laws in the south, the Civil Rights Movement, and very much in reaction to this movement, the subsequent War on Drugs, which is still playing out.

Many social workers active in NASW have already read this well-researched book.

While stories of racism and the criminal justice system are being reported everyday in the news, Michelle Alexander provides a thorough and comprehensive understanding of what is going on in the United States. Every family of color has been touched by this, and social workers, regardless of their racial identification, will find this reading to be eye opening and a tragedy calling out for social change on every level, beginning with ourselves.

Members of our staff and leadership at the conclusion of a day-long retreat held in early November. The retreat focused on strengthening NASW-NYC’s core priorities, including around equity and poverty, licensing, and delivery of quality continuing education to NYC social workers.
When you change jobs or retire, or when you have several retirement accounts with former employers or IRAs with different financial institutions – it may be the right time to consider the advantages of a Rollover IRA.

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NASW-NYC TIMELINE
OF ACCOMPLISHMENTS
ON BEHALF OF THE SOCIAL WORK PROFESSION
IN NEW YORK CITY

1925  Am. Association of Social Workers-NYC (AASW-NYC) formed-Parent organization to
       NASW-NYC

1936  AASW-NYC’s first proposal for social work licensing in NY

1955  National Association of Social Workers, NYC formed
       • Merger of 7 organizations:  1) AASW, 2) psychiatric social workers, 3) group workers, 4) school social workers, 5) community organizers, 6) researchers, 7) medical social workers
       • Chapter had 1800 members - NYC was largest chapter in country

1962 to 1968  NASW-NYC forms Civil Rights Committee; organizes national lobby day, meeting held with
               President Johnson.  NY Times covers meeting with southern Senator who shares that the
               filibuster will end.  Holds conference on racism and 500 attend.

1966  Creation in State law of Certified Social Workers (CSW) with NYC Chapter playing lead role
       in lobbying.

1977  Reimbursement passed into insurance law, Creates the P

Late 1970s
      to late 1980s  NASW-NYC holds annual lobby days in Albany with 800 one year as the highest participa-
                    tion.  The Educational Legislative Action Network, ELAN, leads the way.  US Congressman
                    recognizes ELAN for its work in speaking out on welfare reform.

1982  NASW-NYC Women’s Issues Committee holds conference at Columbia University

1982  NYC-PACE formed as NASW-NYC’s political action arm.  Governor Mario Cuomo attends
       PACE fund raiser in 1984.

1984  Reimbursement expanded in insurance law, Creates the R; more insurance policies included.
       Key social workers in NY are recruited to lobby the governor, who had delayed signing the
       bill into law.  Unions are asked to weigh in after well positioned social workers bring them
       along. Opposition from the insurance industry defeated.

1986  Board of Education proposes to eliminate school social workers.  NASW-NYC organizes, goes
       into federal court.  Judge stops the plan and the number of social workers goes from 390 to
       490. The number today is 1400.

1986  First conference on social workers in unions held; nine unions that represent social workers in
       NYC participate.
1987  State Commission on Health Planning and Review proposes to eliminate requirements for social workers in hospitals. NASW organizes the field, lobbies the commission, and defeats the proposal. Standards are strengthened. Leading advocates for health care were surprised by NASW’s success with the commission, but they were unaware that several commission members had MSWs, including the commission chair, and they were open to our concerns.

1988  NASW-NYC joins with social worker James Satterwhite and supports formation of NYC’s child welfare training academy.

1992  NASW-NYC leadership decides to pursue licensing, including the clinical license.

Mid-1990s  Key Assemblyman opposes licensing and says that certification is adequate. Justifies this by saying social work is not a matter of life and death. NASW-NYC runs focus group with members from different fields of practice and is then able to share what was learned with the legislator. “Okay, I get it”, he said, “we’ll do licensing”.

1995  Following death of child known to the city’s child welfare administration, NASW-NYC engages nine media outlets, including the New Yorker, The Nation, The Village Voice, and CBS-TV, helping to pressure Mayor Giuliani to form ACS.


1999  Licensing legislation introduced in Albany, but the LMSW was removed at the end of the session. The bill did not pass but the Assembly leadership said that only the LCSW could be considered in the future.

2000/2001  After a year of preparation, NASW-NYC forms first lobbying Alliance with a labor union in country, 1199. Legislative breakfast with 1199 President raises NASW’s profile in Albany, as one lawmaker said, “to the highest level”.

2001  NASW-NYC office closed due to collapse of World Trade Center on Sep. 11. In following week, from temporary site, NASW organized over 300 volunteers to help with the emergency response. On October 9 NASW-NYC held a forum for the social work community with 650 in attendance, addressing how the disaster affected low income and communities of color, including immigrant communities.

2002  NASW-NYC insists that the LMSW be put back into the licensing legislation despite Assembly leaders’ opposition. Opposition to licensing from a powerful legislative caucus was turned around with help of 1199. This leads to passage of licensing law.

2003  NASW-NYC takes leadership in profession to promote Undoing Racism training for social workers and CEOs of agencies. Thousands take training in subsequent years.

2003  All-day conference held addressing need for bi-lingual, bi-cultural social workers with 400 attending; leads to formation of Latino Social Work Task Force, which initiates efforts for loan forgiveness and ultimately raises $500,000 in scholarships over 10 yrs.

2004  NASW-NYC forms licensing task force and sets out to inform profession and agencies in NYC about requirements, including grand parenting period.
2005  NASW-NYC leadership organizes at the first national Social Work Congress in Washington, DC and gets the need to address racism into three of 12 imperatives for the next decade.

2005  The NYS Social Worker Loan Forgiveness Program established in first year of lobbying. Governor’s staff ask how this was accomplished when several other professions were not able to get a similar program enacted. Loans of up to $26,000 could be forgiven, but the $1 million in funding does not support enough who are in need. Over $7 million expended over the next seven years.

2006  NASW-NYC organizes 250 students from all of the graduate schools to do voter registration. 8,600 New Yorkers registered on one day and NYPIRG says this is the single largest voter registration day they had seen. PACE goes on to do voter registration, bringing along the Human Services Council and a total of 60,000 New Yorkers are registered.

2009-2010  NASW-NYC forms largest ever coalition on behalf of the profession, involving agencies from across all fields, to address the end of licensing exemptions and onerous administrative decisions. Some requirements for the LCSW loosened and the experience requirement was cut by 33%.

2013  Defeated Governor’s proposal to make licensure exemptions permanent; passed requirements for continuing education.

2014  Funding for loan forgiveness increased by $250,000. NASW-NYC begins planning for mandated continuing education program.
Reflections on Social Work in NYC in the Context of Ebola

Madelyn Miller, PhD, LCSW
Chair, NASW-NYC Disaster Trauma Committee

For all of us, our reactions to Ebola are deeply felt. We are profoundly affected by the magnitude of loss and suffering in West Africa, heartbroken for those lost and for their survivors. We are saddened by the death of Thomas Eric Duncan to Ebola, and concerned about the well-being of his family who grieve amidst stigma, rejection, isolation, and fear.

We are concerned about other West Africans and those perceived to be, here in the city, facing animosity, blame, and disdain. Children have been hurt at school, home care workers asked to stay home. And as the Ebola reality continues to evolve, we hope for a full recovery of the NYC patient being treated at Bellevue, and for the safety of his family, friends, and colleagues, here and in West Africa.

At the same time, we recognize the deep commitments of the Dallas medical staff, two nurses now well but still recovering, of the frontline and broader staff at Bellevue, and of the numerous other health care and humanitarian workers actively engaged locally and internationally, working to provide empathic care and community support, including those workers returning home to the US. We hope for their ongoing health and experience of support.

Many across the city and beyond continue to be concerned and worried about their own safety, the safety of the broader community, and the potential impact of this virus. Many struggle with uncertainty and the unknown, helplessness and fear, and some with a range of deeper feelings and unique issues.

At this particular time, and always, we know the essential need as social workers to continually take care of ourselves and especially now, each other, as we approach our work. This may include reflective self-care, staying actively connected with colleagues and support systems, creating more opportunities for discussion and support among ourselves, keeping healthy and well rested, continuing our variety of engagements in social action and social justice work, and recognizing that the meaning of our own unique social work practice, and the strength of our commitments, are themselves active resources for us all, infusing support as we move forward.

A Basic Stance for All Social Workers

In our diverse roles as social workers, and across our various settings, it is possible to incorporate into our broad engagements across the city a basic stance promoting well-being and resourcefulness, safety and calm. This responds to individual and collective fears both expressed, and those anticipated. Whether we work in hospitals and emergency departments, with communities grieving the loss of loved ones to Ebola in their home country, in clinics with those worried about safety in general, or in offices...
with those struggling with other challenges now intensely resonating, across the spectrum of social work contexts we can synthesize what has been learned from many disasters, public health situations, and parallel circumstances, and can play an important role in supporting individuals and communities at this difficult time.

Among several considerations are the fundamental importance of: accurate information, public education, and a public health perspective focusing on the well-being of the community; as well as opportunities to safely and comfortably discuss stress and anxiety, worries and fears; and also the enhancement of social networks, a sense of community, and meaningful connections. These can be integrated into our various clinical and community engagements.

Combined with the principles of Psychological First Aid which promote safety, calm, connection, self-efficacy, and hope in the unfolding aftermath of disaster, we can encourage individuals and communities to consistently seek up-to-date and accurate information offered by trusted experts, to find reliable facts that can lessen ungrounded worries, clarify misinformation, and calm fears in a rapidly changing environment. For instance, learning the fact that Ebola is spread by direct contact with the bodily fluids of an individual who has active symptoms of the disease, can be an important first step, and reassuring, even though more details may be sought. We can frame our work with an effort to offer basic public education as well as psychoeducation when determined to be helpful, and to reach communities of individuals who can become a resource of support with one another.

Our work can incorporate creative opportunities to respond to all who are concerned, and to those most vulnerable and afraid, through being available to listen to their emerging concerns and feelings, and staying engaged in ongoing discussion and conversation. And we understand well the fundamental importance of social connection, building of community, sense of belonging, and feeling cared for in relationship, that can be of essential support.

**Responding From Within Our Own Contexts**

At this important time, we have unique positions across the five boroughs to offer individual and collective support. We can respond in our particular contexts as clinicians, organizers, administrators, educators, students, and group workers, working with those in hospitals, at schools, community based organizations, hospices, and clinics, engaging with refugee communities, those seeking asylum, and with those in residential treatment communities, veterans groups, mental health programs, adoption services, prisons, aging-in-place communities, pre-school environments, housing and homeless services, and after-school programs, as only some.

Just as we encourage a sense of agency and empowerment for those with whom we work, experiencing our own sense of agency is essential in this environment. We may take greater initiative in response work, or decide to volunteer with the variety of disaster organizations. We may engage in social action efforts, community initiatives, or decide to be more active in advocacy efforts during this time. We may wish to expand teaching and training commitments, broaden our supervision, attend related workshops, or as is so important now, engage further with peers for support. Each initiative is a dynamic aspect of our resourcefulness and resilience.
In case you missed it...
Social Work Updates

Securing Safe, Stable and Affordable Housing for Young People Aging Out of Foster Care

Background
In federal fiscal year 2012, approximately 23,396 young people transitioned out of foster care (U.S. Department of Health and Human Services, 2013) and faced the obstacles of adulthood – tight job markets, low wages, elevated tuition rates, and a lack of affordable housing – with limited, if any supports (Torrico Meruvia, 2013). Unlike their peers who may have family to rely on, life’s challenges can make older foster youths’ transition into adulthood a daunting and difficult one. Therefore, it is not surprising that former foster youth experience poor educational outcomes, high rates of unemployment, poverty, health issues, single parenthood, and homelessness (Courtney & Heuring, 2005; Torrico Meruvia, 2013).

While housing stability is critical to the wellbeing of youth, young people leaving care continue to experience periods of housing instability and homelessness at startling rates. In fact, 12 to 36 percent of former foster youth experience homelessness (White & Rog, 2004; Courtney, Dworsky, Lee & Raap, 2010) and between 25 to 50 percent of young people frequently change living situations (e.g., couch surf, double up, face evictions, etc.) after leaving foster care (Dion, Dworsky, Kauff & Kleinman, 2014; Casey Family Programs, 2008). With a limited safety net, older foster youth face the demands of obtaining enough money for a security deposit and first and last month’s rent, furnishing their home and making monthly rental payments once they transition out of foster care. These responsibilities, combined with limited incomes and a narrow housing pool, make the transition into adulthood challenging at best.

Policies and Programs that Address the Housing Needs of Older Foster Youth
During the last 25 years, federal and state governments have recognized that young people transitioning out of foster care need support with the development of independent living skills, support of education and employment and securing stable housing (Courtney & Heuring, 2005; Dworsky, Dillman, Dion, Coffee-Borden & Rosenau, 2012; Torrico Meruvia, 2013).
While there are a range of laws and programs that support the various needs of young people aging out of foster care, below is a list of highlighted laws and programs that can support their housing needs.

- **John H. Chafee Foster Care Independence Program**, established by the Foster Care Independence Act, doubled the funding to states to $140 million while also expanding eligibility for services such as Medicaid, mentoring and room and board services (e.g., security deposits, housing subsidies, etc.) for current and former foster youth up to age 21.

- **Education and Training Vouchers (ETV) program** was authorized by the Promoting Safe and Stable Families Amendments of 2001 as part of the John H. Chafee Foster Care Independence Program, allowing states to pay up to $5,000 towards tuition, room and board and other school-related costs for students up until the age of 23.

- **Fostering Connections to Success and Increasing Adoptions Act of 2008** resulted in significant improvements for youth who spent time in foster care including mandating the development of a personalized transition plan 90 days before discharge from foster care (which must address housing) and allowing states to use federal funding to keep youth who meet certain conditions in foster care until the age of 21.

- **Family Unification Program (FUP)** provides families involved with child welfare with a Housing Choice Voucher and supportive services to reunify families or to avoid a foster care placement altogether (if appropriate). In 2000, eligibility for FUP was extended to include former foster youth ages 18 to 21 who were at least 16 when they transitioned out of foster care; youth receive an 18-month housing voucher while also receiving case management services. FUP is administered on the local level by public housing agencies in partnership with public child welfare agencies. Public child welfare agencies are responsible for referring youth to the public housing agencies for determination of eligibility for rental assistance.

- **Housing Choice Voucher (HCV) and Public Housing programs** are generally administered by public housing agencies (PHA). Some PHAs set aside housing vouchers for youth aging out of care or prioritize youth on voucher waiting lists. Likewise, some public housing agencies prioritize former foster youth’s applications for public housing units. Housing Choice Voucher and public housing recipients typically pay 30 percent of their adjusted gross income towards rent.

- **Runaway and Homeless Youth Act Transitional Living Program** aims to ensure the basic safety of homeless youth while supporting their education, employment, health and permanent connections. Congress initially enacted the Runaway and Homeless Youth Act (RHYA) in 1974; it is currently funded through the Reconnecting Homeless Youth Act of 2008. Administered by the Family Youth Services Bureau (FYSB), the Runaway and Homeless Youth Act Transitional Living Programs serve youth aged 16 to 21 who are homeless and cannot return home; grantees can include programs with host homes, group homes, or supervised apartment settings. In addition, RHYA programs also include Basic Center and Street Outreach programs which provide emergency shelter and services and outreach services for homeless youth. Young people who have aged out of foster care and are homeless are eligible for these services (Fernandes-Alcantara, 2013).

### A Range of Housing Options

The shortage of affordable housing options coupled with the high costs of homelessness are forcing states and local communities to identify permanent, transitional and emergency housing options for young people leaving care. States and communities across the country are crafting housing solutions such as: creating all-year dorms for college bound students; including youth in locals plans to end homelessness; using up to 30 percent of Chafee funds for room and board services (e.g., security or utility deposits, rental subsidies, emergency funding) and to support housing assistance programs (e.g., Illinois Department of Children and Family Services); and developing their own state-funded programs (e.g., California’s THP+, North Carolina’s NC Reach) (Pergamit, McDaniel & Hawkins, 2012).

The best housing option for a young person preparing to transition into adulthood must depend on the specific needs of the young person; each young person may reflect a different level of readiness to live independently at different points in their young adult life. In fact, he or she may
Caught in the Middle: Supporting Families Involved with Immigration and Child Welfare Systems

Background
In the last decade, the U.S. immigrant population has dramatically increased. In 2011, there were an estimated 40 million immigrants in the U.S.; 11 million of these individuals were undocumented (Pew Research Center, 2013). Children living in immigrant families now represent the fastest growing segment of the child population. In fact, it is estimated that one in four children and youth have an immigrant parent or are immigrants themselves (Capps & Passel, 2004; Torrico, 2010; NASW, 2013). It has also been reported that as many as 5.5 million children are part of a mixed status family (Passel & Cohn, 2009) [See Key Terminology]. Unfortunately, due to immigration enforcement, many of these children are at risk of being separated from a parent at any time. While federal laws and policies that impact immigrants’ status have evolved as a result of the political, social and economic climate (Morgan & Polowy, 2010), the failure to reform outdated immigration laws and policies continues to have devastating and unintended outcomes on children and their families. In 2011, approximately 392,000 individuals were deported from the United States (U.S. Department of Homeland Security, 2011). The Department of Homeland Security reported that over 200,000 parents of U.S. citizen children were deported in just over two years, accounting for nearly 23 percent of all deportations in that period (Wessler, 2012). Sadly, many of these parents left their children behind. There are an estimated 5,100 children in child welfare systems across the U.S. as the result of a parent’s immigration detention or deportation (Wessler, 2011). In addition, it is estimated that 15,000 more children and youth are at risk of entering the child welfare system over the next several years (Wessler, 2011). To date, hundreds of thousands of U.S. born children have already left the U.S. with their deported parents (Children’s Defense Fund, n.d.; Kline, 2013).

Challenges Facing Children and Families Involved with Child Welfare
There are a number of ways that an immigrant child or family can become involved with the child welfare system. In some instances, involvement is a result of immigration enforcement. For example, a parent may not
be provided with the opportunity to make child care arrangements at the time of apprehension or in other cases, a child may come into state custody as a result of a parent’s criminal arrest or conviction—which can eventually lead to their deportation. However, in other more common scenarios, a child may already be system-involved, and then a parent’s subsequent detention or deportation interrupts the family reunification process.

When a detained or deported parent is unable to make childcare arrangements for their children, these children may be left in unstable and risky situations (First Focus, 2013). The abrupt separation of families resulting from immigration enforcement can also have profound and negative impact on a child’s mental and physical health and academic performance. This is particularly true in cases where the child actually witnessed his or her parent’s arrest (Cervantes & Lincroft, 2010). In two-parent households, the deportation of a parent can also lead the family to experience higher rates of poverty and reduced access to food (Satinsky, Hu, Heller & Farhang, 2013). All of these outcomes put children at higher risk of entering the child welfare system.

Too often, the acts of detention and deportation put children, both documented and undocumented, in danger of being permanently separated from their families. According to the Adoption and Safe Families Act (ASFA), if a child has been out of a parent’s custody for 15 of the last 22 months, the child welfare department must petition the court for the termination of parental rights. Therefore, unless children are placed in a permanent guardianship arrangement or another legal custody arrangement with the other parent, parental rights may be terminated and children can be put up for adoption (Wessler, 2011). Unfortunately, in many jurisdictions family members who could serve as potential placement options are not considered solely because of their undocumented status, leaving children lingering in the foster care system.

Once parents have been detained or deported, it is difficult for them to participate in child welfare proceedings. A parent’s ability to navigate the immigration and child welfare systems is compromised by conflicting laws and lack of coordination between the systems. These systemic challenges can negatively impact their ability to meet the requirements of their child welfare case plan and within the specified time constraints. Detained parents typically do not have access to the services (e.g., parenting class, psychological evaluations, regular visitation, etc.) often identified in case plans putting them in a difficult position to reunify with their children. In some instances, parents may never receive notification of child welfare proceedings because the child welfare system does not know how to locate them or if they do become aware, their participation (in person or virtually) has not been supported by detention facilities. While immigration status is not a reason for the termination of parental rights (Butera, 2010), unless detained or deported immigrant parents are provided with the supports to fully participate in child welfare proceedings, there is a risk of a permanent separation of families causing irreparable harm to children.

In an effort to reduce harm to immigrant children and families, several state and local agencies have taken steps to establish internal policies or in some cases, dedicated units to address issues related to immigration. However, California is the first in the country to address family separation matters resulting from the current immigration enforcement system in its “Reuniting Immigrant Families Act” (SB 1064) (Lincroft, 2013). This law authorizes child welfare courts to extend the family reunification timeline so that child welfare agencies can conduct a thorough search for detained or deported parents or relatives; ensures that the immigration status of relatives is not considered reason not to place a child in their home; and allows the use of foreign documents (e.g., passports) to conduct background checks for relative caregivers. Lastly, this law requires the California Department of Social Services (CDSS) to provide social workers with guidance to explore potential immigration relief options for children and parents; and provide guidance to local agencies to establish agreements with relevant foreign consulates to facilitate family reunification in child custody cases (American Immigration Council, 2012).
Welcome New NASW-NYC Staff and Intern

Christina Wilkerson, MSW
Program Manager for Continuing Education

Christina Wilkerson is our newest staff member, joining NASW-NYC in September of 2014. Christina received a Master’s of Social Work with a specialization in Non-Profit Management from Columbia School of Social Work in May 2014. Prior to this, Christina attended the University of Southern California where she received Bachelor’s of Arts in Sociology focusing on racial equality and human rights.

Christina is a talented community organizer and social justice activist. We are so happy to welcome her to our staff. She will be heading up NASW-NYC’s new Continuing Education program, developed to comply with the new requirements for licensed social workers in New York state.

Luis Roberto Machuca
MSW Student, Intern

Luis Roberto Machuca is currently serving as the Chapter’s MSW Intern. Luis is a second-year student at Hunter College’s Silberman School of Social Work. He is pursuing the Organizational Management and Leadership concentration with a specialization in World of Work. He graduated in 2012 with a bachelors in Sociology from the University of Puerto Rico. Luis is working with Alayne on our Membership Associates Program and Planning for the Chapter’s annual gala. We are delighted to have him on board for the academic year.

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Questions?
Contact Sarah Strole, LMSW
sarahstrole@gmail.com
or Janelle Stanley, LMSW
stanleyj@gmail.com

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1 Caron electronic patient record, 4th quarter of 2013-2014 fiscal year. ² Caron 2012-2013 Annual Report: July 1, 2012-June 30, 2013 ©2014 Caron Treatment Centers

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