

## A TOUCH OF HISTORY

By Sandra (Sandy) J. Brake, MSW, ACSW  
*Social Work Service  
 VA Headquarters*



An unusual thing happened at Headquarters the other day. Our new Director, Jill Manske, was in a meeting (no, that is not the unusual thing) and was asked (here it comes) to provide information about the beginning of professional social work. Thrilled, and more than a little surprised at this opportunity for educating other clinical managers about social work, we did a little research and selected the following highlights to present. It occurred to us that somewhere in the field, some of you might also have an opportunity to do a little educating during this Centennial Year. So, we are sharing with you what we found in the hope that more questions will be asked.

Social Work Month is coming up in March and this gives us another opportunity to let people know what social work is about. There is much more historical information available in The Social Work Dictionary and on the National Association of Social Workers (NASW) website, <http://www.naswdc.org/NASW/center/index.htm> and you can put your own interpretation on the historical events. Here's to our history – and letting others know who we are!

Professional Social Work has been around for a long time, longer than you may think. Lets look at some evolutionary themes.

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## A Quick Read

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## PROFESSIONAL SOCIAL WORK

### EVOLUTIONARY THEMES

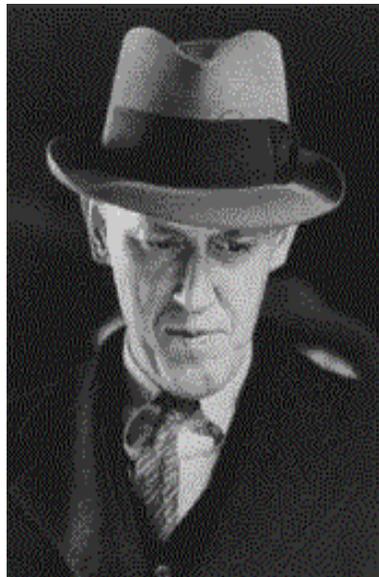


- **1750 BC**  
The Babylonia “Code of Justice” was the first recorded requirement for people to help one another during times of hardship. Volunteers and religious groups provided social welfare for centuries throughout the world. Israel in 1200 BC, Greek Philanthropy (acts of love for humanity) in 500 BC, Confucius bond of Jen to help the needy in 300 BC were followed by exhortations to help the poor from Christ, Mohammed, and religious leaders around the world.
- **1500s AD**  
Poor laws were enacted in European countries to regulate beggars, require public work (usually unpaid) and private servitude, discriminate between the “worthy and unworthy poor”, and to institutionalize poor houses (first begun in India in 400 AD). This approach to social welfare was imported to the Colonies.
- **1800s**  
Volunteer religious and philanthropic organizations increased in America to provide individualized services to help the poor and mentally ill improve themselves.
- **1865**  
The Freedmen’s Bureau, the first federal welfare agency, was established at the end of the Civil War in 1865, to provide temporary relief, education, employment, and health care for newly released slaves. It was abolished in 1872.
- **1869**  
The first Charity Organization Society was founded in London to coordinate fund raising and disbursement and to assign volunteers in making individual assessments for reasons of poverty and to correct their problems.
- **1872**  
The American Public Health Association was established.
- **1874**  
The National Conference of Charities and Corrections (later the National Conference on Social Welfare) was established to share knowledge and study causes of poverty and individual dysfunction.
- **1886**  
The Neighborhood Guild in New York opened as the first settlement house in America, based on Toynbee Hall established in London two years earlier. This volunteer movement contrasted with the individual approach to poverty by focusing on social advocacy, community development and group work. It was a consumer advocacy, self-help and customer service approach, starting with understanding the desires, needs and goals of the people, sharing ideas and information, and planning as neighbors.
- **1900s**  
During the 19<sup>th</sup> Century, a number of philanthropic and religious organizations were formed to study and exchange information on the causes of poverty. Both the individual efforts of friendly volunteer visitors to reform individuals, and the efforts of settlement houses to empower people to reform society, began to see the need for training to better use this knowledge to help people improve their lives.

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## PROFESSIONAL SOCIAL WORK

### CENTENNIAL MILESTONES



- **1898-1900**  
The New York School of Philanthropy (Columbia University School of Social Work) was established in 1898. The term “Social Worker” was used to describe trained practitioners in 1900.
- **1905**  
Massachusetts General Hospital in Boston formed the first Social Services Department to help patients deal with the social problems of illness. Over the next ten years, over 100 hospitals developed social work programs.
- **1907**  
Psychiatric Social Work was begun to work with mentally ill patients. By 1914 many other departments were formed and the term “Psychiatric Social Worker” was used.
- **1915-1935**  
Many social work organizations were formed to promote professional knowledge, skills, and practice.
- **1915-1950**  
Social Workers took developmental and leadership roles in the establishment of public and private social welfare organizations and programs such as: NAACP, National Urban League, Boy and Girl Scouts, YMCA and YWCA, U.S. Children’s Bureau, U.S. Department of Labor, National Conference of Catholic Charities, Child Welfare League, Community Councils, New Deal programs, Social Security, U.S. Bureau of Public Assistance, United Nations’ Social Agencies, and the National Mental Health Association.
- **1926**  
The U.S. Veterans Bureau established a Social Work Section. Since 1921, VA Regional Offices utilized social workers, often from the American Red Cross, to provide social work services for the military and veterans. By 1927, 36 social workers were hired to provide psychiatric and medical social work, and to obtain psychosocial histories for determination of benefits and treatment.
- **1939**  
The American Association of Schools of Social Work required a two-year graduate program for the Masters of Social Work degree.
- **1945**  
California became the first state to regulate social work practice, requiring registration. They also became the first to require licensing of social workers in 1950.
- **1952**  
The Council on Social Work Education was founded to work on improving and standardizing social work education. Curriculum Policy Standards were issued in 1983.
- **1955**  
The National Association of Social Workers was established, merging seven separate social work organizations.
- **1979**  
The American Association of State Social Work Boards was formed to promote and improve state licensing and regulatory efforts.
- **1983**  
The National Peer Review Advisory Committee was formed to train social workers for peer review to improve accountability.
- **Current**  
As in the first half of the 20<sup>th</sup> Century, social workers continue to take leadership roles in private and governmental social welfare organizations and programs. ♦

## WHO IS LOOKING FOR A CHANCE TO EXCEL?

### Vietnam Memorial Moving Wall Project

By Rick Newell, LSW and Bob Malec, MPM  
VAMC Butler, PA

When we were in the Army, our commanding officers and senior non-commissioned officers (NCOs) would ask, "*Who is looking for a chance to excel?*" We were given that chance in June 2000. VAMC Butler hosted the Vietnam Memorial Moving Wall from June 23, 2000 through June 29, 2000. A lot of planning, meetings, coordination, and collaboration with the county government and community-based agencies made this possible.

The Vietnam Memorial Moving Wall was a wonderful event for the medical center, and a wonderful experience for the city of Butler and surrounding communities. The opportunity to witness the spiritual and psychological healing of "The Wall" firsthand was perhaps the most memorable experience of the week. Many veterans of Vietnam and other wars took advantage of the occasion and visited "The Wall" to remember fallen comrades and to deal with a variety of memories. The comments that were received by the medical center's volunteer staff were overwhelming. A number of veterans wrote letters to the Wall Committee thanking them for the opportunity to view "The Wall". Some of these letters were published in local newspapers.

"The Wall" also provided a chance for family members and friends to pay homage to veterans who were killed in the Vietnam War. Of the many highlights, two stand out. During the opening day ceremonies, family members placed flowers on "The Wall" next to the names of the 43 Butler County residents as their names were read. One evening a silent candlelight vigil was held. Both of these ceremonies were very moving during the week long event.

There were other moving events during the week as well. Each service organization had a ceremony at "The Wall" during the week. The VA Lead Chaplain had an Ecumenical Church Service on Sunday at "The Wall" which was attended by many from local communities. A chapter of Rolling Thunder, the Vietnam Veterans Motorcycle Club, had a commemorative program at "The Wall" and they also spent an afternoon on the Transitional Care Units distributing gifts to the patients. Those who came to pay their respects to fallen comrades and family members left hundreds of mementos at "The Moving Wall". Members of the Vietnam Veterans Group at the Butler VA's Center for Behavioral Health planted a tree in memory of a group member who had died unexpectedly earlier in the year. The playing of Taps by two trumpeters highlighted the closing ceremony. It was estimated that 18,000 visited "The Wall".

The medical center benefited from the planning and executing of the activities of "The Wall" visit in addition to



the enjoyment of a good working relationship with local government officials and the community. This experience enhanced these relationships. Butler County had two employees serving on the committee, along with a number of VA employees, and members of the Armed Forces and the community. The manpower, services, and resources brought to the committee by county employees and members of the Armed Forces were outstanding. Donations made by local businesses, organizations, and individuals covered all needs from a paved walkway along the expansion of the wall, to food for volunteers, lumber and lighting, and flowers for the opening ceremony. By the time all was said and done, the cost to the medical center consisted of employee time for committee meetings, constructing the wall panels, and taking the wall down. This experience formed a great partnership between the medical center and the community for future collaborative endeavors.

The same commanding officers and NCOs who asked, "*Who is looking for a chance to excel?*" would now ask, "*What were the lessons learned?*" As we see it, these lessons were learned:

1. The Vietnam Memorial Moving Wall is an opportunity to provide spiritual and psychological healing for a number of veterans, family members and friends – especially those who may never get a chance to visit the Vietnam Wall in our nation's capitol.
2. The Vietnam Memorial Moving Wall offered a chance to develop or expand collaborative relationships with local governments, veterans groups and communities near medical centers.
3. The Vietnam Memorial Moving Wall provided an opportunity to pull VA employees together to work in team building efforts on the many phases of a project of this magnitude.
4. The Vietnam Memorial Moving Wall is a great opportunity to feel good about yourself as a medical center and have others feel good about you too.

So, if anyone out there in VA-land is looking for an opportunity to excel, coordinating an effort to have the Vietnam Memorial Moving Wall at your medical center, or in your community, will give you that opportunity. For additional information. call (724) 477-5011. ♦

## RESEARCH CORNER

### Effectiveness of the FairCare System for Patients with Advanced Illness

By Joe Engelhardt, PhD

*Research Social Worker*

*VA Health Care Upstate New York (VISN 2)*

**CHI 99-071**, funding period 10/1/00 – 9/30/04 was approved.

#### ABSTRACT

The proposed study is designed to evaluate the impact of the FairCare program (FC), an End-of-Life (EOL) counseling and education intervention, on: (1) improving the quality of life for Chronic Heart Failure (CHF) patients, (2) reducing their fears about dying, (3) increasing their use of advance directives, and (4) improving provider compliance with advanced directives. The FC program includes a physician-supported interdisciplinary team, which includes a nurse practitioner and a social worker. The overarching strategy of FC is to empower patients to direct their own dying process to the extent that their health, personality, and environment allow. The program is based on a recently published book that has received wide attention. It has four components: (1) counseling, (2) education, (3) advocacy, and (4) care coordination. FC is delivered in 12 weekly visits. As recommended in a recent Institute of Medicine report, the FC program is comprehensive, addressing physical, psychological, spiritual, and practical concerns.

To assure that CHF patients who need an EOL intervention are targeted, 150 CHF patients screened for ejection fractions of 35% or less, or assessed as being at level III or IV on the New York State Heart Association Classification System, will be recruited from the VAMC Stratton Cardiology Department and randomly assigned to FC or to usual care (UC).

Patients will be administered the McGill EOL Quality of Life Questionnaire and the Revised Death Anxiety Scale at baseline, three months, and then again six months after intervention. In addition, change in the rate of formulation in advance directives will be assessed baseline to 3 and 6 months, change in compliance with advanced directives will be assessed from baseline to 2 years.

#### EVALUATION

An evaluation of the quality of EOL care from the perspective of the surrogate of each patient in the study will be measured at baseline, three months, and six months using a revised version of the Integrated Care Systems After Death Interview.

Although there are no hypotheses concerning group differences in survival or health care utilization and cost,



we propose to collect and analyze survival as well as health care utilization and cost data to document any trends that may occur during the intervention and over a 24-month post-intervention period.

The Veterans Information System Technology Architecture (Vista) will be used to collect data on survival and health care utilization, and the VA Decision Support System (DSS) will be used to evaluate VA cost. Because of its ability to include cases with missing data, and other analytic advantages, random effects regression will be primary analytic method.

Dichotomous variables will be analyzed using  $\chi^2$ . Rates of survival will be assessed using the log-rank test, which appropriately accounts for censored data. The Cox Proportional Hazards Model will be used as an alternative if inclusion of covariates is warranted. ♦

### Evaluating Subacute Rehabilitative Care

By Ron L. Evans, MSW, Principal Investigator

Robert D. Hendricks, PhD

*Investigator*

*VA Puget Sound Health Care System - Seattle Division*

Funding period 1/1/97 – 9/30/00 (Report Date 9/30/00)

**This abstract presents the findings and conclusions of the authors and does not necessarily represent the Department of Veterans Administration (VA) or Health Services Research and Development Service (HSR&D). The VA, Veterans Health Administration, and HSR&D supported this research.**

**Final report for HSR&D project IIR 94.125 has been submitted as of 12/4/00. The abstract as submitted is as follows:**

#### ABSTRACT

Background: Prior rehabilitation outcome studies have had many weaknesses. They have: (1) evaluated rehabilitation effects only in isolated subgroups, (2) focused on functional ability rather than on quality of life, (3) not used randomized control groups, and (4) had inadequate sample sizes. Differences in methodological approaches have resulted in inconsistent findings. The lack of long-term benefits suggests that services may need to be continued at home or in subacute care settings to optimize their effectiveness. Unfortunately, prior research did not include behavioral outcomes.

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These could thus, not evaluate the potential benefits of rehabilitative care studies in more meaningful detail, and they did not accurately reflect the psychosocial objectives of rehabilitation.

**Objectives:** The goal of this study was to measure the additive effect of outpatient, subacute rehabilitation as follow-up services to acute, inpatient rehabilitation on adults diagnosed with a disabling disorder in four major diagnostic groups (nervous, circulatory, musculoskeletal, and injury).

**Methods:** A randomized clinical trial was conducted to determine the effects of subacute rehabilitative care on: (1) physical function, (2) health and mental health, (3) mortality, (4) family function, (5) personal adjustment, and (6) use of health care resources. Patients hospitalized for the first time with a disabling condition (n=180) were provided inpatient rehabilitation and then randomly assigned to either subacute rehabilitation at home (n=90) or to usual outpatient follow-up (n=90) in which only medical services were provided but no scheduled rehabilitative therapies were offered. To compare the two groups, analysis of covariance was conducted for the outcome variables. The between subjects factor was subacute rehabilitative care versus usual medical services as an outpatient.

**Results:** The major finding of the study was that there was no significant effect of the study intervention on any study outcome.

**Impact:** Some prior clinical trials have noted a short-term treatment effect on functional ability but not on mortality, need for skilled care, or for health or mental health status. Any long-term benefit, however, may not be detectable across disability categories and may require closer evaluation in studies with a more homogeneous population than in the current study. Providing follow-up services to all clients is apparently not beneficial. Future studies should determine if services are more effective when provided to those with the most unmet rehabilitative needs. ♦



## **Research Announcement**

**Attn:** Social Work Managers and Research Directors  
**From:** The VA Social Work Program Evaluation and Research Committee

If you know of social workers who have been involved with research lately, or are currently involved, could you please share their names and locations so that we might contact them. We are attempting to compile a list of research and program evaluation projects and related activities with which social workers in the VA have been involved.

We plan on contacting those persons directly via e-mail and will ask them to share a citation, abstract, or any other description of said research activity. We think this information will be useful to policy makers and planners within the VA and may stimulate even further evaluation efforts.

Please respond via Outlook Exchange mail to [Ron.Evans@med.va.gov](mailto:Ron.Evans@med.va.gov) or [Susan.Barfoot@med.va.gov](mailto:Susan.Barfoot@med.va.gov). You may also respond via a written memo to Ron Evans (S 111-SW), VAPSHCS, Seattle, WA 98108; or to Dr. Susan G. Barfoot (11H), Tuscaloosa VAMC, 3701 Loop Road East, Tuscaloosa, AL 35404.

If you have further questions, please feel free to call me at (206) 764-2728.

Thank you for this consideration.

Ron Evans, MSW, Committee Chair  
Susan Barfoot, DSW, Committee Member

## **Next Edition:**

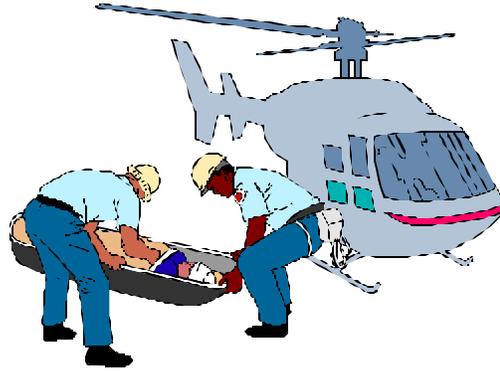
We welcome articles from anyone who wishes to address health care issues within the Department of Veterans Affairs. While social workers are our primary target group, contributors can be from any discipline. *SYNERGY* is an excellent tool for communicating information and ideas with hundreds of your peers. Articles for the next edition of *SYNERGY* should be faxed by March 2, 2001 to Rocco Bagala at (206) 764-2514 or transmitted to him via MS Exchange.

## Developing Critical Incident Stress Management (CISM) Programs for the VA

By Troy Scott Martin, MSW, Clinical Social Worker  
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Bruce K. Martin, EMSHG Area Emergency Manager  
VISN 7

Paul Kim, MD, EMSHG Area Emergency Manager  
VISN 2



As crises and disasters become epidemic, the need for effective crisis response capabilities becomes obvious. Critical Incident Stress Management (CISM) represents a powerful, yet cost-effective approach to crisis response (Everly, Flannery, & Mitchell, in press; Flannery, 1998; Everly & Mitchell, 1997).

A critical incident is defined as "any event that has a stressful impact sufficient enough to overwhelm the usually effective coping skills of either an individual or a group, and are typically sudden, powerful events outside of the range of ordinary human experiences" (Mitchell & Everly, 1993). The critical incidents and stressors that could be experienced by VA employees in VHA outpatient, inpatient, and VBA settings include: held hostage, physical/sexual assault, death or serious injury in the line of duty, suicide of patient or employee, use of forced restraints and take-downs, and witness to any of the above.

Workplace violence has been an issue of much attention in the last 15 years. According to the National Institute for Occupational Safety and Health (NIOSH), an estimated 1 million workers are assaulted annually in U.S. workplaces. The majority of these assaults occur in service settings such as hospitals, nursing homes, and social service agencies. Violence is a substantial contributor to occupational injury and death, and homicide has become the second leading cause of occupational injury and death. An average of 20 workers are murdered and 18,000 are assaulted while at work or on duty each week (NIOSH, 1995). Workers in health care and community services settings are at increased risk of nonfatal assaults. Nonfatal assaults result in millions of lost workdays and cost workers and their employers millions of dollars in lost wages (Jenkins, 1996). Surprisingly, less than half of all of these crimes are reported to the authorities due to the lack of complete and comprehensive programs that will assist the workplace in managing the risk. Compounding the problem, law enforcement has historically taken a "hands off" attitude due to the fact that these crimes have occurred in the workplace and are considered an "internal" problem or event.

The role of stress in workplace violence has been a topic of heavy discussion. The most important thing to remember is that stress can be both a cause and an effect of workplace violence. That is, high levels of stress may lead to violence in the workplace, but a violent incident in the workplace will most certainly lead to stress, perhaps even to post-traumatic stress disorder. The data from the National Crime

Victimization Survey (Bachman, 1994) present compelling evidence (more than a million workdays lost as a result of workplace assaults each year) for the need to be aware of the impact of workplace violence. Employers should not only be aware of the risk of violence erupting in the workplace, they should be sensitive to the effects of workplace violence and provide an environment that effectively manages the risk which includes established procedures for reporting and responding to violence. This can only be accomplished in an atmosphere that promotes an environment of open communication. Yet, with the statistics and headlines that point to a growing problem, few companies, businesses, agencies and organizations support a comprehensive workplace violence prevention program. A fewer number that maintain prevention programs employ the Comprehensive Emergency Management (CEM) concept to managing the problem. The CEM concept of mitigation, preparedness, response and recovery will provide the ideal building blocks and foundation for a state-of-the-art risk management program. Vital parts of the program will include appropriate referrals to employee assistance programs or other local mental health services may be appropriate for stress debriefing sessions after critical incidents.

Just recently three separate critical incidents occurred within VISN 7, and no CISM was provided to the involved VA staff members. It was also noted that VISN 7 staff involved with Operation Provide Refuse, Ft. Nix, was not afforded any CISM upon completing this assignment, although the VISN 7 Emergency Management Strategic Healthcare Group (EMSHG), Area Emergency Manager (AEM) brought this to the attention of EMSHG Headquarters and United States Public Health Service (USPHS), Office of Emergency Preparedness (OEP). Unfortunately, none of these incidents, and the fact that CISM was not implemented, is surprising. The typical disaster management plan or philosophy does not include CISM as part of the process. Why? Because the typical plan does not follow CEM principles and concepts. Make no mistake, an incident of violence in the workplace no matter the circumstance, the size or

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severity of the problem, is a disaster for the affected workplace, all the employees, clients, visitors, and family members.

### **What is CISM?**

CISM is a comprehensive, integrative, multicomponent crisis intervention system. CISM is considered comprehensive because it consists of multiple crisis intervention components, which functionally span the entire temporal spectrum of a crisis and critical incident. CISM interventions range from the pre-crisis phase through the acute crisis phase, and into the post-crisis phase. CISM is also considered comprehensive in that it consists of interventions, which may be applied to individuals, small functional groups, large groups, families, organizations, and even communities.

Historically, public and private hospitals have offered specialized assistance to employees who have experienced critical incidents and stressors through various programs. The assistance programs usually fall into three broad categories:

1. Employee Assistance Program (EAP), a contracted service with the local, state, and/or federal agencies or facilities. Traditionally, the EAP provider is typically an individual mental health clinician (i.e., counselor, social worker, or psychologist). Since employees in these settings tend to be cautious and somewhat suspicious of mental health providers and outsiders, few EAP programs include clinician-trained peer support personnel selected from the employees likely to be represented in an event.
2. Peer Support Program (PSP), which consists of non-clinician employees who are representative of the workforce, and trained in crisis intervention.
3. Critical Incident Stress Management (CISM) Program, the International Critical Incident Stress Foundation (ICISF) model. The CISM Team is "described as a partnership between professional support personnel (mental health professionals and clergy) and peer support personnel (employees) who have received training to intervene in stress reactions" (Mitchell & Everly, 1993). Professional support personnel are required to have academic training at the master's degree or higher level, and/or recognition of their training and skills through certification or licensure. They must also have education, training and experience in critical incident stress intervention.

### **Components of a Comprehensive CISM Program**

A comprehensive CISM program is multi-faceted (Mitchell & Everly, 1993; PDOC, 1992). Pre-incident prevention and stress inoculation are essential. While attending new employee orientation, all employees should receive education and training in everyday and work-related stress awareness and stress management techniques, as well as how to access the EAP program and CISM team. Employees whose jobs require direct contact with patients should attend bi-annual refresher stress management classes. Managers should receive training in recognition of employee stress and referral procedures. Families and significant others should be provided similar stress awareness and coping skills, and how to access referral services at the medical center and in the community.

When developing a VA CISM team, member selection and training need to be well planned and foster a partnership between employees, management, and labor relations. The leadership of the CISM Team should fall under the direction of the Emergency Preparedness Coordinator (EPC) or Mental Health Council. A CISM Program policy/standards and procedures manual should be established. Best results are achieved if team membership is voluntary. A selection committee comprised of management and employees/labor representatives should develop an application form and include an interview in the selection process. Team members, professional and peer, must be trusted and accepted by their fellow employees. Peer members should be representative of the employee population including engineering, education, clinical support and mental health, medical, clerical, etc. It is recommended that each VAMC have a CISM Team available for rapid deployment. In order to respond to major events, in large systems, VHA ESMHG Districts or VISN CISM teams composed of members from various facilities are also suggested. Although there are similarities in the training programs available, the model should adhere closely to the International Critical Incident Stress Foundation (ICISF) standards. All team members should be required to complete ICISF Basic Critical Incident Stress Debriefing Training. Peer Support/Crisis Intervention Strategies is also recommended. All members should also have an understanding of Emergency Response protocols. The CISM team should participate in joint training exercises at least once annually and be included in the VHA Disaster Emergency Medical Personnel System (DEMPS).

### **The CISM Program services should include:**

- On-scene support (usually provided by peer support members during a major/prolonged event).
- Demobilization or de-escalation (brief intervention to assist employees in making the transition from the traumatic event back to routine or stand-by duty, formal debriefing to follow in several days).

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- Defusing (a three-phase group crisis intervention provided immediately or within 12 hours after the event to mitigate the effects of the stressors and promote recovery, usually 20-45 minutes in duration).
- Debriefing (a seven-phase group crisis intervention process to help employees work through their thoughts, reactions, and symptoms followed by training in coping techniques, usually lasting 1-1/2 to 2 hours).
- One-on-one support (individual intervention if a single or small event and a group intervention is not possible or additional individual assistance is deemed necessary after a group process).
- Significant other/family defusing/debriefing (services may be provided separately from traumatized employees).
- Line-of-duty death support (defusing provided immediately after event for staff, team assists family, and a debriefing provided for staff after the funeral).
- Referrals (team member recommends and instructs employee to access additional support/treatment through EAP or other resources).
- Follow-up (team leader or designated member contacts employee(s) and/or employees' supervisor a few days after team services).

### **Records and Program Evaluation**

Employee(s) confidentiality must be maintained. However, in order to maintain service continuity and program quality improvement minimal record keeping is necessary. A request for service form including time of event, nature of incident, number of personnel involved, contact person and contact number will assist the team leader in selecting team members and establishing meeting location and time. The provided service form should include information from the request form and a summary or themes of reactions, thoughts, and symptoms presented, educational material provided and coping techniques recommended and if referrals were made. Individual(s) names and comments are not recorded. The team leader may, with the majority consensus and participants' permission, provide administrative staff with a report of recommendations to improve conditions or remedy situations that led to the critical event.

In most situations, consumer satisfaction will be determined informally through follow-up with the participants and from supervisory staff. However, after major events, a participant's satisfaction questionnaire is recommended. A combination of checklist, multiple choice and general comment format works best in this employment setting.

### **Interagency and Community Support**

VA medical centers are geographically located throughout the United States. The medical centers and VISN CISM teams can be a resource for smaller communities and municipalities that provide services for community health clinics, hospitals, mental health centers and other emergency responders. The VA CISM Team professionals may act as consultants or supplement communities' volunteer peer teams. The VA CISM teams can, along with the Emergency Medical Response Team (EMRT), assist communities affected by a disaster. The VA CISM Teams may also work very effectively with other state and Federal agencies such as NDMS Disaster Medical Assistance Teams, FEMA's Urban Search and Rescue Teams, local, and state hospitals and mental health facilities.

### **Conclusion**

CISM, as an integrated system of services designed to prevent and/or mitigate critical incident stress, assist and accelerate recovery, restore the affected person(s) to function, and maintain worker health and welfare, is the most effective model available for the initial response to critical incident stress. A VA CISM program can help reduce the negative effects of traumatic stress, both in terms of severity and longevity, in the majority of people so treated.

**Further information can be obtained on CISM by contacting:**  
Troy Scott Martin at (205) 554-2000, ext. 3837 or e-mail [Troy.Martin@med.va.gov](mailto:Troy.Martin@med.va.gov) or

Bruce Martin at (205) 933-8101, ext. 5896 or e-mail [Bruce.Martin@med.va.gov](mailto:Bruce.Martin@med.va.gov)

**Further information can be obtained on *Workplace Violence, Managing the Risk* by contacting:**  
Paul D. Kim, MD at (518) 462-3311, ext. 2364 or e-mail [Paul.Kim@med.va.gov](mailto:Paul.Kim@med.va.gov)

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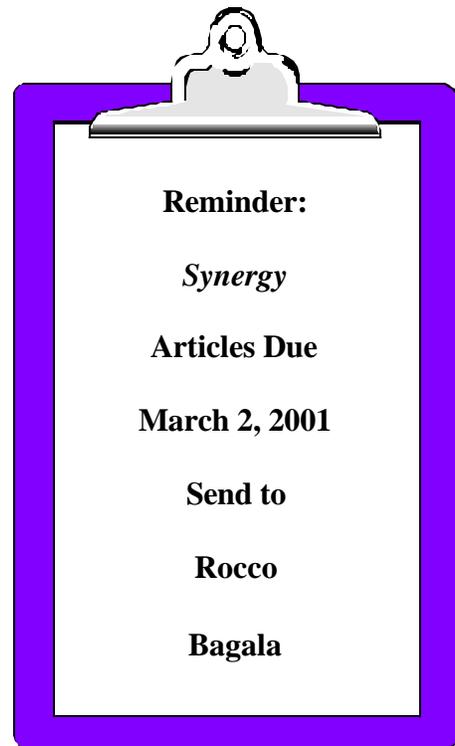
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## SOCIAL WORK LICENSURE PUBLIC LAW 106-419

By Jill E. Manske, ACSW, LISW  
*Director, Social Work Service*  
*VA Headquarters*

Since the early 1980's, Social Work in VA Headquarters has been advocating for mandatory licensure of all VA social workers. Former Social Work Director, John Fulton, felt that licensure would assure acceptable standards of practice for professional social workers across the system. After many years of hard work and negotiations by Mr. Fulton, the President signed PL 102-86 (Veterans Benefits Programs Improvement Act of 1991) in August 1991. The new law required all social workers hired after August 14, 1991 to become licensed in the state in which they practice within three years of employment. Those hired prior to August 14, 1991



were covered under a “grandfather” clause; licensure for those social workers was voluntary.

Soon after the law was passed, it became clear that the language of the law created obstacles for recruitment and retention of social workers. Since VHA social workers transfer within the system and from state to state, the requirement to be licensed in the state in which they practice became a problem. Attaining a license within the prescribed three years was not as easy as the drafters of the legislation had anticipated. When states tightened their criteria for eligibility for licensure and increased the number of hours of practice and supervision required, social workers across VHA struggled to meet the three-year limit.

Over the past year, Social Work in Headquarters, along with General Counsel, Congressional Operations, Human Resources & Administration, and VHA Executive Management worked on draft legislation to remedy the problems created by the wording of the original law. Information was gathered on the number of social workers negatively impacted by the law, some of whom were terminated from employment or downgraded to positions outside of Social Work. The Headquarters group faced a long, difficult process for seeking support from Congress in amending the law. Then Congressman Lane Evans learned of the issue and suddenly it was brought to the front burner in the House Veterans Affairs Committee.

*(continued on page 11)*

### Palliative Care

By Larry Peterson, ACSW, LCSW  
*Chief, Social Work Service  
VAMC Durham, NC*

The new Director of Social Work, Jill Manske, was invited to meet with House and Senate Veterans Affairs. The new Director of Social Work, Jill Manske, was invited to meet with House and Senate Veterans Affairs Committee staff to explain the issues and the need for a legislative remedy. The meeting was a turning point in terms of "fast-tracking" the needed legislation. The wording of the Headquarters group found its way into House Bill 5109 and then into Senate Bill 1402. In October 2000, President Clinton signed Public Law 106-419, the Veterans Benefits and Health Care Improvement Act of 2000. Section 205 of that law corrected the problems with PL 102-86 for Social Work licensure in the following ways:

- The requirement to be licensed in the state in which the social worker practices was replaced with "licensed in a state". This language was consistent with licensure law for other VHA professionals, such as physicians. Social workers in VHA may now retain out-of-state licenses.
- The mandate that VHA social workers become licensed within three years was replaced with "within a reasonable amount of time determined by the Secretary".

Human Resources & Administration, VHA Executive Management and the Director of Social Work are drafting a VHA directive to interpret the law, particularly the clause referring to "within a reasonable amount of time". The Social Work Qualification Standards will be revised accordingly. Publication of the new directive is anticipated in mid-February 2001. In the meantime, Human Resources Officers have been advised to take no action against social workers with out-of-state licenses and those who have failed to become licensed, through no fault of their own, within the three years required by the old law.

Many thanks to Sandy Brake, Acting Director of Social Work; Suzanne Demong, Chief of Social Work VAMC San Diego; Angela Prudhomme, Office of General Counsel; Deborah Bittinger, Office of Congressional Operations; Cindy Wade, Office of VHA Executive Management; and Jan Stanley, Office of Human Resources and Administration for the many hours spent in gathering information, word-smithing and negotiating with Congress on the proposed legislation! Without their persistence and hard work, Section 205 of PL 106-419 would not exist.

For more information on social work licensure, please call Jill Manske, Director of Social Work, at (202) 273-8549. ♦

**Background:** Prior to FY99 and early in FY99, VAMC Durham had not met the Palliative Care Performance Measure of 95% compliance with External Peer Review Program (EPRP) review standards. In order to improve the Medical Center's attention to the palliative care needs of patients with terminal diagnoses, a task group was convened in early calendar year 1999 to address possible changes that would improve our response. The Task Group was interdisciplinary and included physicians, nurses, social workers, dietitians, chaplains, and PAs across treatment programs and included representatives from inpatient and outpatient programs.

**Discussion:** The Task Group met weekly at the beginning, and then met less often as changes were put into place. The group took several actions:

- Information Resource Management (IRM) developed a template to screen for the International Classification of Diseases 9<sup>th</sup> Edition (ICD 9) Codes that were screened by EPRP. If a patient entered the hospital with one of these diagnoses, we would be alerted to follow up with that patient regarding palliative care needs.
- Medical Service History & Physicals were revised to include a question regarding the presence of terminal illness. If the answer to the question was "yes", then the physician was directed in the template to make a palliative care referral to Social Work Service.
- Social workers received all consults for palliative care and brought in other team members as needed. They were aware of palliative care issues and documentation necessary to meet EPRP standards.
- Notes with titles reflecting palliative care activity were made available in the Computerized Patient Record System (CPRS).
- The Task Group educated their respective disciplines on appropriate palliative care activities and on EPRP review criteria.
- Task Group members made themselves available to EPRP reviewers regarding any questions.

Since the activity of the Task Group, the Medical Center met the EPRP Palliative Care performance criteria in FY99 and reached 100% compliance in FY00.

**Transportability/Implications for Other Medical Centers:** Assuming the same electronic networking capacity, all of the above should be transportable to any VA Medical Center. ♦

## USING THE INTERNET AS A SOCIAL WORK RESOURCE

By Kate Buike, MSW

VA Puget Sound Health Care System – Seattle Division

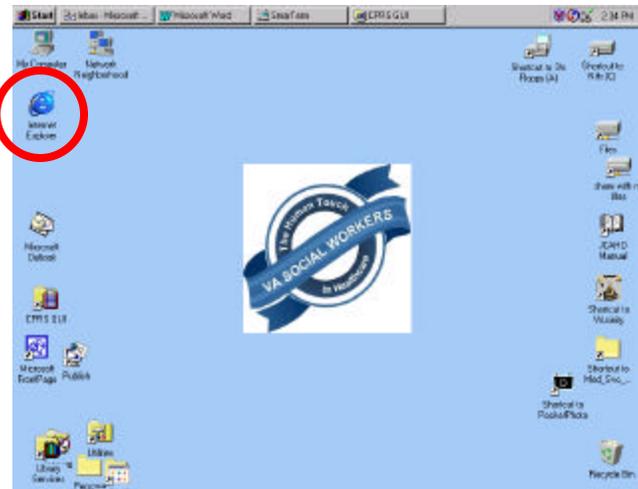
This article addresses the use of the World Wide Web (WWW, W3, or “the Web”) as a social work resource, the use of E-mail to communicate with patients, basic information on how to use web-browsing software, and how to use one's own Internet and Intranet web pages.

### Searching for Information or Resources

The WWW is a great resource for social workers. Most medical organizations and states have web sites to inform the general public of their services. A well-maintained web page is usually more current than printed resources.

Some health related organizations also have "members only" sections where additional resources are available. The National Hospice and Palliative Care Organization is one such example.

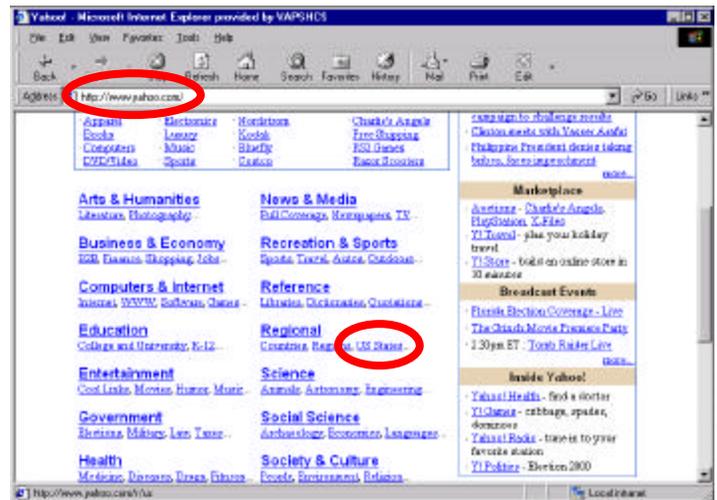
Access the WWW by double clicking the Microsoft Internet Explorer (IE) icon (circled below). IE is the browser most commonly used by VA.



Where do you go to find resources? A search engine is software that searches an index and returns a match based on a key word or a phrase. Searches may sometimes result in an overwhelming number of sites. Searches Sites such as Yahoo ([www.yahoo.com](http://www.yahoo.com)) or Excite ([www.excite.com/](http://www.excite.com/)) are web sites that contain catalogs of web resources that can be searched by headings, Universal Resource Locators (URLs) and keywords. Dogpile ([www.dogpile.com](http://www.dogpile.com)) is a "meta searcher" in that it searches through a dozen search engines. The underlined blue texts above are "hypertext" links that accesses the web sites by clicking on the link.

I work at a VA facility that serves a wide geographic area and it would be difficult to keep a current collection of resource directories from every town, city or county in this area. Therefore, I use the Internet as a current resource.

I wanted to find a home delivery meal program for a patient. I was quite certain that the State's Department of Aging Services would offer such a program. Using Yahoo's search engine, find the state's official website by clicking on *US States*.



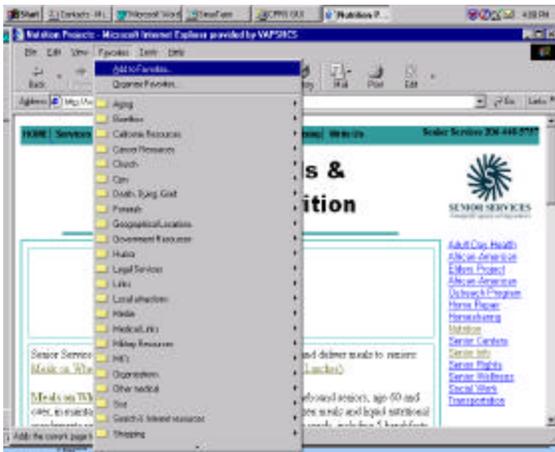
Click on *Government* under the “State Web Directory” heading. Click on the “State of (state's name)” hyperlink to open that states homepage. The design of state homepages vary therefore, you may find a link for Public Services, Health Care, and Social Services, etc. If these exist, click on the link and do a search for “meals on wheels”. If these links do not exist, from the state homepage, do a search for “meals on wheels”.



The "back" and "forward" buttons on the browser allow you to move among the pages that are stored in the hyperlinks history.

Saving these web sites in the “Favorites” folder can access a record of the web sites that were visited frequently. The saved sites will display each time the “Favorites” folder is opened.

(continued on page 13)



The WWW can also be a tremendous resource of disease specific information for the social worker and for patients. However, you need to be careful, as there is as much misinformation on the WWW as valid information. Government sites, such as, the American Cancer Institute ([www.nci.gov](http://www.nci.gov)) or the web sites of specific reputable organizations like the Alzheimer's Association ([www.alz.org](http://www.alz.org)). Personal sites can also offer the support of "one who has been through it", but judge the site carefully by its content and apparent motives.

The National Association of Social Workers (NASW) web page (<http://www.naswdc.org/>) and the VA Social Work Web page (<http://www.va.gov/socialwork/>) are valuable resources for social workers. My personal web page includes information for cancer patients, as well as a number of other social work links under "Links for Clinicians" (<http://members.aol.com/mkbuike>).

### Searching for People

Many search engines have an option to search for people. On Yahoo, it is called "People Search". These lists are often based on the nation's telephone directories. There have been times when I have searched for a patient's family member in this manner. It works best if the family name is unusual and/or you have some idea of where the family lives. This search could be used if you needed to locate a patient's family for surrogate decision-making.

### Using E-mail to Communicate with Patients and their Families

On a case-by-case basis, I have used e-mail to communicate with patients and their families. It can sometimes eliminate the annoyances of "phone tag". An e-mail allows the message to contain more detail than a voicemail message. This is especially useful when communicating with families that live overseas.

However, one must utilize every precaution when transmitting confidential patient information by e-mail. Unless a good encryption program is used, one cannot be absolutely certain that the message is not intercepted. I do not use the patient's name in e-mail messages; instead I refer to the patient as "your father/mother".

### Your Facility's Social Work Web Page

Prior to posting information about social work on your VA's web page, consider your audience. VA employees have access to two types of web pages: Internet and Intranet. The Internet can be viewed by anyone in the world; those on a VHA computer have access to the Intranet. The social work department had a paper pamphlet about Social Work Service that I used as the basis for the content of the Internet web page that I developed. I also included a list of the individual social workers, their specialty areas, phone numbers and an e-mail link. On the Intranet page, I also included their pagers.

My design philosophy is that you consider the audience prior to developing the web page. It is important to remember that the viewer may not have state of the art equipment. Therefore, a web page should be as simple as possible. The inclusion of pictures, graphics, and moving objects will effect the time that is involved in the web page loading.

I hope this information has been useful. I would welcome comments or questions, preferably via Outlook e-mail at [mkbuike@med.va.gov](mailto:mkbuike@med.va.gov).

Kate Buike is a social worker in the General Internal Medicine Clinic of VA Puget Sound Health Care System, Seattle, WA. She took a 1-1/2 year sabbatical from social work to work as a Clinical Application Coordinator and a member of a VISN team in support of CPRS. ♦

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