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Newsletter for the National Organization for Human Services

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Compassion and Wisdom in Action: The Power of Support Groups

John Paulson

Throughout my professional career, I have been an advocate for group work. I have had the privilege of facilitating a number of different psychoeducational and psychotherapy groups over the years, both for addiction and behavioral health difficulties. I also have routinely referred individuals to a wide variety of community-based support groups.

I am consistently impressed by the experiences that individuals have who participate in group interventions and the benefits they report from attending and being involved. Repeatedly, I hear comments about how attending group helped the person to combat isolation and to feel less alone. Participants describe a sense of relief and liberation to know that they are not the only one that suffers and struggles with certain issues. They describe the transformative warmth of acceptance and affirmation from being part of a healing community, a place where they are both supported and where they can offer support to others.

My confidence in group work has been further strengthened over the course of the past year by my experience facilitating the Family & Friends Support Group for Gilda's Club Evansville (www.gcevv.org) each Tuesday night. The first Gilda's Club in New York was established in honor of the late comedian and original Saturday Night Live cast member Gilda Radner, who was diagnosed with ovarian cancer in 1986. While she was receiving medical treatment for her condition she was also travelling to California to participate in a supportive wellness community. Following her passing her husband, actor Gene Wilder, and her psychotherapist, Joanna Bull, established Gilda's Club "so that no one faces cancer alone."

There are now clubhouses throughout the United States, and while Gilda's Club is not a treatment provider, each clubhouse offers a wide variety services and programs to support those with cancer and the family and friends of those affected by cancer. My group is one of those programs. Each week the loved ones of those with cancer: spouses, siblings, parents, friends, come together to share their common experiences, to express their struggles and successes, and to support each other through this daunting and frightening experience.

The following observations and perspectives have come out of the rich discussions that our group has had this past year. We have noticed some amazing dynamics that, hopefully once shared with others, will be of benefit and service to those who are supporting loved ones with cancer. These observations can be consolidated and expressed as ten P's: Personal, Parallel, Patterns, Perspective, Party, People, Places, Persistence, Play, and Patience.

The first "P" is personal. It is important to recognize that each caregiver's experience in dealing with their loved one's cancer is personal, in that it is different, unique, and that each perspective is special. We say "cancer" as if it is a single entity, but in actuality there are many cancers, and within each there is an amazing variety of experiences. It is important to remember to honor this uniqueness because doing so protects against the tendency to think that there is "one set way" to think and feel when something happens. There is no script that specifies exactly how to feel or what to do.

> "It is important to recognize that each caregiver's experience in dealing with their loved one's cancer is personal, in that it is different, unique, and that each perspective is special."

GILDA'S CLUB EVANSVILLE

An Affiliate of the
CANCER SUPPORT COMMUNITY

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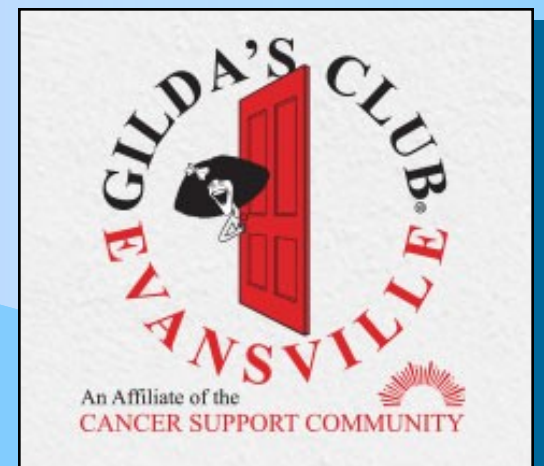
A poignant illustration of this was a comment shared by one of my group members, a mother whose daughter has cancer. During an argument her daughter made the comment that she did not know what it was like to have cancer. The member acknowledged that this was indeed true, but she also reminded her daughter that she did not know what it was like to have a child with cancer.

The second "P" is parallel, meaning parallel paths. While there is incredible individuality in the experiences of the caregivers for those with cancer, there is also an amazing similarity of shared dynamics and frustrations between caregivers across cancer diagnoses. All caregivers, at some point, will struggle with questions such as "why" and "what:" "Why my loved one; why now? What will I do, how will I get by and cope when they're gone?" They will also share the conviction that "It's not fair; it's not right" that their loved one has cancer.

Through recognizing and embracing these common experiences, caregivers come to see that seemingly opposing dialectics can both be true and exist simultaneously, that one can have hope for improvement and also be hesitant about being too optimistic. Although appearing to be mutually exclusive, one can appreciate the blessings in their life and still be apprehensive about what will happen next. A common sentiment in my group is, "I am thankful for what I have, and I am depressed, scared and mad as hell." Acknowledging these commonalities helps the caregiver to validate their experiences, as opposed to shaming them.

This parallelism is not only between various caregivers, but it also exists between the paths of the individuals with cancer and those of their loved ones as well. Both the person with cancer and their caregiver, for example, quickly discover that neither can control cancer. There is also a shared sense loss of control for both. For the person with cancer, there is a loss of control over their health, activities, functioning, and independence. The caregiver shares this loss of control over schedule, plans, hopes and predictions for the future with their loved one. Caregivers, however, also share the sense of loss of control over not being able to protect and safeguard their loved one. There is a sense of powerlessness in that the caregiver wants to help but often does not know how, wants to comfort and make it go away but can't.

Part of the ongoing struggle with control is re-negotiating who does what in the relationship and how flexible that can be, both for the person with cancer depending on how they feel and for the caregiver in their willingness to let them try, even if that means they might fail. Both get used to doing certain activities and then no longer doing them, and each has to relinquish some control over the roles, tasks, and responsibilities they have adopted.

The third "P" is patterns. Over time, caregivers start to learn what to look for, what to expect, and what to predict in their loved one. Patterns start to develop in how the loved one reacts to chemotherapy, how they experience side effects, and how quickly they bounce back. Ultimately, however, the caregiver learns that although a better idea of what to expect emerges, one can still never fully or accurately predict what will happen or how the loved one will respond.

The fourth "P" is perspective. Becoming more intimate with these patterns offers a sense of perspective. As the caregiver starts to better understand the experiences and struggles of the loved one with cancer, they are able to react and respond more skillfully. Understanding that a loved one's irritation and short temper are not always about or directed at the caregiver specifically allows one to not take it as personally and to react with less defensiveness.

Perspective also comes from experiencing a serious, possibly life threatening medical condition. Doing so often brings into focus what is truly important in one's life. One starts to realize that time is limited and that every moment is a gift. This clarification of values can also highlight what is not as important or significant as it once seemed, creating this greater sense of perspective.

While there is incredible individuality in the experiences of the caregivers for those with cancer, there is also an amazing similarity of shared dynamics and frustrations between caregivers across cancer diagnoses.

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The fifth "P" is party. Learning to celebrate accomplishments and signs of improvement, even if they seem small, is essential. Remembering to party also helps one to be present to the moment and the opportunity it offers to be grateful and joyous, even if these subside rather quickly. The sixth and seventh "P's," people and places, invite one to take inventory of who and where serves as a supportive presence. There is no way to navigate this alone, so each caregiver must find resources in the form of people and places to help.

The eighth "P" is persistence. It is incredibly natural and normal for caregivers to become tired and discouraged. The principle of persistence reminds one to keep going, to support and nurture their loved one with cancer even when it is difficult. A member of my group often points out that everyone in the group has a 100 percent success rate for dealing with situations, regardless of whether they classify how they dealt with them as "good" or "bad."

The ninth "P" is play. Self-care for caregivers is vital and necessary, not a luxury. Nurturing one's own well-being is not selfish, and it helps the caregiver to better take care of the other. Learning how to take care of one's self is an on-going process of discovery. One learns that the question "How do I care for myself" becomes more important to ask than to answer.

The tenth "P" is patience. There is a strong and understandable desire to know things "right now" and for situations to resolve "right now." Being a caregiver, however, requires patience in the presence of uncertainty and turmoil. Accompanying patience is the need to cultivate and express compassion and forgiveness: towards one's circumstances, towards others, and most importantly towards oneself. Caregivers begin to recognize that there are many uncertain choices to make about how to be and respond, and there is a deep realization that none of these choices are easy to make. Patience, compassion, and forgiveness become essential for continuing to move forward.

With patience and compassion, there is a sense of wise discernment that develops between acceptance and action, figuring out when one can control something and subsequently harnessing energy to take action, and realizing when one cannot control what is occurring and not wasting energy on that. Often one must determine between soothing and solving. Since not every situation can be solved, sometimes he best that can be done is to soothe in the presence of distress.

So 10 P's, one for each finger, and when all are brought together they form the universal prayer position, a reminder that these principles are not separate and that each is interconnected and interdependent, reliant on the others. The same is true for members in a community of support.

Eastern traditions often refer to the two wings of the bird, one wing being compassion and the other wisdom. Without both the bird cannot fly. The sense of compassion and wisdom in my group is amazing. These people come together and care for each other in a way that is both humbling and inspiring. A recurrent comment in our group was that "it's the club you don't want to belong to, but are glad that you do." Experiencing their courage and kindness has impacted me in a way that I can neither adequately describe nor could I ever repay. I am truly grateful for the time I have been able to share with them.

"Self-care for caregivers is vital and necessary, not a luxury"

Courtesy of Wikipedia

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River City Advocacy

Merideth McCallick Erickson

River City Advocacy, Inc. is a 501(c)(3) nonprofit organization in New Braunfels, Texas specializing in recovery support services for people with persistent mental and behavioral health issues and various developmental difficulties. We are a Consumer Operated Service Provider with 50% of our staff and 100% of our governing board having lived experience with persistent mental health issues. River City Advocacy provides our services at little to no cost for our consumers; we serve the underserved, underinsured, and uninsured in our community. As the Executive Director, I strive to reduce stigma associated with persistent mental illness, behavioral health issues, and developmental difficulties in our community through community awareness efforts.

At River City Advocacy, we provide peer based mental health recovery support systems needed in our community. Our vision is to advocate, educate, and facilitate acceptance of mental health issues. We offer free peer support, person centered recovery planning, support groups, life-skills workshops, career and job coaching, computer skills training, and art therapy. Our individual, couple, and family counseling services are offered based on a sliding scale fee system. Our socialization opportunities assist with life and social skills and offer a sense of community and acceptance.

Mental health issues are more common than heart disease, lung disease, and cancer combined. It is estimated that one in four Americans will have a diagnosable mental disorder at some point in their lives. Former President Bill Clinton said, "Mental illness is nothing to be ashamed of, but stigma and bias shame us all." Stigma is a cluster of negative attitudes and beliefs that motivate the public to fear, reject, avoid, and discriminate against people with mental illnesses.

What is a Mental Illness? Mental illnesses are medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others, and daily functionality. Just as diabetes is a disorder of the pancreas, mental illnesses are medical conditions that often result in a reduced capacity for coping with the ordinary demands of life. Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, PTSD, and borderline personality disorder. Mental illness recovery is possible. Mental illness does not discriminate; it can affect people of any age, race, religion, and/or socioeconomic status. The general public needs to understand that mental illnesses are NOT the result of personal weakness, lack of character, or poor upbringing. Mental illness is treatable, and most people diagnosed with a mental illness can and do experience relief from their symptoms by actively participating in an individualized recovery treatment plan. In addition to psychosocial treatments such as cognitive behavioral therapy, individual therapy, or counseling, peer support groups assist consumers with recovery.

> Former President Bill Clinton said, "Mental illness is nothing to be ashamed of, but stigma and bias shame us all."

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Here are some important facts about mental illness and recovery from the National Alliance on Mental Illness website:

- Mental illnesses are serious medical illnesses. Even though mental illness is widespread in the population, the main burden of illness is concentrated in a much smaller proportion-about 6 percent, or 1 in 17 Americans-who live with a serious mental illness. The National Institute of Mental Health reports that one in four adults-approximately 57.7 million Americans-experience a mental health disorder in a given year.
- The World Health Organization has reported that four of the 10 leading causes of disability in the US and other developed countries are mental disorders. By 2020, Major Depressive illness will be the leading cause of disability in the world for women and children.
- Mental illness usually strikes individuals in the prime of their lives, often during adolescence and young adulthood. All ages are susceptible, but the young and the old are especially vulnerable.
- Without treatment the consequences of mental illness for the individual and society are staggering: unnecessary disability, unemployment, substance abuse, homelessness, inappropriate incarceration, suicide and wasted lives. The economic cost of untreated mental illness is more than 100 billion dollars each year in the United States.

What is Peer Support? By definition, peer support is getting help from someone who has been through similar situations, illnesses, etc. People that have similar experiences may be able to listen, give hope, and guidance toward recovery in a way that is different, and may be just as valuable as professional services. In addition to the direct services one may receive, many peer-run organizations advocate to improve opportunities for people recovering from mental illnesses. Peer support programs like River City Advocacy, Inc. strengthen primary care practice and community health by reaching the vulnerable populations and reducing health disparities. We offer a variety of peer support groups with the hope of meeting the recovery needs of mental health consumers in the community.

What happens in a Support Group? The Support Groups are the core of River City Advocacy's programming. In support group meetings consumers meet in a friendly, nonthreatening environment that we like to call the "judgment free zone." The meetings run for about an hour, and we ensure confidentiality for all of the participants. We encourage active participation, however if a consumer is not quite ready to share, then they do not have to. When thoughts and emotions are shared, encouragement is offered in a variety of ways; we do not say "you need to do X, Y, Z" or pass judgment; this is a time for facilitators and peers to step in and help them to come up with positive solutions to their issues. Facilitators are licensed professional counselor interns and certified peer support specialists.

At River City Advocacy we meet our consumers where they are and help them realize they are MORE than a diagnosis. To learn more about our programs at River City Advocacy, call us at 830.643.0200 or go to our website: www.rivercityadvocacy.net. Like us on Facebook www.facebook.com/rivercityadvocacy and Follow us on Twitter @RCAmentalhealth

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National Alliance on Mental Illness website http://www.nami.org/

"The National Institute of Mental Health reports that one in four adults experience a mental health disorder in a given year"
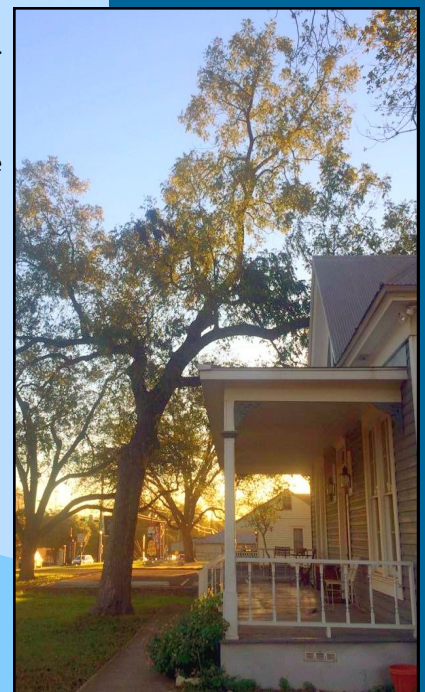
There is a Difference: Plus ça change, plus c'est la même chose

Steve Cockerham

I get asked the question a lot, "Now, what are Human Services?" or "How is this different from psychology and social work?" I can understand why. It's an emergent field, and many have arisen in the last few decades. Human services comes naturally to me, having begun my career after college in 1975 as a Mental Health Technician! You'd think most everyone would know about human services. One of the largest federal departments is named after it. Across the nation, there are hundreds of degree programs in Human Services. Well, maybe this is not so unusual. I just learned what are zoography, combinatorics, and the International Early Psychosis Association.

The world is changing, at least as far as the helping professions are concerned. Take psychology and social work, for example. They used to form the bulk of professionals in areas such as mental health, poverty, and other problems in living. Over the years, psychology refined their professional designation to require a doctorate and governmental licensure. Social work also took the route of escalating qualifications for licensure and graduate requirements. They have and will continue to make a substantial contribution to the helping professions; however, the needs and demands of agencies and organizations outweigh just hiring psychologists and social workers.

Along the way, the process of counseling became an area of psychology that resulted in licensure in counseling as well as marriage and family therapy. Substance abuse counseling also became a competency that is often licensed. As a degree in college, psychology has become a primary means to understand people rather than become a counselor. Most psychology majors do not become psychologists. They learn about people and then work in the variety of settings where that knowledge is particularly valuable such as sales, management, and uber (I could also add beautician!). Graduate students in psychology typically use their doctoral degrees for teaching, research, and private practice. Most of the work in mental health is now provided by counselors, therapists, and human service practitioners. Social work will one day be considered a subfield of human services.

Over the years, nonprofit and corporate organizations began to contract with government entities and seek other sources of funding, enabling an expansion of job positions for people with degrees and training in the helping professions. What initiated human services was based on the hierarchy of psychologists, social workers, and nursing assistants operating in the medical model of treating people with problems. As the roles changed to research and clinical supervision by psychologists and social workers, people with expertise in administration, supervision, direct care, family services, residential programming, community prevention and intervention were needed to provide relevant and comprehensive services. The helping profession proliferated with specializations such as professional counseling, occupational therapy, communication disorders, and applied behavioral analysis as well as generalists like program administration, residential services, community programming, or health education.

The human service model now characterizes the helping professions. Health and human services combines a variety of specializations alongside a plethora of general positions based on the problems as presented. Human service practitioners lead nonprofits, non-governmental organizations, mental health treatment, child care agencies, child life services, extended school programs, adventure programs, foster care, group homes, disability services, youth activities, eldercare, substance abuse treatment, homeless shelters, food distribution, community health education and support, and the list goes on…

Human services offers a multi-tiered approach where each level and individual contribute to the welfare of people in need of personal, social, community, national, and global assistance for their developmental needs. Human services initiated a process where its workers attained increasingly improved training and education, first in the technology of human services and next in the application of maintaining and improving human services. Initiated in the early 1970s with the advent of intensive training in human services through community colleges, the expectations of professional development have grown to baccalaureate and graduate programs in the field. The diversity and complexity of helping others have transformed the way health and human services are provided.

We continue to evolve and change in order to most effectively and efficiently meet the needs of human development. We are all of the above and most of the rest. We change yet always remain the same. Our mission is to assist others through the personal and social changes and problems everyone encounters. People may experience them differently, but all have them. Like diversity, we are different, but we are all human. In the service of humanity, we are here to help, in whatever role that takes. For human services, we're all in this together, and there are more and more of us.
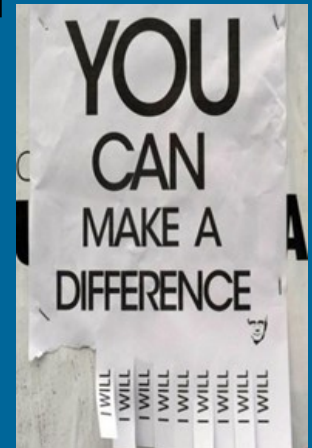
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Understanding Bullying within the Autism Spectrum Disorder Population

Leanne Scalli, Kristina Rosa Cruz Bolling, April Minio, & Rachel Rice

Abstract

The Autism Spectrum Disorder (ASD) population is at increased risk for exposure to bullying at some point in their lifetime. Symptoms of ASD such as poor communication and poor social skills contribute to the increased likelihood of individuals with ASD either being the victim or the aggressor of bullying. If left unaddressed, bullying behavior can cause increased social withdrawal in children with ASD. Addressing the problem of bullying within the ASD population entails developing research that specifically addresses the symptoms of ASD that increase the risk of the individual experiencing bullying. Future research should focus on understanding how to help professionals develop effective bullying interventions specifically for the ASD population.

Risk factors associated with bullying in ASD

More and more children are experiencing bullying at some point during their childhood, and children with Autism Spectrum Disorder (ASD) are no exception. According to Sterzing (2012), adolescents with ASD experience significantly higher rates of victimization (19%-94% vs. 12%-41%) and perpetration (16%-83% vs. 10%-44%) compared with typically developing peers. It is important to address the risk factors of bullying associated with ASD in order to help children with ASD to develop positive social interactions with their peers.

The risk factors associated with children with ASD being a victim of bullying are similar to the risk factors that contribute to children with ASD becoming the perpetrator or the aggressor of the bullying. The victim of bullying is the target of repeated acts of intentional aggression that result in a power differential between the victim and the perpetrator of the aggression (Green, Felix, Sharkey, Furlong, & Kras, 2013). Some factors that increase the risk of being a victim include a diagnosis of ADHD, poor social skills, challenges with maintaining a conversation and participating in general education classes (Sterzing, 2012). Deficits in understanding social behavior of others may also contribute to children with ASD becoming victims of bullying. Anger was a strong predictor of victimization (Rieffe, 2012). Increased risk of victimization occurs as a result of trouble with social interactions, deficits in communication, stereotyped behaviors, and a lack of friendships (van Roekel, 2010).

The risk of becoming a perpetrator of bullying increases when the child is Caucasian, has a diagnosis of ADHD, and there are opportunities for social interactions among children on an ongoing basis (Sterzing, 2012). A child with a speech or language impairment in addition to ASD is at even greater risk of becoming a perpetrator. There is a link between emotion dysregulation and the occurrence of bullying and victimization in typically developing children that seem to affect children with ASD in a similar way (Rieffe, 2012). Children that are bullies, with and without ASD, often report "fewer feelings of guilt and more anger" (Rieffe, 2012).

Bullying in both typically developing children and children with ASD appears to be related to anger and frustration arising from "a (hostile) misinterpretation of others' intentions" (Rieffe, 2012). Emotion dysregulation contributes to both the anger and a following lack of guilt, which is present in bullies both with and without ASD. The bullies "have difficulties in feeling remorse and responsibility for their conduct," so they are likely to repeat the behavior (Rieffe, 2012). Difficulty understanding social processes may also cause the children with ASD to be unaware of the consequence of their behavior (van Roekel, 2010).

> "Adolescents with Autism Spectrum Disorders experience significantly higher rates of victimization and perpetration compared with typically developing peers"

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Social Awareness & Empathy

Difficulty relating and connecting with others not only puts children with ASD at risk of being bullied but also of unwittingly becoming the perpetrator themselves. Only recently has this topic become a focus of study. Sterzing (2012) notes that "adolescents with an ASD may be uniquely vulnerable to this form of aggression given the social and relational problems that are hallmarks of their condition." Children with ASD are more likely than typically developing children to be victims but equally likely to be perpetrators (Rieffe, 2012). Problems with communication, having fewer friends, and having a lower family income were found to be significant correlates of bullying involvement among children with an ASD (Sterzing, 2012). ADHD is another significant correlate of bullying perpetration. Children with ASD and ADHD were found to be five times more likely to bully than children with only ASD (Montes & Halterman, 2007).

The Negative Effects of Bullying

A child with ASD is likely to withdraw from social situations as a result of bullying. Increased withdrawal from social situations only exacerbates the child's challenges in learning to interact appropriately with others and to participate in structured group activities. A lack of opportunities to engage socially will impede the child's progress in terms of developing age-appropriate motor skills and improving communication skills caused by a speech delay or a delay in processing (Parks, 2013). All of these factors contribute substantially to the child's inability to engage in meaningful social interactions with peers.

The general community often views children with ASD as being "different" and may not truly understand how the symptoms of ASD contribute to an increased risk of bullying. It is important for children with ASD to develop their ability to interact with peers in a safe and nurturing environment. Due to being perceived as "different" or "abnormal," children with ASD are more likely to retract from social interactions, thereby eliminating opportunities to improve their ability to communicate effectively (Bejerot, Plenty, Humble & Humble, 2013). Children with ASD need more opportunities to work on using social skills, so it is important that effective interventions focus on providing ample time for practicing these skills. Creating a culture of "practice makes perfect" when it comes to social skill development will reduce the likelihood of children with ASD withdrawing from social interactions. Increased opportunities for these children to develop social skills will decrease the likelihood of the child becoming a victim or perpetrator of bullying.

Future Research Considerations

To fully understand the unique needs of children with ASD and to protect them from perpetrating or being victims of future bullying incidents, more research is needed on the topic. An effective bullying intervention targeted towards children with ASD would need to address specific deficits. The intervention should focus on increasing social integration into protective peer groups by educating typically developing children on the need for empathy (Sterzing, 2012). A key piece of developing an effective intervention is differentiating between the types of bullying (i.e. physical, verbal, relational, and electronic) that affect children with ASD. Once the types of bullying are pinpointed, the selection of the appropriate bullying interventions can occur (Rieffe, 2012).

Children with ASD would also benefit from research addressing the placement of children with ASD in schools and designing programs to aid in developing social skills and fostering peer groups (Rowley, 2012). Placement in general education classrooms has been found to correlate with increased incidents of bullying, so the development of placement programs or social skill programs could help to reduce incidents. Future studies should continue to include ADHD as a predictor of bullying behaviors (Sterzing, 2012). Lastly, differences in bullying victimization and perpetration in children with ASD by gender needs to be examined (van Roekel, 2010). Since ASD is more prevalent in boys, gender differences are rarely studied but may be present. Determining whether or not bullying in children with ASD reflects similar gender patterns as typically developing children would also aid in the creation of more effective interventions.

> "Problems with communication, having fewer friends, and having a lower family income were found to be significant correlates of bullying involvement among children with an Autism Spectrum Disorder"

Conclusion

In summary, the symptoms of ASD such as social deficits and poor communication lead to an increased risk of experiencing bullying. The development of effective interventions specifically targeted at the ASD population should be the focus of future research. The effects of bullying are harmful to the physical as well as the psychological well-being of the children, so it is imperative that this topic is studied in greater detail in the near future.

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Courtesy of Wikipedia

The Impact of Motor Delays on Social Skill Development within the Autism Spectrum Disorder Population

Leanne Scalli, Kristina Rosa Cruz Bolling, April Minio, & Rachel Rice

Abstract

The role of motor skill deficits in the Autism Spectrum Disorder population is often largely overlooked when designing interventions for children. Interventions for children with Autism Spectrum Disorder (ASD) primarily focus on social skill development. Children with ASD often shy away from physical activities, thereby limiting their opportunities to practice social and physical skills with their peers. Dual-focused interventions that address social as well as motor skill deficits have the potential to benefit children with ASD. Professionals in the field can help to facilitate the implementation of dual-focused interventions to provide children with the opportunity to practice newly acquired social as well as motor skills. Future research should explore cost-effective and evidenced-based methods of providing dual-based interventions for children with ASD.

Motor Deficits

Autism spectrum disorder (ASD) is a developmental disability characterized by impairments in social communication, social interaction, and restricted, repetitive patterns of behavior, interests, or activities (American Psychiatric Association, 2013). The prevalence of ASD is estimated to be about one in every 68 children (Centers for Disease Control and Prevention, 2014). Typical ASD interventions primarily target the impairments associated with social communication and social interaction. For school-aged children with ASD, programs and services are focused on core impairments and are often packaged as a "social skills" program (MacDonald, Lord, & Ulrich, 2013). The social communication and interaction programs available to children with ASD are essential to the development of adaptive behaviors and social skills. However, deficits in social skills are not the only impairments plaguing children with ASD. An effective intervention for the ASD population would target motor deficits in addition to social deficits.

Dual-Focused Interventions

It is important to create and implement evidence-based, cost-effective interventions for children with ASD that are beneficial to their overall development (Bremer, Balogh, & Lloyd, 2014). A recent study of young children ages 14-33 months diagnosed with ASD demonstrated that fine and gross motor skills were a significant predictor of autism severity (MacDonald et al., 2014). The children with better motor skills demonstrated fewer core symptoms of ASD (MacDonald et al., 2014). Therefore, creating interventions that accurately assess and improve fitness and participation in physical activities are imperative to the improvement of gross motor function in children with ASD.

Montes and Halterman (2009) explored the issue of the prevalence of motor deficits in children with ASD. 76.2% of parents of children with ASD reported the need for physical, occupational, or speech therapy versus 18.1% for parents of children with other special health care needs (Montes & Halterman, 2009). The need for therapy services in children with ASD suggests that motor deficits are present, and programs that target motor deficits through the use of specialized therapies are essential for improvement. Teaching functional motor skills to children with ASD may help in creating an optimal environment that provides a context for practicing social skills during physical play (Lord, MacDonald & Ulrich, 2013).

Gross motor deficits and decreased participation in physical activities are common impairments associated with ASD in children. Basic movement skills are crucial for development of the skills to participate in games, dance, sports, gymnastics, active play, and recreation physical activities (Lubans, Morgan, Cliff, Barnett, & Okely, 2010; Payne & Isaacs, 2002). The gross motor deficits of children with ASD are linked to decreased participation in group recreational activities and can lead to problems developing social relationships.

> "The gross motor deficits of children with ASD are linked to decreased participation in group recreational activities and can lead to problems developing social relationships"

Decreased participation in team sports can be attributed to motor skill deficits (Borremans, Rintala, & McCubbin, 2010; Potvin, Snider, Prelock, Kehayia, Wood-Dauphinee, 2013). Recent research indicates motor deficits are present even in children with ASD that have average cognitive abilities (Green, Collingwood, & Ross, 2010). Motor delays can impact the social development of children with ASD. O'Connor et al. (2014) noted that the skills learned through structured sports activities carry over into other aspects of life for children. Children who participate in sports are more accepted and respected by their peers. Children with ASD are missing opportunities to practice social skill development if their motor skills are weak and they are unable to keep up with their peers sports such as tee-ball or soccer.

Screening Tools

There are a number of assessment tools available to professionals concerned about motor and social skill development in children with ASD. A recent study completed by Bremer, Balogh, and Lloyd (2014) showcased some of the assessment tools available to scholar-practitioners in the field. Bremer et al. (2014) examined the progress of children enrolled in a motor skills intervention. The children's progress was measured using tools such as the Vineland Adaptive Behavior Scale -Second Edition (VABS-II), the Movement Assessment Battery for Children – Second Edition (MABC-2), and the Peabody Developmental Motor Scales –Second Edition (PDMS -2) (Bremer, Balogh, & Lloyd, 2014). The VABS-II assessed adaptive functioning. The VABS-II is an assessment tool that is appropriate for use with children and adults, and it measures communication, daily living, socialization, motor skills, and problem behaviors. The MABC-2 and the PDMS-2 assessed the motor skills of the children in the study (Bremer et al., 2014). The MABC-2 assesses motor skills in children ages three years to 16-years-old, and the PDMS-2assesses motor skills in children from birth to age six-years-old (Bremer et al., 2014). Professionals have a number of tools at their disposal for assessing the gross motor, adaptive, and social skills of children with ASD.

Professionals Can Help!

Children learn through play, so it is important that professionals ensure that a child with ASD has a safe place to practice and learn appropriate social and motor skills. Skills should be practiced in a structured setting to ensure that children have a positive experience and are motivated to continue acquiring new skills. The optimal learning environment is a small group setting of two children and one adult (Hong, Neely, & Lund, 2015). Some strategies that are useful when teaching appropriate motor and social skills in the group setting may include the use of visual modeling, social stories, and role playing (Hong et al., 2015). In addition, human service professionals can help to facilitate communication between parents and educators in regards to how the child is progressing (Hong et al., 2015). Good communication between professionals can help detect occurrences of bullying that may cause physical or psychological harm to a child with ASD (Hong et al., 2015).

Future Research Considerations

There is a need to develop studies and programs that seek to integrate motor skill and social skill interventions. Implementing specialized therapies to help with motor delays may benefit the child in the long run because they are properly engaging in a set schedule of physical education. Programs such as this will help children with ASD become more engaged socially during interactions with other children. When children experience motor delays, they may not be motivated positively to engage socially with other children. This could be due to fear of ridicule or that they are unable to participate as effectively as properly developing children. Experiencing distressing events may lead to an increase in isolating behaviors (Bejerot, Plenty, Humble, & Humble, 2013). While implementing change in the child's physical activities, it is equally important to educate parents/caregivers on the effects that ASD has on social skills and communicative skills in children. Increasing parent awareness of what they can do at home to increase positive communication with their children may carry over to the school setting. It may indirectly lead to increased communication with other children and strengthen the child's social skills.

Children learn through play, so it is important that professionals ensure that a child with Autism Spectrum Disorder has a safe place to practice and learn appropriate social and motor skills.

Conclusion

Recent research has recognized the need to study how motor skill deficits contribute to social skill delays in children with ASD. In order to prevent children with ASD from avoiding physical activities, professionals need to create structured interventions that enable these children to practice social and motor skills with same-age peers under the close supervision of a trusted adult. Professionals can use a number of tools to assess progress in the areas of adaptive, social, and motor development. Human service professionals can be critical to the development of an effective intervention plan in that they can communicate the child's progress between teachers, administrators, and the child's family.

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Courtesy of Wikipedia

# Making Data Meaningful in Child Welfare

Erica Novak

At Partners for Our Children, we strongly believe that data need to be used in all decision-making, especially when it affects the lives of vulnerable children and families. But the data also need to have enough context to make it understandable and truly tell the *right* story. That's one reason why we launched the Washington State Child Well-Being Data Portal through a data-sharing agreement with Washington's DSHS Children's Administration.

We know that facts and figures are thrown out left and right these days, but so often these numbers are not put into context. How does a number compare to the average? Are there any upward or downward trends? Is this something we should even be concerned about? Context is what brings data to life; without it, people could easily make decisions based on their own perception of how "good" or "bad" the data appears.

For instance, when we look at the number of Native American/Alaskan Native children in foster care in Washington State, it is much lower than the number of white children – approximately 560 compared to 5,600 in 2013, respectively. Without any other information, that might not appear concerning to some. But when you look at these numbers relative to the state's general population – or the overall rate – Native American/Alaskan are 4x overrepresented in the foster care. Calculating the rate in comparison to the general population highlights a problem that would not be noticeable with just a total number of children.

> "Context is what brings data to life"

Number of Children in Out-of-Home Care
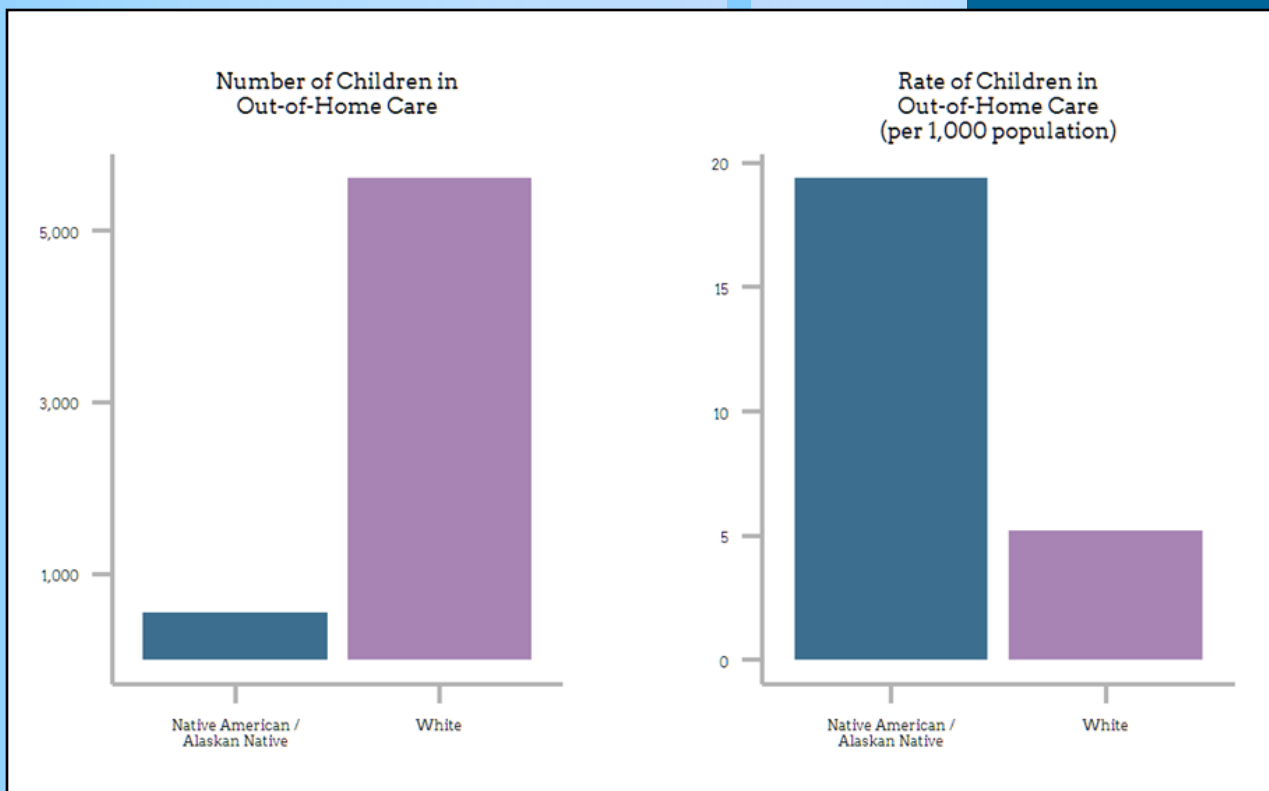
Rate of Children in Out-of-Home Care (per 1,000 population)

With today's technology, we can also create clean, easy-to-understand data visualizations or custom county reports that automatically update with newly available data – moving us beyond just a table of numbers or a spreadsheet with rows and rows of numbers that can be hard to draw any conclusions from.

Being able to see the data in different ways has made the Data Portal valuable for decision-making among many professions across the state – everyone from policymakers to family court judges to advocacy partners – have found the tool to be helpful in understanding how the system is working and what areas may need improvement. Our goal is to provide people with meaningful data that can be used to inform a decision or start a conversation.

There are only a handful of other states that have made their child welfare data accessible online, including California, Arizona, Iowa, North Carolina, and Colorado. But we know there are many more looking into different options.

If your organization or agency is considering developing an online tool to improve transparency and provide access to meaningful data within the child welfare system, let us know – email us at info@partnersforourchildren.org. We would be more than happy to discuss our development process – right down to our own trials and tribulations. We are very proud of the Data Portal and want nothing more than to share our learnings so that decisions – across the country – are based on clear, meaningful data, which ultimately will improve outcomes for vulnerable children and families.

> "Our goal is to provide people with meaningful data that can be used to inform a decision or start a conversation"

Introducing our New Field Editor, Alice Walters

The LINK is expanding its staff to continue providing up-to-date coverage for membership interest and to improve our publication process. Alice Walters is the new **Field Editor** for LINK and responsible for managing contributions from our members in the field to LINK issues. We are also seeking volunteers to serve as **Field Correspondents** for LINK content. Field Correspondents will assist the Field Editor in generating and developing content in regional areas. If you are interested in the Field Correspondent position, please email Alice Walters at: alice.walters@waldenu.edu

LINK is introducing a new section titled **"Field Notes."** We are looking for very short news items for "Field Notes." This is a paragraph (200 words or less) on any newsworthy item from the human services field. Something in this section might be:
• a new program development
• an agency grant award
• an award going to a human service worker
• latest statistics from the field, etc.

Please send content for "Field Notes" to Alice Walters at: alice.walters@waldenu.edu

If you have questions about LINK content, submitting articles, idea development, or editing assistance, feel free to contact Alice Walters. LINK relies on membership contributions to share current developments in human services. LINK staff are available to assist in the process of article development and publication.

NOHS ANNOUNCEMENTS

The Annual Conference - Fall 2015

## NOHS 2015 National Conference

When: October 21-24, 2015

Where: Sheraton Charlotte Hotel
555 South McDowell Street, South Tower
Charlotte, North Carolina 28204
(704) 372-4100
www.sheratoncharlottehotel.com
Room rate: $149.00 per night
A special rate for NOHS has been reserved.
This rate will expire on September 20, 2015

Theme: Diversity Matters

Human service providers work with persons of different cultures and ethnicities as clients, coworkers, or employers. Individuals and families in the United States have, as a group, become increasingly diverse. This diversity has emerged from many sources such as changes in immigration patterns, ethnic and racial distribution in the general population, greater inclusion of individuals with disabilities, increased longevity, and broadening views of gender appropriate behaviors.

This year's NOHS conference focuses on celebrating diversity whether with clients, students, colleagues, programs and communities. Our theme "Diversity Matters" highlights the many facets of diversity in human service disciplines.

To register, become a vendor or sponsor, book a hotel room, or purchase your CEU's, please visit: www.nationalhumanservices.org/charlotte-2015

NOHS ANNOUNCEMENTS
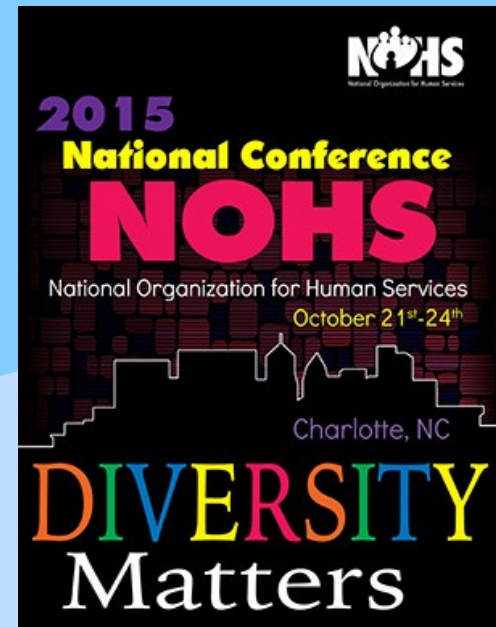
CSHSE-Published Monograph on Fitness for the Profession: Articles from _Students and Graduates_ in Human Services

The Council for Standards in Human Service Education is going to publish a peer-reviewed monograph that focuses on working with students who have behavioral or legal issues that could interfere with their development and effectiveness as professionals ("fitness for the profession"). Shoshana Kerewsky, Director of the Family and Human Services Program at the University of Oregon, is the editor, and she is working in conjunction with Gigi Franyo-Ehlers, CSHSE Vice President of Publications, and a team of reviewers. The monograph will be published electronically on the CSHSE website, and we anticipate that it will be composed of articles from human services faculty members, practitioners, and students/graduates.

Center for Credentialing & Education (CCE)

Professional Development Award

The NBCC Foundation is pleased to announce a scholarship opportunity available through a partnership with the Center for Credentialing & Education (CCE).

This award advances the professional identity and development of CCE credential holders. Four awards in the amount of $500 each are available. **APPLICATION DEADLINE: May 31, 2015**

Applicants must meet the following eligibility criteria:

- Currently hold a CCE credential maintained in good standing for a minimum of one year;
- Promote their CCE credential or contribute to the related field through one or more of the following:
  o Providing credential-related training for others;
  o Bringing programs that promote the credential to their campus or organization;
  o Delivering a presentation at a relevant conference;
  o Conducting relevant research;
  o Writing for a relevant publication;
  o Holding leadership positions in relevant groups or associations; and
  o Mentoring another who is pursuing the credential.

CCE provides the funding for these awards, which the Foundation administers on CCE's behalf.

For more information, see our Frequently Asked Questions at http://www.nbccf.org/Assets/FAQ.pdf. Please contact the Foundation at foundation@nbcc.org or 336-232-0376 with any questions.

Council for Standards in Human Service Education

Assuring the quality, consistency, and relevance of human service education programs.

http://www.cshse.org

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Newsletter for the National Organization for Human Services

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Contributions and comments may be submitted for consideration to
cockerha@etsu.edu
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bergvall@goldmail.etsu.edu
We welcome your input!

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