Understanding the Critical Ethical Loop of Direct Practice, Recordkeeping, and Data Collection

Where’s the fun in that??

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Our Objectives and…

(1) Convict you in the importance of accurate recordkeeping and data collection as a source of both doing ethically, holistically, and culturally competent direct practice with children, youth, and families and maintaining best direct practice.

(2) Increase your understanding of how cultural awareness and cultural humility is important to ethically sound direct practice and can be reflected in your recordkeeping and data collection.

(3) Provide you an enjoyable workshop to help increase commitment to consistent and accurate recordkeeping and data collection.
…Our Methods

• Pre- and Post-test (mostly for our own self-evaluation…and maybe research, with your informed consent, of course!)
• Bingo!
• Use of PowerPoint (what we’re using now)
• Ethical and Cultural Feud…yep, based on the very same game show, Family Feud
• Role play scenarios of Supervisor vs. Worker…with only willing and voluntary participants
Consider this quote…and how in the world it applies to competent practice with our child, youth, and family clients?

"The numbers have no way of speaking for themselves. We speak for them. We imbue them with meaning." — Statistician Nate Silver in the book *The Signal and the Noise*
OK...so how do we “imbue” our data for our service delivery? A look at data/learning/knowledge management site might be a good start:

<table>
<thead>
<tr>
<th><strong>Data</strong></th>
<th><strong>Information</strong></th>
<th><strong>Knowledge</strong></th>
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<tbody>
<tr>
<td>• Facts</td>
<td>• A collection of data</td>
<td>• Information that allows you to make a decision</td>
</tr>
<tr>
<td>• Figures</td>
<td>• Knowledge to allow you to act—provides with capability and “know how”</td>
<td>• Knowledge provides you with capability and “know how”</td>
</tr>
<tr>
<td>• Simply “bits and pieces” of larger information</td>
<td></td>
<td>• Allows you to take effect action—to make the right decision and to do the right thing</td>
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<tr>
<td>• Do not alone tell anything</td>
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So **macro practice** is what happens after we collect pieces of information about our clients (data) that we combine together to tell us something about our clients’ lives and situations (information)—but *when* do we go from collecting data and information to **micro practice**? And where exactly does this connect to **ethical practice**?

Good question! And here’s an answer we “recordkeepers” and “data collectors” might like related to our direct practice:

https://www.ted.com/talks/hilary_cottam_social_services_are_broken_how_we_can_fix_them/transcript?language=en
Ethics and Cultural Feud

Revealing real-time data collection to “check ourselves”!
And now—a test to see how much we really remember about our professional “codes of ethics”!

We think we know about ethical practice and being honest in our recordkeeping, data collection, and analysis…but you mean there’s more to it?

P.S. Although “social worker”, “social workers”, and the NASW Code of Ethics are our reference points, it is noted that all disciplines—such as FCS degreed professionals, MFTs, LPCs, and others have corresponding ethical professional standards. Furthermore, many of these ethics for social workers and all other “helping professions” are also specified in state laws and in their agency rules and policies in work with children, youth, and families.
True or False?

There are no limits to the amount of commitment a social worker must make to a client.

False!

Yes, Standard 1.01 mentions the legal obligations social workers have to society. Although social workers occasionally choose to ignore some illegal acts of clients during therapy, we have a commitment to the law, and we are responsible for the consequences of those decisions. Standard 3.09 states that social workers should abide by their commitment to employers, as well. Agency procedures and rules should be followed if they are not in conflict with the Code, which may at times limit our ability to help a client with a specific need.

True or False?
The NASW Code of Ethics does not direct social workers specifically about when or how to decide if a client’s self determination may be restricted.

False!

Standard 1.02 states to do so if “in the social worker’s professional judgment” [or any other discipline working in Child Care agencies], “a client’s actions or potential actions pose a serious foreseeable and imminent risk to themselves or others.” Potential and imminent violence must be reported, according to the Tarasoff ruling. (See http://tinyurl.com/newswtarasoff.) Rules of behavior in the agency must be enforced—and this includes recordkeeping that indicate clients are informed of this professional responsibility. A parent may be discovered to use and sell marijuana—but is this a real “threat” to that parent’s well-being, his/her child or children, or to the family as a whole? And in what ways do we determine this, if so? For example, what laws, rules, and policies exist for public agencies providing services to children, youth, and families?

Standard 4.07 disallows endorsement from clients or soliciting clients informally, as this may create an undue influence.

True or False?
Psychosocial counseling over the phone or by computer is OK, but it is not ethically accepted practice for helping professionals.

False!

Yes, but NASW Standard 1.03e states that clients must be made aware of the limitations of distant forms of treatment. Again, true with all licensed helping professionals who use internet for mental health or other forms of psychosocial treatment. Never-the-less—one might wonder how the race/ethnicity/gender/age/class impacts the interaction---and some of us might wonder if that really makes a difference?

True or False?

It does not matter what your discipline is—social work, psychotherapy, or counseling—or where/how you work, you must transfer any client who has an issue you don’t know anything about.

True!

Standard 1.04c states that social workers should “ensure the competence of their work and protect clients from harm.” This standard in the Code originated from Hippocrates. We can refer clients to whom we are not capable of providing good treatment, and we have trainings, formal and informal education, research, consultation, and supervision to support us. At these times, a team approach is helpful. We may transfer a client, but Standard 3.08 tells us that we should minimize difficulties for the client in transfers by giving them adequate notice and explanation. Also, we should assure no duplication of services.

True or False?

Helping professions are required by all state licensing laws to be competent about their client’s culture and to obtain education to understand diversity and oppression.

False!

Not all state licensing laws are this specific about how to respond to cultural variances among our clients. Whereas it is impossible to know about every culture and subculture we may encounter in our practices, we can understand surrounding experiences of those whose sociocultural/socioeconomic functioning might be impacted by oppression, access, social justice, liberty, status liability, and other difficulties. We must study and deliberately put knowledge we gain about those who are culturally different from ourselves into our practices. A good start is to practice the value of “respect for human dignity,” that all cultures can relate to (see NASW Code of Ethics, Standard 1.05). Standard 3.08 requires continuing education, which at times address these diversity issues Standard 4.01 requires competence overall in our ethical responsibilities as professionals; 4.02 requires we “do not discriminate in our practice nor condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, immigration status, or mental or physical disability.”

Ethical and Cultural Issues Involved in Recordkeeping and Data Collection

(1) **Hubris**: extreme overconfidence or arrogance about our findings (Cassidy, 2013) and document accordingly; can then lead to inaccurate data collected and a skewed (i.e., inflated or false) analysis that misinforms agency policy and direct practice.

(2) **Incompetence**: when those analyzing data don’t recognize the limits of their expertise (Holosko, Thyer & Danner, 2009; Wasserman, 2013)

(3) **Carelessness**: hurried, distracted, stressed, or simply inattentive to details (Wasserman, 2013); worker lack of proofreading for interwoven cultural issues that can impact service delivery, resulting in unintentional inequity in service delivery or services delivered that are inappropriate for certain children, youth, or families (Karttunen, 2012).

(4) **Uninvolvement or resistance in accurate recordkeeping**—when data is collected from recordkeeping and put into new policy that impacts direct practice—without workers’ review and input before implementation (Herbert, 2015)
(5) **Dishonesty Indirectly Related to Work as a Researcher:** researcher’s character deficits, poor management skills, and overextension of one’s resources could lead to “actions that may not directly involve the actual conduct of research itself (but) can still corrupt science” (Wasserman, 2013, p.9) —for those of us engaged in direct practice, this means that we can corrupt our recordkeeping, data collection, and the resulting analysis and policy that then feeds back into the loop to our direct practice (Herbert, 2015; Holosko, Thyer & Danner, 2009).

(6) **Inadequate Supervision:** not monitoring the capacity of supervisees or workers in importance of recordkeeping as source of data collection; therefore, there is no “ethical environment” for these tasks that inform practice (Wasserman, 2013, p. 14); supervisors who do not convey relevance to “real work” that workers’ recordkeeping and data collection contribute to not only agency funding, but to the “real work” with children, youth, and families (Herbert, 2015).

(7) **Difficult or Stressful Work Environment:** “morals may not be enough” (Wasserman, 2013, p. 13) when it comes to getting your recordkeeping done and reported; can be partially created by the time-consuming nature of recordkeeping for accurate data collection—resulting in workers’ shortcutting and devaluing recordkeeping and not valuing any analysis from data collected from their records (Herbert, 2015, p.443; Holosko, Thyer & Danner, 2009, p.359).
10 Standards with Indicators of Ethical Inclusion of Culture in direct practice, recordkeeping, and data collection (NASW, 2015):

**Standard 1: Ethics and Values**

Indicators: Knowledge/understanding of (1) professional ethics; (2) social justice and human rights issues; (3) conflicts within professional/personal ethics and values with those of other cultures; (4) disparity between those most served or represented and those less served; (5) cultural differences and strengths; and (6) ethical dilemmas between workers and clients.

**Standard 2: Self-Awareness**

Indicators: Based on knowledge, an ability to (1) examine own cultural background; (2) recognize “isms”; (3) increase awareness of/change detrimental attitudes, beliefs, and feelings; (4) act on personal cultural limitations and refer when needed; (5) develop comfort level with own uniqueness among unfamiliar cultural groups; (6) work with/respond to acknowledged deficits with supervisors, mentors, and colleagues. [https://www.youtube.com/watch?v=mgyjnxr6OCE](https://www.youtube.com/watch?v=mgyjnxr6OCE)
Standard 3: Cross-Cultural Knowledge

Indicators: Practice that includes: (1) studying about a client’s culture that you do not experience or share; (2) knowing how to access traditional and nontraditional providers appropriate to the client’s culture; (3) understanding how power differentials between dominant and non-dominant cultures impact services; https://www.youtube.com/watch?v=Wf9QBnPK6Yg; (4) understanding government and political processes; (5) recognizing commonalities/differences within specific cultural groups; (6) knowing how to select practice theories and methods appropriate to a specific client’s culture; (7) understanding privilege and intentional/unintentional assertion in the helping process; (8) recognizing cultural variance among workers and its impact on clients; (9) recognizing/minimizing/eliminating biased efforts that may be from a worker’s own unexamined prejudices that may or may not be embodied/reinforced by the institution/agency.
**Standard 4: Cross-Cultural Skills**

**Indicators:** Ability to (1) willingly work with culturally different clients; (2) respond to communication indicators that may be unique to the specific culture of clients, including direct and indirect patterns of communicating; (3) effectively utilize appropriate interviewing techniques and recognize limitations/seek assistance when not sure; (4) effectively include culture as a factor in service delivery with the same weight as other sociocultural and demographic client identifiers; (5) develop culturally specific service plan when necessary; (6) effectively use the client’s natural support systems; (7) evaluate, select, and implement appropriate intervention methods.

**Standard 5: Service Delivery**

**Indicators:** Services that include (1) identification of and connections to formal and informal resources in the community where the client lives; (2) advocacy for a client who needs specific cultural accommodations either in the community or within the agency/institution delivery service—from working with community service providers to develop new or expand existing services to assuring staffing that is diverse; (3) opportunity to build culturally competent organizations through policies and practices.
**Standard 6: Empowerment and Advocacy**

**Indicators:** Practices, interventions, and policy that (1) allow for advocacy for agency/institution and public policies that respond to the needs of nondominant cultural groups in a given service area; (2) address oppression, prejudice, discrimination based on prevalent and frequently unexamined or unintentional (or intentional) worker/agency/institutional biases; [https://www.youtube.com/watch?v=f83xc1sM_j4](https://www.youtube.com/watch?v=f83xc1sM_j4) (3) help the client facilitate connections with his/her own power; (4) support diverse cultural groups advocating on their own behalf by partnering/allying with them; (5) outwardly and intentionally demonstrate encouragement of self-awareness and identification and revision of biased practices, interventions, services, and policies.

**Standard 7: Diverse Workforce**

**Indicators:** Support and advocacy for recruitment, admissions and hiring, and retention efforts of child/youth/family workers, programs, and agencies to ensure diversity among all staff. [https://www.youtube.com/watch?v=hNeR4bBUj68](https://www.youtube.com/watch?v=hNeR4bBUj68)
**Standard 8: Professional Education**

**Indicators:** Staff and agencies/institutions advocate for and participate in educational and training programs that help advance cultural competencies in child/youth/family service delivery.

**Standard 9: Language Diversity**

**Indicators:** Workers and agencies/institutions provide and advocate for information, referrals, and services in a language appropriate to a client, including use of an interpreter when necessary *(not a translator or another family member—particularly children—if can be avoided)*

**Standard 10: Cross-Cultural Leadership**

**Indicators:** Child/youth/family agency administrators and policy-makers disseminate knowledge about diverse groups and assures inclusion of culturally competent service delivery.
So...how do we commit to more ethically and culturally responsive recordkeeping and data collection?

(1) Checking ourselves & our agencies: https://nccc.georgetown.edu/

(2) Practice: Role play!
https://www.dshs.texas.gov/socialwork/sw_cmp.shtm
# Promoting Cultural Diversity and Cultural Competency

## Self-Assessment Checklist for Personnel Providing Behavioral Health Services and Supports to Children, Youth and their Families

**Directions:** Please select A, B, or C for each item listed below.

- **A** = Things I do frequently, or statement applies to me to a great degree
- **B** = Things I do occasionally, or statement applies to me to a moderate degree
- **C** = Things I do rarely or never, or statement applies to me to minimal degree or not at all

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### Physical Environment, Materials & Resources

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<tbody>
<tr>
<td>1</td>
<td>I display pictures, posters and other materials that reflect the cultures and ethnic backgrounds of children, youth, and families served by my program or agency.</td>
</tr>
<tr>
<td>2</td>
<td>I insure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of children, youth and families served by my program or agency.</td>
</tr>
<tr>
<td>3</td>
<td>When using videos, films, CDs, DVDS, or other media resources for mental health prevention, treatment or other interventions, I insure that they reflect the cultures of children, youth and families served by my program or agency.</td>
</tr>
<tr>
<td>4</td>
<td>When using food during an assessment, I insure that meals provided include foods that are unique to the cultural and ethnic backgrounds of children, youth and families served by my program or agency.</td>
</tr>
<tr>
<td>5</td>
<td>I insure that toys and other play accessories in reception areas and those, which are used during assessment, are representative of the various cultural and ethnic groups within the local community and the society in general.</td>
</tr>
</tbody>
</table>
6. For children and youth who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other intervention.

7. I attempt to determine any familial colloquialisms used by children, youth, and families that may impact an assessment, treatment or other intervention.

8. I use visual aids, gestures, and physical prompts in my interactions with children and youth who have limited English proficiency.

9. I use bilingual or multilingual staff or trained/certified interpreters for assessment, treatment and other interventions with children and youth who have limited English proficiency.

10. I use bilingual staff or multilingual trained/certified interpreters during assessments, treatment sessions, meetings, and for other events for families who would require this level of assistance.
COMMUNICATION STYLES – cont’d.

11. When interacting with parents who have limited English proficiency I always keep in mind that:

_____ • limitations in English proficiency are in no way a reflection of their level of intellectual functioning.

_____ • their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.

_____ • they may or may not be literate in their language of origin or English.

12. When possible, I insure that all notices and communiqués to parents, families and caregivers are written in their language of origin.

13. I understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information.
14. I understand the principles and practices of linguistic competency and:

- apply them within my program or agency.
- advocate for them within my program or agency.

15. I understand the implications of health/mental health literacy within the context of my roles and responsibilities.

16. I use alternative formats and varied approaches to communicate and share information with children, youth and/or their family members who experience disability.

17. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.
____18. In group therapy or treatment situations, I discourage children and youth from using racial and ethnic slurs by helping them understand that certain words can hurt others.

____19. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with children, youth and their parents served by my program or agency.

____20. I intervene in an appropriate manner when I observe other staff or parents within my program or agency engaging in behaviors that show cultural insensitivity, bias or prejudice.

____21. I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).

____22. I use bilingual staff or multilingual trained/certified interpreters during assessments, treatment sessions, meetings, and for other events for families who would require this level of assistance.
23. I accept and respect that male-female roles in families may vary significantly among different cultures (e.g. who makes major decisions for the family, play and social interactions expected of male and female children).

24. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decisions of elders or the role of the eldest male in families).

25. Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision makers for services and supports for their children.

26. I recognize that the meaning or value of behavioral health prevention, intervention and treatment may vary greatly among cultures.

27. I recognize and understand that beliefs and concepts of emotional well-being vary significantly from culture-to-culture.
28. I understand that beliefs about mental illness and emotional disability are culturally-based. I accept that responses to these conditions and related treatment/interventions are heavily influenced by culture.

29. I understand the impact of stigma associated with mental illness and behavioral health services within culturally diverse communities.

30. I accept that religion, spirituality and other beliefs may influence how families respond to mental or physical illnesses, disease, disability and death.

31. I recognize and accept that folk and religious beliefs may influence a family’s reaction and approach to a child born with a disability or later diagnosed with a physical/emotional disability or special health care needs.

32. I understand that traditional approaches to disciplining children are influenced by culture.

33. I understand that families from different cultures will have different expectations of their children for acquiring self-help, social, emotional, cognitive and communication skills.
34. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture-to-culture and even within cultures.

35. Before visiting or providing services in the home setting, I see information on acceptable behaviors, courtesies, customs and expectations that are unique to families of specific cultures and ethnic groups served by my program or agency.

36. I seek information from family members or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children, youth, and families served by my program or agency.

37. I advocate for the review of my program’s or agency’s mission statement, goals, policies, and procedures to insure that they incorporate principles and practices that promote cultural diversity and cultural and linguistic competency.

38. I keep abreast of new developments in pharmacology particularly as they relate to racially and ethnically diverse groups.
39. I either contribute to and/or examine current research related to ethnic and racial disparities in mental health and health care and quality improvement.

40. I accept that many evidence-based prevention and intervention approaches will require adaptation to be effective with children, youth and their families from culturally and linguistically diverse groups.

How to use this checklist
This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural diversity and cultural competence in human service settings. It provides concrete examples of the kinds of values and practices that foster such an environment. There is no answer key with correct responses. However, if you frequently responded “C”, you may not necessarily demonstrate values and engage in practices that promote a culturally diverse and culturally competent service delivery system for children and youth who require behavioral health services and their families.

Tawara D. Goode • National Center for Cultural Competence • Georgetown University Center for Child & Human Development • University Center for Excellence in Developmental Disabilities Education, Research & Service • Adapted from Promoting Cultural Competence and Cultural Diversity in Early Intervention and Childhood Settings • June 1989. (Revised 2009).
RESOURCES

• HRSA on AIDS and multiculturalism: https://aidsetc.org/resource/cultural-competence-and-multicultural-care-workgroup-training-exchange-0

• SAMHSA: TIP 59: Improving Cultural Competence, KAP Keys for Clinicians https://store.samhsa.gov/shin/content/SMA16-4933/SMA16-4933.pdf

• HOGG Foundation: http://hogg.utexas.edu/new-resources/publications


• Project Implicit: https://implicit.harvard.edu/implicit/index.jsp


