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Social Workers' Perceptions of a Rural Emergency Mental Health Trauma Service

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This is to certify that the doctoral study by

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Abstract

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by

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MSW, University of Washington, 1966

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Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Social Work

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Abstract

Studies have shown that emergency mental health trauma (EMHT) services can significantly reduce the long-term effects of trauma after a disaster. However, rural municipalities may find they do not have the capacity to create such a service, or may not realize that their disaster planning includes no provision for emergency mental health care. Such was the case in a rural island community in the state of Washington, where, in 2014, several residents initiated a discussion that helped to identify the community's lack of EMHT services. This project, framed by action research and based on collaboration theory, sought to advance the potential for the community's 21 resident social workers to address this issue collaboratively. Accordingly, the project's research question asked how social workers on south Whidbey Island perceived the issue of a rural EMHT service in their community. Data consisted of responses from 8 participants who completed mailed questionnaires and participated in brief telephone interviews. Descriptive coding analysis of the data confirmed a nearly universal lack of knowledge about an EMHT service, a clear perception of the need for such a service, and a unanimous commitment from the respondents to participate in addressing this problem. Such collaborative activity is expected to have a positive impact on the micro, mezzo, and macro levels of social work practice in south Whidbey, as well as on the community itself, not only in spearheading a dialogue about EMHT but also in activating a group of social workers who had no prior association.

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Section 1: Foundation of the Study and Literature Review

This project was initiated by several community residents of south Whidbey Island who raised concerns with me because they knew I was a social work doctoral student specializing in crisis intervention. Motivated by anxiety about the potential for a major earthquake to strike the island (Liberty & Pape, 2006; Blumenthal, 2015), these residents asked what I knew about emergency mental health trauma (EMHT) services that would be available in case of this natural disaster. I admitted to knowing little about such service plans but promised to look into the question. While I had assumed south Whidbey fire and medical first responders would be trained to handle such mental health trauma, several telephone calls to local and state emergency management agencies informed me that these assumptions were incorrect. As a matter of fact, the community's first responders had no mental health training for disaster survivors (R. Palmer, personal communication, April, 14, 2015). Furthermore, the Federal Emergency Management Agency (FEMA), charged with providing grants for training, had not allocated any mental health training funds to the island due to the size and rural nature of the community (R. Palmer, personal communication, April, 14, 2015). In effect, the residents were on their own to provide any such services. This initial evaluation suggested the high risk of a community-wide problem with serious consequences.

In the process of making initial inquiries, I discovered there were social workers living in the community who had neither organized into a professional presence nor publically voiced perspectives on this community vulnerability issue. This observation was supported by the absence of any reporting on their professional presence in *The*

South Whidbey Record, the local newspaper dating back to 2007. Of the 100 news articles called up in *The South Whidbey Record* using these keywords—*social workers*, *emergency mental health*, *trauma counseling*, and *local social services*—four articles mentioned social work involvement with either (a) domestic and sexual abuse or (b) adult and adolescent homelessness and drug abuse. None discussed crisis intervention or an EMHT service. In these four articles, "social work" referred to social services performed by compassionate volunteers rather than MSW-trained professionals (whereas social workers are licensed, social service volunteers are not). One exception was an article on a forum on Whidbey's mental health issues; the article noted that one of the forum's panelists was a licensed social worker who spoke as an expert in nontraditional therapies, such as alchemical healing, guided imagery, voice dialogue, and equine-assisted therapy (Reid, 2015). However, the forum did not address EMHT services in any way.

This absence was also evident in the archives of the local professional social work activities. For example, over the past decade there has been no mention in the Washington State chapter newsletters of the National Association of Social Workers of EMHT service activities by south Whidbey social workers. Nor has any related literature appeared in the professional social work journals reviewed as part of this project's literature review. Finally, none of the original non-social work community members who expressed concern about a lack of EMHT service had any knowledge of social workers' participation in such a service.

The further I investigated, the more apparent it became that there was an opportunity for a research project that would serve three functions: I would (a) attempt to

understand the resident social workers' perspectives on the issue of a local EMHT service, (b) follow through with my evaluation and research responsibilities to the social work profession as outlined in the profession's code of ethics (NASW, 2008), and (c) take this opportunity to fulfill research requirements for the Walden University Doctor of Social Work degree. My research project stemmed from an apparent lack of EMHT services and whether there might be a community of social workers on south Whidbey that could be consulted to understand this apparent gap in social services.

This project appeared to me to be all the more pressing because rural communities, such as south Whidbey, are consistently underserved due to their geographic isolation, population size, and lack of political voice at state and national levels (McCabe, et al., 2011). This combination of features leaves at-risk groups living in rural areas—particularly minorities, seniors, and persons of low socioeconomic status—susceptible to stress (McCabe et al., 2011). Understanding the resident social workers' perspective could prove to be a significant step in addressing this issue. Such a social work presence has had historical value throughout the country in addressing unmet needs of vulnerable populations (Jansson, 2014). It would be reasonable to assume that the same could be extended to south Whidbey.

Problem Statement

Disasters and other public health emergencies in the United States often reveal deficiencies in response capacity and in overall preparedness to safeguard the welfare of a community's citizens—especially citizens in rural and geographically isolated areas (McCabe, Semon et al., 2014; Murphy, Anderson, Bowles, & Cox, 2014). This was true

of EMHT services on south Whidbey. Many disaster survivors in underserved areas fail to receive needed care, and this deprivation is associated with mental health morbidity and increased rates of suicide (Kar, 2010). Unattended psychological trauma following a disaster leaves survivors vulnerable to symptoms that resemble those of posttraumatic stress disorder (McCabe, Everly, et al., 2014; Wang et al., 2009), especially if they have suffered any type of physical injury (Bugge et al., 2015). As a result, a community without immediate EMHT services is a vulnerable community.

As a profession, social work has continually striven to identify, and participate in correcting, inequalities resulting from a range of social problems such as poverty, homelessness, and mental illness (Hodgkin, 2011). This project poses the following question: How has that professional commitment been demonstrated with respect to an EMHT service in south Whidbey? Although south Whidbey has had a long history of community volunteers' successful efforts at addressing a host of social service issues (goodcheer.org; Watanabe, 2015), never in the 13 years that I have been a resident has there been any documented mention of professional social work participation in these issues—neither in the twice-weekly local newspaper nor in any of the social service newsletters representing not-for-profit organizations on the island. This apparent absence raised a number of questions that eventually led to this research project. Collaboration theory served as the framework for this project; it emphasizes the identification of need, process-determined outcomes, group cohesion, and stage development.

Research Question

When I was approached a year and a half ago by several non-social work community members about an EMHT service, I knew of no such service, and as I sought answers to this question, I discovered the existence of a group of 20 other social workers with listed addresses on south Whidbey. So many colleagues within such a small geographic location came as a surprise, since south Whidbey is known more as a tourist attraction and for its rural way of life than as a residency destination for social workers. It occurred to me that they might have some professional knowledge about the community's history with emergency mental health services. I decided to create a doctoral research project structured around the following research question: How do social workers on south Whidbey Island perceive the issue of a rural EMHT service in their community?

As part of an early background search related to possible public participation by these social workers in local affairs, I conducted a review of the community's twice-weekly newspaper. In the paper's nine-year archive, I found, as mentioned above, only one article that quoted a resident social worker, but without any mention of an EMHT service (Reid, 2015). Nor did any other references relevant to a service for south Whidbey turn up. These results suggested a blind spot where coverage for EMHT services is concerned. This blind spot is especially apparent in articles describing the catastrophe that south Whidbey could face due to the community's earthquake vulnerability (Blumenthal, 2009; Liberty & Pape, 2006; Thompson, 2016), which make no mention of an EMHT service.

For instance, a recent article was published on the efforts of leaders in one south Whidbey community to prepare its residents for earthquake survival (Thompson, 2016). Headed by the district's fire chief, the Community Emergency Response Team (CERT), and other south Whidbey officials, this group of community leaders spoke about their disaster response plans for when the "Big One" hits. Focused solely on residents' physical safety and medical needs, the article made no mention of any collaborative strategies to address survivors' mental health needs. In fact, throughout the article there was nothing implied, stated, or quoted about even the need for an EMHT service. So the question remained: Is there such a service for south Whidbey that could be more thoroughly integrated into the community, or is this gap being overlooked by local leaders and media? In either case, there is a pressing need to connect such conversations about disaster response to psychic trauma research, as documented by McCabe, Semon, et al. 2014; Wang et al., 2009; and Zhang et al., 2012.

Furthermore, these service gaps raise important new questions about the role of social workers on south Whidbey: Why does there not appear to be any public or professional record of social work participation and collaboration in addressing, or at least commenting on, the issue of an EMHT service? Is this a professional oversight on the part of the resident social workers? Are they even aware that this is an issue? If they are aware, does an absence of action reflect a lack of time, collaborative interest, or specialized expertise? Could the gap be related simply to a lack of organized collaboration? Or is it possible that social workers have in fact been more active in the community than the newspaper suggests? The newspaper's silence might reflect editorial

priorities that have obscured social workers' involvement in community issues. In that case, is it possible that these social workers have operated outside the spotlight and behind the scenes, preferring accomplishment rather than publicity? This research project addressed these and similar questions through a questionnaire and telephone interview, whose formats aligned with my problem statement and research protocol (see Appendix A, Sections 1 and 2).

Purpose Statement

Traditional social work community practice, as codified in the profession's code of ethics as well as in its history and mission statement, emphasizes engagement by social workers to alter the behavioral patterns of individuals and organizations for the betterment of society (NASW, 2008). Such activities are designed to apply social workers' professional training at the levels of micro, mezzo, and macro systems to find more effective ways to meet their community members' needs. However, south Whidbey appears to have little such community engagement involving the social work profession**.** Prior to this project, the reasons for this absence were entirely unknown. My action research project was proposed to address this question by seeking to understand a specific clinical social work problem associated with the apparent lack of an EMHT service in south Whidbey. My aim in doing so was to make a social change contribution consistent with my profession's code of ethics (NASW, 2008) and Walden University's mission statement**.**

The knowledge gained from this action research program was expected to point to additional change activities in which this group of stakeholders might choose to

participate. For example, given stakeholders' expressed interests, they could opt to move forward in establishing an EMHT program that would meet the need that has motivated this project in the first place. However, the specifics of such an undertaking go beyond the scope of this work and would require a separate research project.

More immediately, this project's potential to bring about social change revolves around the power of understanding resident social workers' thinking about a rural community's EMHT service and/or its lack thereof. While my project focused on the profession of social work, this research approach is not meant to exclude participation by other professions. Nurses, school psychologists, psychiatrists, and public health workers who maintain a rural address could all be potential collaborators, and their participation would be equally relevant, if social workers were not present in the community to be studied.

A further aspect of this project's potential for social change relates to my own career as a social work professional. Rural social work is a field of specialization in its own right (Ginsberg, 2011; Humble, Lewis, Scott, & Herzog, 2013), and this project has given me significant research and clinical experiences in such a setting. With this background, I have gained more professional authority to speak about such services as practiced in a rural community.

Nature of the Project

This project's objective was to understand the social work community's thinking about the issue of an EMHT service. This objective can be best approached from an action research perspective (Fenge, 2010; Stringer, 2014) based in collaboration theory

(Bosque & Catlin, 2011). Within this framework, resident social workers designated as stakeholders were contacted to gauge their interest in participating in this research project. Those who wished to participate were invited to share their perspectives and, if interested, propose collaborative ways to develop solutions to the community's trauma service problem. Such participation by the island's social work community is consistent with social workers' professional commitment to engage in changing individual and community behavior (NASW, 2008).

Action research is based on the premise that all members of a researched community, in this case the 20 social workers, are affected by and part of the research process (Lewin, 1948/1999). It is a systematic approach enabling these community members to find solutions unique to their localized situation. Participants, also known as stakeholders, are afforded the opportunity to be heard and their contributions integrated into the research project as a whole (Bradbury & Reason, 2015). In contrast to the objective role of quantitative researchers, the action researcher provides leadership to the other stakeholders, believing that their contributions, beyond just yes and no answers, are an indispensable asset to the research process and outcome (Stringer, 2014).

This commitment to stakeholders' perspectives is based on an epistemological paradigm that understands knowledge to stem from individual, collective, and collaborative experiences. The researcher's role is to facilitate the expression and negotiation of that knowledge and to organize it to the group's benefit. Without such stakeholder participation, there can be no research that is representative of that group's interests, and hence no community enrichment that results from the research.

Action Research Terms

Specific terms related to action research are drawn from Fenge (2010), McNiff and Whitehead (2010), and Stringer (2014). These authors are in fundamental agreement about the terms as well as their definitions.

Research facilitator: One who coordinates or facilitates the research.

Potential stakeholders: Those people who are centrally affected by the issues(s) investigated.

Principal stakeholders: Those participants most significantly affected by the research issue.

Actors: People relevant to the story.

Community: Not a geographic location but rather a group of people who make up a community of interest.

Gatekeepers: Significant people in relevant organizations.

Trustworthy data: Research results that have met the standards of credibility, transferability, dependability, and confirmability.

Rigor: Evidence that indicates substantial inquiry.

Guided-tour questions: Questions that are open-ended; for example, "Tell me about . . . ."

Task questions: Closed-ended questions that can be answered by a yes or no response.

Participant observation: A research approach that draws data from observations of individuals and groups from within a whole-world context that self-reflexively includes the researcher's participation.

In this project, *potential stakeholders* were defined as the 20 social workers with south Whidbey addresses. *Principal Stakeholders* (also known as stakeholders) are those social workers who agreed to participate in this research project. *Actors* are the non-social work community members designated as "opinion makers." *Professional community* describes the professional social work community living in south Whidbey. *Gatekeepers* (a.k.a., opinion makers) are members of the south Whidbey community such as business, political, and nonprofit decision-makers who are not part of this project, but who may become involved at a later time.

Methodology

Based in action research, this study's methodology incorporated qualitative inquiry methods to collect, analyze, and disseminate the data. The primary sources of data in this project were the principal stakeholders themselves—that is, those of the 20 social worker residents on the island who volunteered to participate in this research project. They provided data in the form of a paper-based questionnaire and telephone interviews via a 1-888 toll-free line established specifically for this project.

When this study began, it was not yet clear how many of the 20 social workers still lived in south Whidbey. Nor was it known how many were full- or part-time residents, retired or not, practicing on or off the island. Requests for this information and other demographic data were included in a research packet mailed to the 20 social

workers, featuring a questionnaire of both closed-ended questions (Appendix A, Section 1) and open-ended questions (Appendix A, Section 2). All data collected in this format, including decisions *not* to participate, were returned in a prepaid envelope to an island post-office box. Research participants' willingness to participate fully was documented with signed consent forms. All data were stored securely in locked file cabinets in my professional office, and only I had access to this information. All confidential information associated with this project will be destroyed five years from the date of the project's approval (June 2, 2016).

Data analysis involved identifying themes and significant issues. The process necessarily involved a subjective element, and, as a resident of the community, I had a vested interest in understanding my colleagues' opinions, perceptions, and knowledge regarding the issue of EMHT aid on south Whidbey. To be fully effective, I worked to recognize, identify, and contain that bias, remembering my role as a facilitator, not an advocate, in this project. To further reduce personal bias, my process incorporated peer review (i.e., from my faculty committee and chair), a consistent reflective attitude, transparent documentation, and a self-reflexive notebook.

My reflexive notebook followed the format outlined in Appendix D. It includes a notation of the activity I was engaged in, what I was thinking and feeling about the activity, and whatever actions I was considering in response to this process. Having participated in a similar self-appraisal model with a clinical study group for over 40 years, I felt the continuation of my analytic approach to be well suited to this research project. Selected excerpts from my notebook accompany the analytic coding of

Stakeholder 4's telephone interview (see pp. 67–71). Such reflexive comments were included to highlight the relationship between the interviewer and interviewee and the need for thoughtfulness when the researcher shares the experiences of the study participants (Berger, 2015).

Limitations

This study was subject to certain limitations. Chief among them was the length of time I was able to devote to data collection. As part of a capstone project, the research is structured by institutional timelines that cannot accommodate ongoing data collection over months or years. In an organized and strategic fashion, I collected what data I could while also recognizing the constraints of my research assignment. My overarching goal was to help stakeholders define the problem as they saw it and generate whatever collaborative solutions they felt represented their thinking. Although the project's primary research had to be finite, a secondary goal was to understand the south Whidbey social work community's thinking about extending some of the project's research efforts. Continuing to work together toward community goals would ensure a wider impact for the efforts this project initiated.

Theoretical/Conceptual Framework

This project was informed by collaboration theory, for which several authors have contributed to an evolving definitional framework. Beginning in the late 1980s, Gray (1989) first defined collaboration as "a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible" (p. 5). Two years later,

Wood and Gray (1991) refined their definition: "Collaboration occurs when a group of autonomous stakeholders of a problem domain engage in an interactive process, using shared rules, norms, and structures, to act or decide on issues related to that domain" (p. 146). Himmilman (1996) added layers of risk and reward, defining collaboration as "a process in which organizations exchange information, alter activities, share resources, and enhance each other's capacity for mutual benefit and a common purpose by sharing risks, responsibilities, and rewards" (p. 22). Potapchuk and Polk (1994) stressed the goal of shared decision-making and proposed that "collaboration is a locally based process in which parties (stakeholders) who have a stake in the outcome of a problem join together in a structured forum to engage in joint decision-making" (p. 2). More recently, Bosque and Catlin (2011) defined collaboration as an iterative activity: "a recursive process where two or more people or organizations work together toward an intersection of common goals" (p. 108).

Despite differences in approach, theorists agree that collaboration is a problem-solving process designed to achieve success through mutually beneficial cooperation. Successful collaboration occurs when a group of stakeholders engage in a problem-solving process designed to address a need that is unsolvable by one individual alone. According to this theory, collaboration among micro, mezzo, and macro community systems can effectively address a specific need. Bosque and Catlin (2011) established five basic principles of collaboration that are applicable to south Whidbey social work residents: Collaboration (a) centers on the principle of individuals working together, regardless of what the process may be called; (b) is fundamentally a process, not a

destination, and the nature of the process determines the outcome; (c) is highly personal, and as such involves trust as requisite to fostering effective alliances among people; (d) develops in a series of stages involving assembly, order, performance, and adjournment; and, finally, (e) is imperative for the accomplishment of any community action (pp. 108-113).

These central features of collaboration theory were applicable to this project's research question: How do social workers on south Whidbey Island perceive the issue of a rural emergency mental health trauma (EMHT) service in their community? In mobilizing south Whidbey's social work community to address a common question, this project was driven by a goal of collaboration for the greater good (Dukes, Firehock, & Birkhoff, 2011). Collaboration theory provides a framework for those social work stakeholders to accomplish a shared vision that is greater than one that could be achieved independently.

Yet collaboration theory also brings into focus a more fundamental problem that this project sought to understand. If one aspect of social work at its best is to promote forms of community collaboration that align with the definitions provided by collaboration theorists, then there would appear to be a professional disconnection between south Whidbey social workers and the behavioral health needs of their resident community. For whatever reason(s), 20 professionally trained social workers lived in south Whidbey with no apparent public or professional record of participating in a community-wide mental health trauma service. My project aimed to understand how they, as social workers, perceived the issue of a rural EMHT service and to begin a

discussion that would foster an enduring collaborative between the south Whidbey community and its resident social workers.

Collaboration theory is generally understood to be a problem-solving process that identifies and addresses a specific need that was unresolvable by a single individual or entity acting alone. My study's open- and closed-ended questions are compatible with this definition (Appendix A, Sections 1 and 2).

Significance of the Study

Forming a social work professional community in order to serve a vulnerable population is consistent with the social work profession's ethical commitment to engage in public emergency mental health issues (NASW, 2008). As the concerns of community opinion makers attest, such an opportunity exists on south Whidbey. While 20 social workers had listed addresses on south Whidbey, there was no public evidence that they had contributed professional service as change agents in the community—either individually or as a group. My project sought to understand whether that supposition was correct and to understand that history. I formally reached out to my colleagues, explaining this project's purpose and asking them to participate in the study. Their responses suggested the potential to both organize a professional community and take collaborative action on creating a local EMHT service. Those stakeholders who continue to be interested in offering their professional knowledge on this issue can make a considerable contribution to social change.

Values and Ethics

In the longer term, establishing and maintaining a viable group of social work residents would have positive implications for other issues facing south Whidbey. Social workers' professional code outlines social change efforts directed to issues of poverty, unemployment, discrimination, and other forms of social injustice (NASW, 2008). To varying extents, these are some of the issues facing the south Whidbey community. A sustainable social work presence would be poised to collaborate on solutions that, up to this point, could have eluded the community's problem solvers and, in the process, to serve the ethical imperatives of the profession.

Review of the Professional and Academic Literature

This project's research question—How do social workers residing on south Whidbey Island perceive the issue of a rural EMHT service in south Whidbey?—brought together four areas of interest: action research theory and practice; collaboration theory and practice; social work's commitment to vulnerable populations at the micro, mezzo, and macro levels of practice; and social work EMHT relief efforts in rural communities. While these topics together focus the following literature review, relatively few research sources bore directly on the totality of my project. Even with the assistance of research librarians, literature searches turned up a sparse body of specific scholarship. In total, I examined 2,682 journal articles and 12 books for my initial literature review. From this number, I selected four books and more than 70 peer-reviewed journal articles. Despite its modest size, this body of scholarship provides a crucial foundation for working across my four areas of investigation.

In this review, the following databases were used: Academic Search, CINAHL Complete, LGBT Life, PsychINFO, Social Services Abstracts, and SocINDEX. To search these databases, the following keyword combinations were used: (a) *collaboration theory* or *action research* and *mental health* or *emergency services*; (b) *rural community emergency mental health service*; (c) *rural social work practice*; (d) *social work* and *community organization*; (e) *social work* and *rural communities*; (f) *social work* and *macro practice*; (g) *social workers* and *rural* and *remote health*; (h) *rural communities* and *social work* and *practice*; (i) *rural* or *remote social work*; (j) *rural community organization*; (k) *social workers* and *disaster relief*; (l) *social workers* and *psychological first aid*; (m) *social workers* and *paraprofessionals*; and (n) *social work* and *crisis services*.

The items I reviewed represented a broad spectrum of professional interests that address specific aspects of my project; however, none reflected an integrative approach that aligned with this project's research priorities. In addition to social work journals from the United States, I have also included Australian and British social work perspectives as well as journal articles and books from the fields of business ethics and evaluation, education, ecology and environmental sciences, emergency management, nursing, psychiatry, public health, and qualitative research.

Study Methodology: Action Research

Action research is a qualitative method of investigation that empowers people to find solutions to problems confronting them in their everyday lives. Unlike traditional quantitative methods that seek generalizable principles with broad-based application,

qualitative research focuses on specific situations with tailored solutions (Stringer, 2014). Operationally, action research can have a significant impact at the micro, mezzo, and macro levels of rural social work practice.

At the theoretical level, Stringer (2014) is a comprehensive textbook that explains the theory and practice of action research methodology. It is a text widely used at the graduate level to introduce social workers to the fundamentals of action research. Each chapter, from theory through process and formal reports, is well explained and referenced. This text is in its fourth edition, a testament to its enduring contribution since its first publication in 1999.

Stringer spelled out the essential components for detailing an action research plan. He clearly defined pragmatic terms such as "research rigor" and the "look, think, and act (LTA)" principles that constitute his framework for project construction. Stringer likewise paid careful attention to the more complex processes by which action researchers can develop sustainable solutions in a world becoming dominated by social media. Case illustrations were liberally provided, although, drawing heavily from indigenous Australian populations and educational institutions, they often featured a social environment remote from that of my project. So long as illustrative comments were brief, this case illustration bias was minimized. Nevertheless, I found it difficult to generalize some of the author's comments to populations here in the United States. However, it provided an important grounding for my capstone project, and I would recommend it as an introductory text to students who have no prior exposure to action research.

A quasi-companion text to Stringer (2014) was Kemmis, McTaggert, and Nixon (2014). With the primary purpose of providing access to ideas rather than justifying them, the authors fulfilled that mission in an abstract way, in counterpoint to the practical orientations of both Stringer (2014) and McNiff and Whitehead (2010). Kemmis et al. (2014) portrayed action research as more than simply a research approach and instead considered the multiple ways this method can change traditional social practices and customs. The authors' detailed case examples were drawn from rural regions of Canada. While the text was interesting, I found little transferable value for my project either in theory or practice. If I were pedagogically inclined, Kemmis et al. (2014) would be a worthwhile introductory text; yet, measured against Stringer (2014) and McNiff and Whitehead (2010), its practical value for me was not sustained.

At the practical level, McNiff and Whitehead (2010) provided a comprehensive text with introductory guidance on conducting an action research project from start to finish. It is a key textbook in the field, lucidly describing the practice of action research as well as the underlying values of this qualitative research method. While not as detailed as Stringer (2014) on the theoretical rationale for action research, McNiff and Whitehead (2010) nevertheless served as an admirable companion, especially as a manual for designing an action research project.

A brief text from Hacker (2013) was specifically tailored to community-based participatory research focused on community health care needs. Historically, scholarship has conducted investigations *about*—but rarely *with*—the community. As a result, community members, especially those who have been underserved, have felt excluded

from the research process and reduced to observational status. Hacker's book addressed these issues by proposing to improve the relevance and acceptability of research through community engagement, which she described as community-based participatory research (CBPR). Her book detailed CBPR principles, defined a community and its associated power relationships, articulated advantages and challenges of the CBPR model as well as ethical considerations, and translated community-based theory into practice. Drawing on the basic principles of action research, Hacker focused specifically on how action research should be played out in a community setting when the primary goal is to address the health needs of a vulnerable population. As such, the book was an excellent fit for this project.

Micro practice. Bosque and Catlin (2011) offered an application of collaboration theory at the micro level of practice. Functioning as an independent neonatal nurse practitioner, one of the authors described her successful model of clinical practice with neonatologists. She observed that transitioning from the traditional hospital or clinic model to independent practice presents many challenges for nurse practitioners and so identified five factors that were helpful in addressing these challenges: (a) maintaining her professional identity; (b) paying close attention to formal and informal communication with the community's neonatologists; (c) engaging in strategic negotiations—or, as Savage et al. (2010) put it, win-win negotiations; (d) respecting professional boundaries; and (e) identifying mutually beneficial scenarios for herself, neonatologists, and their patients.

Mezzo practice. In a research case study directed at the mezzo level of social work practice, Fenge (2010) examined the ramifications of a participatory action research study (PARS) for a vulnerable population. Selecting older (55 years and above) lesbian women and gay men from a United Kingdom community, the author set out to establish the impact of the PARS approach with this minority group. The author's purpose was to encourage individuals to have a voice in defining knowledge about themselves and providing direction for their future within the larger heterosexual community. This project was government-funded for three years. Participants included a core group of more than 20 volunteers who self-identified as nonheterosexual. As is common with PARS, research members (a.k.a., stakeholders) participated in every aspect of the research project. These core stakeholders recruited other members of the lesbian and gay community to function as temporary and part-time assistants during the multiple years of the project.

The project attempted to support and facilitate the participation of older lesbians and gay men in research about their shared experiences of social exclusion and marginalization. Out of this research project the author hoped to inform local social service agencies about governmental policy that needed to be changed in order to address underserved needs. Six principles for working with disempowered groups framed the study: nonintrusive collaboration, mutual trust and respect, solidarity, equality, focus, and language. In conclusion the author argued that PARS can be effective in empowering marginalized groups by giving them control over the research process and the creation of knowledge.

A research article by Pfefferbaum, Pfefferbaum, Van Horn, Neas, and Houston (2013) also described action research at the mezzo level of community activity. Informed by the principles of PARS, the authors presented a model for community intervention provided by the Terrorism and Disaster Center of the National Child Traumatic Stress Network. This disaster-response model is called the Community Advancing Resilience Toolkit (CART). CART is a publically available, theory-based, and evidence-informed intervention that supports community-based problem solving. This action research intervention model was designed to stimulate analysis, collaboration, skill building, resource sharing, and purposeful action. The authors offered two models for CART implementation. Consistent with the principles of action research, CART applications are community driven and require the active involvement of community members and local organizations.

In an epidemiological study of a large nonmetropolitan city in Australia, Hodgkin (2011) reported that unevenness of participation in social, civic, and community life is linked to such demographics as gender, age, socioeconomic status, and neighborhood identity. This study underlined the importance of understanding such variables when engaging community stakeholders.

All these action research authors shared a common belief in the basic principles associated with qualitative methodology. While they referred to participatory involvement by slightly different names, such as participatory action research study (PARS), community-based collaboration (CBC), collaborative governance, or community-based participatory research (CBPR), action researchers agreed that those

communities and individuals being studied must have their voices heard through participation in the research process.

Macro practice. Rigg and O'Mahony (2013) described a study examining the impact of macro-level action research. Their case study was conducted in a European country with a centralized government and little input from localized communities. Action research stakeholders identified multiple barriers that obstruct their voices from registering, including personal agendas within the governing agency, individual agency politicking, power imbalances, low trust, poor managerial relationships, cultural differences, and manipulative leadership. This study isolated the institutional biases that contributed to stakeholders' frustration and sense of impotence. The authors identified a need for future research to focus on smaller, less centralized institutions and to ask whether, in less centralized contexts, the obstacles would play out differently.

Outside of political examples, Walker and Senecah (2011) provided an illustration of effective collaborative principles at the macro level. They observed that governmental institutions at federal and state levels are often the final arbitrators in policy and performance requirements, which can leave little space for contributions from people whose lives are impacted by such governmental leadership. The authors pointed to the importance of understanding what CBC can accomplish given the roles played by individuals in the community and individuals within such organizations. The authors drew on a number of useful reviews, research reports, and case compilations as examples of successful collaborative governance and CBC. They defined *collaborative governance* as a process bringing together everyone who has some stake in an issue to talk about what

ought to be done. It is fundamentally about the exercise of power in making decisions in the public domain. The authors mentioned several key concepts that are important to using CBC effectively, beginning with identifying an issue that is resolvable only through cooperation. Additional concepts include an individual or organizational sponsor, a leader with power to bring diverse populations together, and a neutral or impartial organization to guide the process. The article outlines the role of the collaborative decision-maker, using such action research terms as partner, stakeholder, information provider, and facilitator. The authors conclude that, regardless of a CBC's process achievements, its effectiveness will be measured by indicators of accountability, inclusiveness, and outcomes. This CBC model is similar to Hacker's (2013) CBPR and Fenge's (2010) PARS model in that all three approaches emphasize a commitment to stakeholder involvement. While Hacker's book focused on health care and vulnerable populations, Walker and Senecah (2011) maintained a more general emphasis.

Theoretical Framework: Collaboration

Collaboration is defined as a reiterative process where two or more individuals or organizations work together toward a common end. Collaboration is not hierarchical; rather it is an effort between co-equals to achieve a greater good than could be obtained individually (Bosque & Catlin, 2011). Collaboration is operational at all three levels of social work practice: micro, mezzo, and macro.

Interorganizational collaboration is a prime example of social work activity at the macro level. Savage et al. (2010) offered illustrative examples of organizational collaboration across public and private sectors that was designed to develop new

advances for society's benefit. The authors identified and defined the differences between integrative strategies, which they described as win-win scenarios for all parties, and distributive strategies, which were characterized as win-lose outcomes where some agencies or communities win at the expense of others. The authors examined how social partnerships, which they called organizational collectives, were formed in order to solve complicated and unwieldy problems that are typically not solvable by an organization acting alone. This last point is the same conclusion reached at the micro level by Walker and Senecah (2011), who determined that a successful use of the CBC model commences with an issue that is only solvable through cooperation.

An example of collaboration at the mezzo level of involvement was demonstrated by Kaufman and Dake (2011). Their study demonstrated how successful collaborative alliances arise, are sustained, and contribute to the advancement of knowledge. Their conclusions were founded on three formal discussions led by both public and private entities, including the Virginia Military Institute, the U.S. Northern Military Command, the U.S. Department of Homeland Security, and FEMA. The authors isolated three common themes among these discussions: the value that alliances represent for their constituencies, the need to identify critical elements common to all participants, and challenges to sustaining alliances. Conclusions drawn from this study included four essential features of collaboration: organic formations, organizational trust, a well-defined focus, and catalytic leadership.

McKinney and Kemmis (2011) described another action research study carried out at the mezzo level of collaboration. Longstanding conflicts between

environmentalists and logging companies have proven fractious, forcing the federal government to impose rules and regulations to mitigate disagreements. Dissatisfied with this top-down approach, leaders representing several Montana lumber mills and environmental groups met to find common ground that would be mutually beneficial for forest management. This citizen-driven collaboration became known as the Beaverhead-Deerlodge Partnership. It provided a collaborative model to bridge persistent antagonism between groups with disparate viewpoints. The outcome of this bridge-building effort was, at the time of publication, pending congressional legislation before the U.S. Senate. The study provided additional support to many of the findings presented by Kaufman and Dake (2011) and others (Busch-Armendariz, Johnson, Buel, & Lungwitz, 2011; Laing, Irwin, & Toivonen, 2012; and Mitchel et al., 2013).

Woodland and Hutton (2012) drew attention to a component of collaboration theory that they described as the collaboration evaluation and improvement framework (CEIF). The CEIF is a quantitative and qualitative tool that aims to provide descriptive and evidence-based practice information to social work action researchers. CEIF comprises five entry points for thinking about when, where, and how to evaluate organizational collaboration. These entry points include: (a) defining the composition of the collaboration(s); (b) identifying and mapping the participating communities; (c) closely monitoring the stages or process of development; (d) determining levels of integration; and (e) evaluating the stages of inquiry. The authors emphasized that using the CEIF model increases stakeholder capacity to engage in efficient and effective collaborative practices. The CEIF model would appear to be a complementary instrument

to the CART model introduced by Pfefferman et al. (2013) and the CBC model put forth by Walker and Senecah (2011).

In an article describing psychological obstacles to effective collaboration, Willis (2015) turned to the psychiatric literature and used the concept of passive/aggressive interaction to frame his argument. Drawing on the work of Lane (2009) and Lukes (2005), Willis described passive-aggressive impediments to effective collaboration as hostile actions expressed in passive ways. Using public relations firms to illustrate this theory, Willis pointed out a number of typical ways PR firms display resistance to clients' comments without saying so directly. For example, an agency may fail to respond in a timely manner, delay the release of information, or limit responding to inquiries to exclusively formal communication channels. The purpose of such strategies is to frustrate and prevent stakeholders' collaborative efforts without the agency having to take responsibility for its decisions. The author extended this agency-specific theory to all agencies regardless of size or scope.

Willis concluded by arguing for *social auditing*, a term that corresponds to financial auditing. Social auditing is designed to determine whether an agency or organization is meeting its corporate and community obligations rather than just its financial responsibilities (Blewett & O'Keeffe, 2011). While financial auditing is designed to reassure the agency's shareholders that the financial books are clean, social auditing is meant to reassure a much larger audience that the organization is operating authentically and transparently. Social auditing is a primary means to contain impediments to collaboration like passive-aggressive behaviors.

Vulnerable Populations

It was impossible to estimate how many people might be affected if a natural or man-made disaster were to strike south Whidbey. The south Whidbey community is primarily a tourist region, with the regular population (14,173) quadrupling during the weekends of May through September. If a disaster such as an earthquake were to strike during those times, especially in one of the cliff-side towns, the toll on survivors—especially vulnerable members of the community such as children, adolescents, and seniors—would be significant. A literature review addressing these vulnerable populations was included to assist the south Whidbey social work community to make informed decisions about potential collaborative action on this issue.

In an article focused on the needs of traumatized children, Cornette and Pui-Ka So (2011) recommended measures to ensure best practices in planning for children in disasters. The authors argued that children have unique needs during trauma-producing events, and community service providers must take those needs into account in their EMHT service planning, which is a conclusion supported by Liu et al. (2011) and Abramson et al. (2007). For instance, Hurricane Katrina displaced more than 160,000 children, many of whom were suffering from the symptoms of posttraumatic stress disorder (PTSD) years after the hurricane struck (Abramson et al., 2007). This persistence of PTSD was largely due to a lack of childcare infrastructure, such as recourse to a safe environment and psychological first-aid services. In Katrina's aftermath, President George W. Bush appointed a presidential commission to make recommendations specifically related to children and disasters. Cornette and Pui-Ka So

reported on several of the commission's most important findings. First and foremost, the commission recommended that children should be prioritized separately from other at-risk populations because of their unique needs. For example, since children are dependent on adults for their care and safety, children who are disaster survivors must be expeditiously reunited with legal guardians, adult relatives, or child-care providers whom the child recognizes.

In a related article, Pfefferbaum, Jacobs, and Houston (2012) offered a theoretical framework for mental health assessment for children and adolescents in the event of a disaster. In the authors' view, selecting measures appropriate for this population depends on four factors: the child's developmental level, timing in relationship to the disaster, point of contact, and available community resources.

In the event of a community-wide catastrophe, another vulnerable population to consider would be persons 55 years old and above. Staley, Alemagno, and Shaffer-King (2011) considered the vulnerability of seniors in an emergency to be a national priority. In a study of 1,496 older adult Ohioans, questionnaires inquired about participants' state of readiness, emergency plans, medical conditions, and social isolation. Analysis of these questionnaires revealed that seniors who were the most vulnerable (socially isolated with medical and/or mobility impairment) were least likely to be prepared to care for themselves.

This vulnerability would be especially acute for south Whidbey. A recent article by Stensland (2011) highlighted Whidbey's census forecast that the population will "gray" faster than the state of Washington or the nation as a whole. While in 1986 25% of

the island's population was 50 years old or above, the census forecasted that by 2025 47% of the population would be over 50. The author pointed out that this aging trend was due to several factors, foremost of which was the number of retirees attracted to the island's pace of life, mild weather, scenery, and recreational opportunities. This demographic shift must be taken into consideration as the south Whidbey community considers its lack of EMHT services.

Although these measures to address vulnerable populations did not directly factor into this project, these past studies provided evidence-based insights that could help shape policy and provide direction. Furthermore, the use of such data established a professional approach to the service issue, one based on facts rather than inference or assumption.

Rural Social Work

Rural social work literature is an important resource for any social worker interested in conducting research in rural areas of the United States. Waltman's (2011) digest reviewed 34 articles on rural social work published from 1981 to 2009 in *Families in Society* and its predecessor, *Social Casework*. Waltman separated the articles he surveyed into five groups: research and theory, direct practice issues, delivery and management of services, global and cultural perspectives, and historical perspective. The author identified key issues that emerged from these five categories and are unique to rural practice, such as an appreciation for rural values and culture (especially a self-reliance philosophy), a lack of formal resources, the reliance on natural helpers and networks, and the need for a generalist social work practice model. Though dated, this

summary of articles retained some current relevance for social workers serving rural communities and wishing to make a research contribution. Future literature reviews should include current articles from other social work journals in order to build on Waltman's groundbreaking effort.

Waltman's depiction of rural volunteerism was germane to south Whidbey. Hindered by a chronic lack of financial resources, south Whidbey has had to turn to local community members to meet essential service responsibilities. For example, South Whidbey Fire and Emergency Medical Services were 98% volunteer staffed and had been for decades (Palmer, n.d.). Furthermore, all the island's current social service operations were staffed to a large extent by local volunteers: the Good Cheer food bank, Hearts and Hammers home repair, the Habitat for Humanity furniture store, and multiple Community Thrift stores, to name a few. For this rural community, as for rural communities in the past, such citizen participation has been simply a way of life.

Social Work and Disaster Relief

Crisis intervention. With the advent of expanded mental health services through the 1963 Community Mental Health Centers Construction Act (1963), the United States faced a shortage of professional staff to provide the services required by this law. To meet some of those service demands, researchers such as Rioch et al. (1963) and Shneidman and Farberow (1965) proposed the use of trained community volunteers called paraprofessionals. Trained and supervised by licensed clinicians, often by social workers, these service providers supplied a partial answer to the service gap, especially in the area of crisis intervention.

Commencing with the groundbreaking work in the mid-1960s of the Los Angeles Suicide Prevention Center, whose paraprofessionals provided telephone crisis intervention services, social workers became both principal literature authors and clinical supervisors in this movement (Shneidman & Farberow, 1965; Farberow & Shneidman, 1961; Litman, Farberow, Shneidman, Heilig, & Kramer, 1965). Paraprofessionals have since established themselves as legitimate and respected crisis intervention service providers and spurred a considerable number of academic contributions by licensed social workers (Getz, Wiesen, Sue, & Ayers, 1974; Getz, Allen, Myers, & Lindner, 1983; McCabe et al., 2011; McCabe et al., 2012).

In a major research effort designed to understand the best counseling interventions following large-scale disasters, Hobfoll et al. (2007) outlined five empirically supported principles to guide an intervention when addressing disaster survivors' needs. These principles were to promote (a) a sense of safety; (b) calming; (c) a sense of self- and collective efficacy; (d) connectedness; and (e) hope. These principles formed the basic framework for psychological first aid (PFA), which was later developed more fully, first by a course in PFA taught by the American Red Cross (2006) and later refined by researchers such as Everly, Barnett, and Links (2012); Everly and Flynn (2006); Everly and Lating (2017); and McCabe et al. (2011).

PFA. The PFA model is theoretically and practically different from the traditional crisis intervention model first proposed by Caplan (1961) in the early 1960s and taught by Shneidman and Farberow (1965). Caplan's model was predicated on a series of counseling sessions stretched over six weeks and designed to return the crisis victim to a

pre-crisis level of functioning through traditional, verbalized insight strategies. By contrast, the PFA model is defined as a set of basic mental health interventions designed to determine immediate basic needs, reduce acute distress, and provide a platform for additional mental health services as needed, all within one or two brief sessions and within minutes of—or no longer than a few hours after—the traumatic event (Everly, Barnett, & Links, 2012; Everly & Lating, 2017). Employing the term PFA, the National Child Traumatic Stress Network and the National Center for Posttraumatic Stress Disorder (2006) developed the *Psychological First Aid Field Operations Guide* to provide an evidence-informed approach to assist children, adults, and families in the immediate aftermath of a disaster. Everly, Barnett, and Links (2012) developed this idea further with their RAPID-PFA model, which incorporates reflective listening, assessment of needs, prioritization of severe versus mild reactions, intervention, and disposition.

Researchers have predicted that, in a large-scale disaster, survivors' needs would far exceed traditional service providers' availability (Hobfoll et al., 2007; McCabe et al., 2011). This prediction would likely hold true on south Whidbey, notwithstanding the number of social workers with local addresses. The PFA strategy, drawing on trained community volunteers, provides a model to address this issue in a rural community such as south Whidbey (McCabe et al., 2011).

Paraprofessional effectiveness. In a series of studies from 2008 to 2014, McCabe and his colleagues addressed the effectiveness of PFA paraprofessionals in treating underserved and underfunded communities in simulated disaster situations (McCabe, Everly, et al., 2014). When tested in simulation, several hundred trained

community volunteers demonstrated competence with the PFA model in terms of their knowledge, preparedness, and efficacy in providing service. In a study of PFA providers working with survivors of Hurricanes Gustav and Ike, Alan et al. (2010) similarly concluded that survivors viewed PFA as appropriate and helpful. In other evaluative studies by Everly, Barnett, and Links (2012) and McCabe et al. (2011), the authors concluded that PFA conducted by paraprofessionals was an effective service in simulated disaster situations. Fox et al. (2012) were more cautious with their conclusion, stating that PFA met the criteria of "evidence informed" but without scientific proof that it was effective. However, the authors went on to state that PFA was an appropriate mental health treatment option that community volunteers could offer for people who have experienced a traumatic event.

These articles point to significant social change opportunities that the principal stakeholders of this project could consider. For example, south Whidbey's social workers might consider patterning a south Whidbey EMHT service after McCabe et al. (2011) and Everly, Barnett, and Links (2012). Their solutions seem particularly well suited to the community, given its long-established and deeply embedded volunteer culture. With such a cadre of mental health first responders available, the licensed social workers would be free to address the more severely impacted survivors, as consistent with the RAPID-PFA model (Everly, Barnett, & Links, 2012; Everly & Lating, 2017). Such an undertaking, however laudable, would clearly exceed the scope of the present project and thus require a separate process.

Conclusions

In my judgment, this literature review assembles the seminal studies defining this project. However, although the review produced a wealth of literature pertaining to fields adjacent to my research question and supporting the merits of my research framework, few, if any, sources feature social workers directly engaged in the type of work that is at the heart of this capstone project. This literature gap suggests that my project could provide important data to address neglected issues in these fields as well as enhance social work practice in south Whidbey. Given the paucity of academic rural social work commentary, I conclude that this study is both timely and necessary, given its considerable social change possibilities.

Section 2: The Project

In the early months of 2015, I was approached by several community members concerned about an apparent lack of EMHT service for south Whidbey survivors in the event of an earthquake. Their concern was prompted by a recent report that confirmed a major fault bisecting the area with the potential to create an earthquake measuring 7.3 to 7.5 on the Richter scale (Blumenthal, 2009; Thompson, 2016). When I investigated this issue, I discovered the lack of an EMHT service for survivors of *any* south Whidbey disaster, such as a school shooting, major landslide, forest fire, or terrorist attack (R. Palmer, personal communication, April, 14, 2015). This surprise was followed by another one when I learned that I was one of 21 south Whidbey residents with a Master of Social Work (MSW) degree. On reflection, I recalled that I had never noticed any newspaper article or social media mention of this MSW presence in connection with local issues such as homelessness, adolescent drug issues, or domestic abuse. Furthermore, to my knowledge, I had never met any of these individuals personally or professionally. A call to the Washington State chapter of NASW informed me that there was no formal organization of NASW members on the island, not even a chapter to represent our professional interests. I was informed that the state chapter could provide a mailing list of members who were island residents, but that list was available only for legitimate research projects. As I thought further about this situation—the concerned citizens, lack of service, the number of social workers living in south Whidbey, and my search for a DSW proposal that excited me—it occurred to me that there might be an opportunity to address these several issues with a formal research project.

In addition to my basic research question, several ancillary issues needed to be addressed. The first was to understand if there was a social work community in south Whidbey. If there was, who were these colleagues, what were their professional backgrounds, and how long had they lived in south Whidbey? The second was to understand how interested these colleagues might be in addressing an EMHT service need. How deep might that interest go? Would colleagues be willing to commit their time and professional skills? Would they be willing to participate over the period of time necessary to make this service a reality? To address these questions, I proposed this action research project, which received Walden University Institutional Review Board (IRB) approval in June 2016.

The following description of the project is organized as follows: background and context, methodology, sources of data, data collection, data analysis, ethical procedures, and summary.

Background and Context

The action research recommendations produced by this project were intended to serve a local mental health need in a rural community and to galvanize a cohort of resident social workers who were prepared to collaborate on issues important to their community. The questionnaire and telephone interviews were designed to determine the clinical social work problem as the research participants perceived it.

Potential stakeholders for the project included 20 social workers with south Whidbey addresses. From this group, principal stakeholders were those social workers who agreed to participate in this research project. Their role was to provide the essential

data for addressing the project's research question. Furthermore, they offered a baseline of information about their professional backgrounds, perspectives on an island EMHT service, and reflections on their interest in collaborating with colleagues on this—and perhaps other—community issues.

This project empowered stakeholders by valuing their expertise and creating the potential for them to empower each other through future collaboration. By mobilizing these principal stakeholders, the project could potentially lead to multiple opportunities for an island social work presence beyond the trauma service issue. In particular, principal stakeholders could develop a social work network positioned to help address other behavioral needs confronting the community. It was my hope that the cadre of resident social workers I located for this project would be able to provide some collaborative insights about how to address service deficits relevant to community need and that utilize our profession's expertise.

As a student-research-facilitator, my role in this project was to initiate a conversation about a potential local EMHT service and to synthesize my colleagues' perspectives on this issue as part of my capstone research project. I was not aware of having met any of the principal stakeholders prior to this project, despite living in close proximity. In its institutional context, this capstone project fulfilled a requirement toward a Doctorate in Social Work at Walden University, whose mission statement aligns closely with the project's purpose: "Walden University provides a diverse community of career professionals with the opportunity to transform themselves as scholar-practitioners so that they can effect positive social change."

Methodology

This project was based on qualitative, secured data collected from principal stakeholders. Information about their professional backgrounds and perspectives was gathered through a questionnaire of open- and closed-ended questions and through individual telephone interviews (see Appendices A and B).

The size of the participant population was estimated at 20, which was the number of social workers with listed residences on south Whidbey (not including myself) at the time of I purchased the mailing list from the Washington state chapter of NASW. However, this population could have been larger or smaller, depending on the accuracy of the list. Social workers included on the list could have been any combination of full- or part-time island residents, independent practitioners or professionals working for not-for-profit or for-profit agencies. Without such questionnaire data from which to work, there was no way to know the cohort's composition beyond those individuals who opted to complete the questionnaire. When I received the mailing list, I did not recognize any names, save one who, I believed, was a retired faculty member of the University of Washington School of Social Work.

The process of recruiting stakeholders began with a letter individually addressed to the social workers with listed residences in south Whidbey, signed by me and supported by my faculty advisor (Appendix C). The letter offered a brief explanation of the project, along with a Consent to Participate form, and a two-page questionnaire (Appendix A) requesting the social worker's participation. To accommodate any respondents who might have preferred to speak with me first before agreeing to

participate, I was prepared to respond to their request by landline telephone, email, standard mail, or in-person contacts, depending on their stated preference. After that initial conversation to address their concerns, those wishing to participate would have been asked to submit the consent form and the completed questionnaire; those who preferred not to participate would have been informed that any and all identifying information would be deleted with no further contact from me.

Data Collection

Instruments

The project involved two primary means of data collection: a mailed, paper-based, three-part questionnaire and person-to-person interviews over the telephone. All contact by telephone occurred using a confidential 1-800 telephone line established for professional use only. In conducting telephone interviews, I followed Stringer's (2014) guidelines related to the functioning of individual interviews. This protocol included the establishment of ground rules, procedures, facilitator functions, permission to take notes, follow-up sessions as needed, combined participant analysis, and future planning. Furthermore, I structured each interview as outlined in Appendix B.

As noted previously, I had little prior information about this social work group and, in advance of my initial mail-outs, knew virtually nothing about their backgrounds, training, opinions, community participation, or professional interests in an EMHT service. My questionnaire asked them to respond to these kinds of questions in order to establish baseline information regarding an EMHT service (see Appendix A). This information was preliminary to the central requirements of collaboration theory (Bosque

& Catlin, 2011): identification of need, trust to foster a working alliance, stage development, and transformational outcome. While it would have been speculative to formulate additional questions before knowing how those initial ones would be answered, I was prepared to follow up by telephone with a series of questions, designed to fill in whatever informational gaps may have remained (Appendix B). My interviewing skills (Getz, Wiesen, Sue, & Ayers, 1974; Getz, Allen, Myers, & Lindner, 1983) were sufficient to secure and accurately record any further information left unanswered by the stakeholders' responses to my questionnaire

All data were collected through traditional means: a review of public records (as previously noted), questionnaire responses, and telephone interviews. The questionnaire functioned as the framework for initial data collection, followed by telephone interviews. Consistent with Stringer's (2014) approach, I recorded verbatim the participants' questionnaire responses and telephone interviews. Any documents reviewed and used have been properly cited.

Having received project approval from the IRB on June 2, 2016 (Walden IRB approval #06-01-16-0499895), I delivered my first packet of questionnaires to the post office for mailing on June 3, 2016. I printed copies of my introductory letter (Appendix C), consent to participate, and Sections 1 and 2 of the questionnaire (Appendix A). All documents were included in one initial mailing. I purchased the necessary mailing envelopes and first-class postage and hand-addressed an envelope to each of the 20 prospective participants. Each of the 20 envelopes was received by the Langley, Washington post office and posted for the 4 p.m. mailing. From June 7 to the end of the

data collecting period, I checked the post office box daily (except on Sundays) for responses. On July 19, I posted 13 second-round questionnaire envelopes addressed to the 13 social workers who had not responded to the first mailing. The project's data collection period ended at midnight on September 14, 2016.

Data Standards

Following the guidelines for data analysis outlined by McNiff and Whitehead (2010) and Stringer (2014), *trustworthy data* is data secured in adherence to four principles outlined by these authors: *credibility*, *transferability*, *dependability*, and *confirmability*. *Credibility* is itself characterized by a number of features: (a) prolonged engagement, in which data result from a research relationship longer than a brief encounter; (b) persistent observation, where the researcher observes and makes note of what they see and feel; (c) triangulation, which means integrating diverse stakeholders' perspectives; (d) member checking, which involves stakeholders in the process of analyzing their own raw data; (e) participant debriefing, where stakeholders are invited to express feelings and affect generated by the action research process; (f) diverse case analysis, a process to ensure that all stakeholder perspectives are included; and (g) referential adequacy, whereby ideas and concepts are clearly drawn from and reflect stakeholders' perspectives. *Transferability* refers to the possibility that the outcomes of an action research study may have relevance elsewhere. *Dependability* describes the extent to which the researcher has followed a systematic research process. *Confirmability* validates the fact that research procedures actually took place and were not faked.

For this project, *rigor* was demonstrated by transparency and completeness of effort, and thorough process documentation that showed how data were extended to logical conclusions. *Guided-tour questions* were employed through open-ended invitations to stakeholders to speak about their experiences; these questions constituted a primary source of interview information. *Task questions* are closed-ended questions soliciting simple yes or no answers or specific pieces of information. This approach was used sparingly. *Participant observation* requires the researcher to take a step away from the project and observe stakeholders from a total-picture perspective. I employed this strategy frequently as a method of balancing the details of the project with the big picture of its objectives.

Data Analysis

As outlined by Stringer (2014), the analysis and interpretation of action research data follows a rigorous set of procedures. Such procedures include conducting data unitizing reviews, coding and categorizing, identifying themes, developing a category system, and developing a report framework. Additionally, key experiences of the participants must be examined in their own words to determine their significance. This process is followed by yet a further examination of individual experiences and significant theme identifications. This reiterative process demonstrates the rigor the researcher has applied to establish the authenticity of their work. I examined both questionnaire and telephone interview data following this traditional action research approach.

Ethical Procedures

The project's main potential conflict of interest with action research principles revolved around my personal preference to have an EMHT service in south Whidbey, which might not have accorded with the wishes of the principal stakeholders. I needed to be aware of this bias and refrain from manipulating any aspect of the project to satisfy my own needs at the expense of the stakeholders' preferences. It was, therefore, imperative for me to be mindful of this bias when engaged with any aspect of the project. Since I had had no prior contact with the primary stakeholders, there was no possibility of bias concerning our personal relationships.

Before constructing this action research project, I had made some preliminary inquiries about the status of south Whidbey's EMHT service. Telephone calls and email exchanges with public officials were strictly informational, initiated in response to questions several community opinion makers had about a service for earthquake survivors. I began a logbook on 9/29/14 and continued up to the present to record all relevant information regarding the lack of an EMHT service, making note of all my contacts with local, state, and federal emergency management agencies, as well as with businesses, religious and educational organizations, community opinion makers, and other community residents. All the information I recorded from public officials was drawn from public sources and located on official governmental websites, although follow-up telephone calls were necessary to confirm the sites' reliability. My logbook identifies but does not quote public officials such as the South Whidbey Fire Department Chief, the Sheriff's Department spokesperson, and other public agency representatives.

In-person contacts with the opinion makers (a.k.a., gatekeepers) whom I had known personally for over 13 years were all informal. These individuals were already familiar with my academic pursuits and rationale for seeking the DSW. During this discovery process I also had contact with one social worker from north Whidbey. He was neither a south Whidbey resident nor one of the 20 social workers I planned to contact for this project. No informed consent letters were required from any of these informational sources.

To gain access to the 20 social workers who had a residence on south Whidbey, I contacted the Washington State chapter of the National Association of Social Workers (NASW). They sold me a mailing list for NASW members with zip codes in south Whidbey for a one-time user fee. I used this mailing list to send letters to my colleagues that introduced myself and my research project (see Appendix C).

The only direct participant in this project whom I knew to represent Walden University was me. I knew of no other Walden University students or faculty living in south Whidbey. Representatives associated with my project through Walden University included my committee chairperson, a faculty committee member, and other university reviewers. For this project, I followed the IRB's guidance in selecting the most appropriate informed consent form to disseminate information to the research participants, informing them of their rights to participate (Appendix C).

Summary

The idea for this capstone project developed as a result of discussions with south Whidbey residents concerned about the psychological vulnerability of survivors in the

event of an earthquake. As I researched their concerns, I discovered that the community had no visible EMHT service in the event of any disaster, earthquake or otherwise. During this investigative process, I discovered there were 20 other Master of Social Work-trained social workers living in south Whidbey, with no apparent record of a professional voice in this issue. The project was designed to understand these social workers' thinking on the matter by means of a mailed questionnaire and a series of telephone interviews. All data were recorded verbatim and rigorously coded and synthesized according to recognized procedures for analyzing action research data.

Section 3: Analysis of the Findings

This project began after several members of the south Whidbey community raised concerns that, in the event of a natural disaster such as an earthquake, survivors would be denied EMHT care due to a lack of service. At the outset of this research, the reasons for this apparent lack of service were unknown, as were any plans to address the situation. Although there were 21 social workers (including myself) who reside in south Whidbey, an extensive review of public records suggested that these social workers had not previously been involved with the issue. This action research study sought to understand the following research question: How do social workers on south Whidbey Island perceive the issue of a rural emergency mental health trauma (EMHT) service in their community?

The subjects of this capstone project were 20 south Whidbey residents with a MSW degree who had listed residences in south Whidbey Island, Washington, and current membership in the Washington State Chapter of the National Association of Social Workers (NASW). Data drawn from this group were based on two separate mailings of research packets, sent by regular mail, the first on 6/17/16 and the second on 7/19/16. The mailings consisted of identical information, which included an introductory letter, a survey questionnaire (which also asked subjects to identify their willingness to participate in a brief telephone interview), and a Consent to Participate form. The consent was to be signed, the questionnaire completed (including a contact number to be used for the telephone interview), and both returned in a self-addressed, stamped envelope. The first research packet was sent in a white envelope with a white return envelope; the

second was sent in a brown envelope with a brown return envelope. Originally the results from these two mailings were kept separate during the data analysis process; however, a comparison of the data sets showed no differences between the two groups at any level. Therefore, it seemed superfluous to maintain separate findings, and I included the second mailing with the first.

The first mailing sent on 6/17/16 yielded the following results: out of 20 research packets mailed, six respondents (30%) returned completed questionnaires, including an agreement to participate in a brief telephone interview, and signed consents to participate. One respondent returned a completed questionnaire accompanied by a signed consent to participate but was, due to illness, unable to participate in a telephone interview. One respondent was moving and unable to participate. Thirteen did not respond.

The second mailing sent on 7/19/16 returned the following results: out of 13 research packets mailed, two respondents (15%) returned completed questionnaires, including an agreement to participate in a brief telephone interview, and signed consents to participate. Three had "moved with no forwarding address." Three stated that they did not wish to participate. Five did not respond. The data collection period ended at midnight on 9/14/16.

As follow-up to the questionnaire, seven telephone interviews were completed. One interview was interrupted near the end due to a family illness, which left one question unanswered; the interview is included with a notation. One respondent did not have telephone reception to allow for a telephone interview.

The following analysis is based on raw data collected from the eight completed and returned questionnaires and seven completed telephone interviews. Analysis of the findings is structured as follows: data analysis techniques, validation and legitimation process, findings, and summary. Sub-headings identify such information as project outcomes, data tracking and organization, data analysis procedures, reflexivity, validation procedures and limitations, key educational points, and impactful findings expected and unexpected.

Data Analysis Techniques

This study produced several important outcomes. One of the more significant was a unanimous recognition of the need for an EMHT service and a strongly worded commitment from the stakeholders to participate in some service solution. Related was the fact that nearly 90% of the research participants had no idea that the community lacked such a service in the first place. Nor were they aware that a total of 21 social work colleagues (including myself) lived within a 10-mile radius of each other in south Whidbey.

Another relevant outcome reported by nearly 90% of the respondents was minimal, if any, training in the PFA intervention model. Thus respondents said they would be inadequately prepared to intervene if they were called on to provide some EMHT service. Retirees as well as non-retirees were nevertheless willing to address this inadequacy by undergoing PFA training. Even though 50% of the respondents were retired, their willingness to become involved in finding a solution nearly matched their non-retired colleagues.

Lastly, nearly 90% of the questionnaire respondents reported some degree of community organization activity prior to moving to south Whidbey. However, only 25% of respondents had continued their involvement after moving to the island.

Due to the study's small sample size, no software was used in the data analysis. I manually tracked, organized, and analyzed the questionnaire and telephone interview information, relying on action research principles outlined by Fenge (2010), Hacker (2013), McNiff and Whitehead (2010), Saldana (2016), and Stringer (2014). I kept track of all work in a secure manner and setting. Electronic information was password protected on my computer and hardcopy materials locked via key in my office files. The identities of respondents were disguised by gender-neutral names and randomly assigned numbers.

For each of the eight questionnaires returned, I typed respondents' answers from Sections 1 and 2 (see Appendix A) onto clean questionnaire copies and password protected them on my computer. Respondents' data were transcribed exactly as written on the questionnaires. Section 1 consisted of nine closed-ended questions regarding professional focus, year of graduation, percentage of time on the island, licensure, and professional status. This body of data was later summarized based on the frequency of each circled response across the eight questionnaires. Section 2 consisted of five open-ended questions. Responses were recorded for each participant but not summarized as a group due to the heterogeneity of respondents' multiple-sentence answers. Data from Sections 1 and 2 served as the basis for the coded, 15-question questionnaires.

All telephone interviews followed the interview protocol outlined in Appendix B. I recorded interview information by hand, transferred it to clean telephone interview documents, and password protected it on my computer. With few exceptions, these interviews lasted about 15 minutes or less. During each interview, I was careful to quote the respondent as precisely as possible. On several occasions, I did this by fact-checking follow-up questions or asking interviewees to repeat themselves until I was satisfied I had recorded their answers correctly. Data gathered from the protocol outlined in Appendix B served as the basis for the coded 10-question telephone interviews.

Descriptive Coding Model

Coding is just one way of analyzing qualitative information, but it is the one most widely used and supported by the literature (Saldana, 2016). Simply put, coding is a procedure that action researchers use to organize and then interpret their data in a systematic manner. However, in a larger sense, action researchers code in order to plumb the data more deeply than the observable surface—to get beyond the numbers that identify individuals and their situations. At its most significant level, coding provides a rational framework for developing topics to analyze the research data anew. It is a project-long process to get beyond the manifest to the latent, similar in function to Freud's framework for dream interpretation (Freud, 1899/1961). For this project, I chose to use the descriptive coding model developed by Richards (2015), which identifies three aspects of descriptive coding: descriptive, topic, and analytical.

Descriptive Coding

Descriptive coding was used to aggregate information about stakeholder characteristics that are relevant to my research question: How do social workers residing on south Whidbey Island perceive the issue of a rural EMHT service in the community? Identifiers were drawn from Section 1 of the questionnaire (Appendix A), specifically regarding south Whidbey social workers' residence status, MSW graduation, professional focus, and percentage of work time on the island; whether they are licensed, active practitioners, or retired; and other pertinent information. Additionally, stakeholders answered questions regarding their knowledge of a south Whidbey EMHT or CERT service, of people associated with either program, and of psychological first-aid treatment models for disaster survivors. Such descriptive data served as one of several baselines to identify not only stakeholders' professional characteristics but also the extent of their knowledge about south Whidbey's emergency mental health services.

The process of reviewing answers from the descriptive coding data indicated several topics for identification. For example, *primary residence* and *length of residency*, *educational background*, *professional focus*, *current employment status*, *knowledge about emergency services on south Whidbey*, and *psychological first aid*, to name several. All these topics carry considerable relevance to my research question. I was especially curious about the retired stakeholders and their knowledge about and commitment to the EMHT issue. I also wondered if there would be a relationship between a stakeholder's work specialty, (i.e., direct service versus administration), and their willingness to participate in an EMHT solution. I was furthermore interested to see what other

correlations there might be between these multiple descriptive topics and a stakeholder's willingness to participate in a south Whidbey EMHT solution.

Topic Coding

A primary purpose of Richards's (2015) second construct, topic coding, is to organize in one place everything that a stakeholder has said about a given topic. In my project, this process involved labeling telephone interview data by subject matter. For example, I reviewed each line of telephone interview text and made notes such as, *this sentence was about educational background*, *this sentence was about professional identity*, or *this sentence was about employment status*. In this manner, I was able to gather an overall view of that stakeholder's many roles, interests, and preferences.

Analytic Coding

Richards's (2015) third construct, analytical coding, represents the core of the descriptive coding model, where interpretation and reflexivity take center stage. At this point in the analysis, I asked a series of questions related to the data and then extended my findings to make some assumptions about these subjects, which in turn led to additional questions and assumptions. My approach was guided by Stringer (2014), who advocated six questions for the enrichment of analytical coding: who, what, where, why, when, and how. I found this strategy especially useful in drawing attention to individual identity issues as well as to conclusions for action. For instance: *Who* were these stakeholders and what were their perceptions about an EMHT service? *What* were their motivations for responding to my research question? *Where* did they acquire the education and experience that led them to think they could contribute? *Why* did they not

know about any of the other south Whidbey resident social workers prior to my questionnaire? And finally, *how* did they feel about my invitation to collaborate on a solution?

These questions, together with a series of related ones, framed my effort to cluster stakeholders' information into the 12 primary topics outlined in Appendix G. To each topic I assigned a number. In order to avoid unnecessary repetition, topic numbers were used throughout the analytic coding process in place of the topic name.

In addition to this analytical format, I coded the eight questionnaires and seven telephone interviews according to these 12 topics. Consistent with the emphasis on revisiting the coded data found in Richards (2015), Saldana (2016), and Stringer (2014), I reread each telephone interview multiple times over a span of several weeks. After each rereading, I corrected my topical analysis to conform to a clearer perception of the stakeholders' opinions, experiences, professional identities, and interests. I then compared these newer perceptions with the questionnaire data and previous telephone interviews, looking for inconsistencies, conflicts, and/or agreements. This data analysis process led me to stronger, more accurate, and comprehensive conclusions about stakeholders' professional identities, the collection of their experiences, and a collaborative path forward.

Validation and Legitimization Process

Reflexivity

Reflexivity is considered a significant strategy for quality control in action research studies. Berger (2015) identified three types of reflexive challenges: (a) when

the researcher shares the experiences of the researched; (b) when the researcher shifts from the role of outsider to insider during the course of the research study; and (c) when the researcher has no familiarity with what is being researched. Because of my acquaintance with the issues and location on which the study is based, I have used the first of these three perspectives, shared experiences.

Even though I was an employed island resident with a vested interest in my research subject, I had few preconceptions about the social workers I was researching. I had no idea who they were, what parts of the island they lived in, what professional backgrounds they represented, how long they had lived on the island, whether they were retired or not, or what other demographic information applied. As far as I knew, I had never met any of these 20 colleagues, though I had lived on the island for over 13 years. As the study unfolded I was continually impressed by the breadth and depth of the participants' backgrounds. I was also surprised by their lack of knowledge regarding any form of south Whidbey's emergency mental health services. Paying close attention to these attitudes and others generated by the telephone interviews helped me to contain my clinical identification and counter-transference issues (Racker, 1982). Such recognition permitted me considerable freedom to represent their opinions in the coding analysis process. In the analysis to follow, my reflexive comments are given in italics.

Validation Procedures

I employed two validation procedures almost exclusively: pattern repetition and respondent validation (Stringer, 2014). In answers to certain items in the questionnaire

and from the telephone interviews, I found a consistent repetition of stakeholders' words and nearly the same phrases recurring from one data source to the other.

For example, Question 10 (Q-10; see Figure 1) asked about EMHT knowledge for south Whidbey. All respondents (100%) answered similarly: five used the word "nothing"; two answered, "not much" or "a bit." One said "maybe a clinic?"

Q-11 asked respondents about their involvement in anything similar to an EMHT service on south Whidbey (Figure 2). Stakeholders 1, 2, 3, 4, 6, 7, and 8 all answered similarly with "Not aware of anything," "No interest," "None what so ever," "No involvement," "No," "Nothing," and "None." Only Stakeholder 5 answered differently, saying "I was a founding member of a volunteer first responder service."

Q-12 asked about the role of a resident social worker in a future EMHT service (Figure 3). Stakeholders 2, 3, 4, 5, 6, and 8 answered similarly with "Crisis management," "A moral and ethical obligation," "To help," "To function according to the NASW code of ethics," "To get involved," and "Employ PFA." Only Stakeholders 1 and 7 answered with "Don't know" and "No idea."

Q-13 (Figure 4) and Q-14 (Figure 5) were related to knowledge about south Whidbey's CERT. In both instances, 90% of the respondents answered they knew "Nothing," "Zero," or "Not a thing." Only Stakeholder 1 answered with some distant knowledge: "I think my boss may be involved."

Q-15 asked about PFA knowledge (Figure 6). Again, 90% of the responses were similar: "Not very," "Not much," "Not familiar," "Nothing," and "Not at all." Only Stakeholder 4 answered, "I am familiar with the Red Cross PFA model." Taken

altogether, respondents' use of the same words or phrases to answer these questions lends weight to the validity of their data.

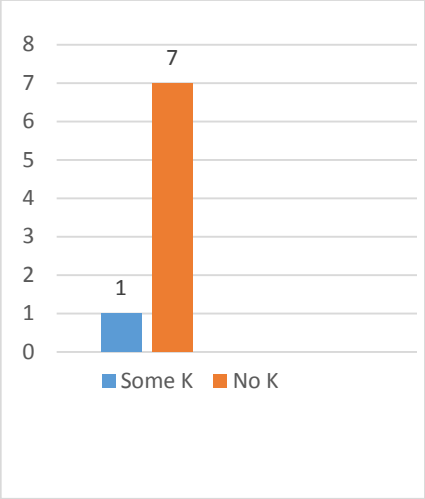

Figure 1. Question 11: Knowledge of Whidbey EMHT.

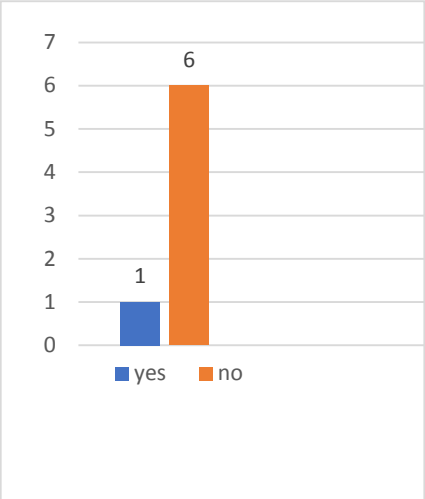

Figure 2. Question 12: Involvement in Whidbey EMHT.

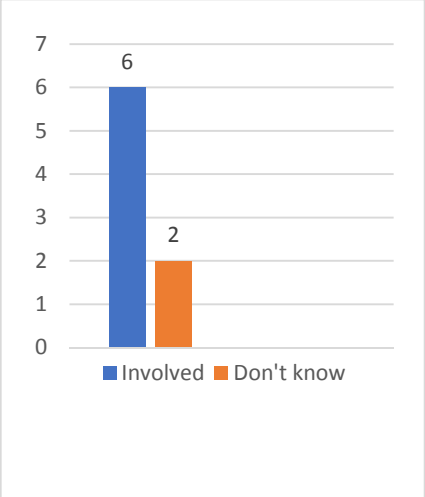

Figure 3. Question 13: Possible role for social workers in Whidbey EMHT.

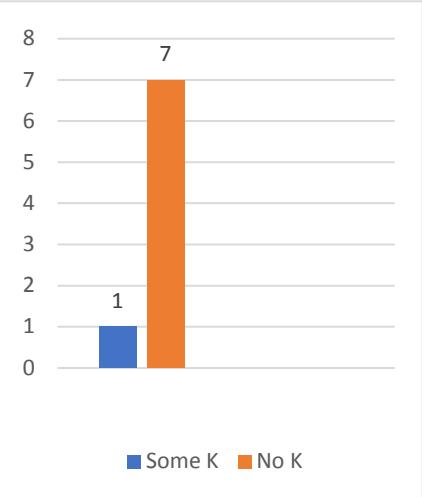

Figure 4. Question 14: Knowledge of Whidbey CERT.

K=Knowledge

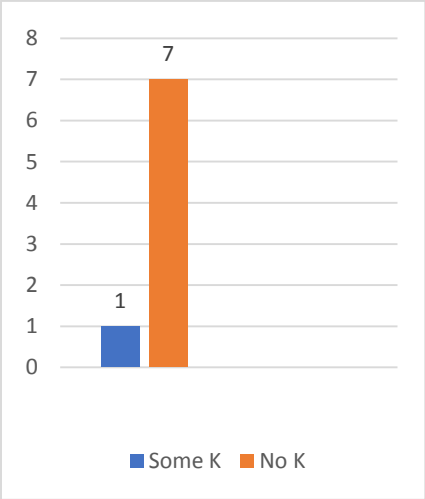

Figure 5. Question 15: Knowledge of social workers' participation in Whidbey CERT.

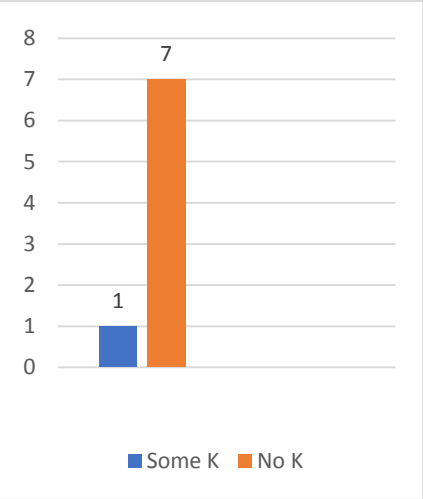

Figure 6. Question 16: Familiarity with PFA model.

K=Knowledge

Respondent validation—that is, having respondents verify the accuracy of their own data, including interpretative material (Torrance, 2012)—occurred when I cross-checked some of the telephone interview answers with corresponding questionnaire answers. For example, telephone interview Question 2b (TIQ-2b) asked about respondents' involvement in public emergencies since they had moved to south Whidbey; 90% of the stakeholders answered either "None" or "Nothing." This response compared favorably with their answers to questionnaire Questions 10 and 11 (Q-10 and Q-11), where the same respondents answered, "No," "Nothing," "Not much." In summary, the authenticity of their answers to Q-10 and Q-11 was confirmed by their answers to TIQ-2b. The consistency of the respondents' answers on two separate occasions from two different but related data sets was conclusive; the respondents meant what they said about their EMHT knowledge in south Whidbey.

In a similar vein, respondent validation appeared in corresponding answers to the telephone interview question about prior involvement in some form of community action (TIQ-1) and the questionnaire question, "What do you think about the roles of the south Whidbey social worker in an EMHT service?" (Q-12). A strong majority (70%) of TIQ-1 answers reported a history of prior community participation. For example:

Stakeholder 2: "I was active as far back as the '60s."

Stakeholder 3: "I have been active for the past 23 years."

Stakeholder 4: "Among other things, I organized a community mental health service."

Stakeholder 5: "I have been very active through my temple with community boards for the past 10 years."

Stakeholder 6: "I have worked with my city to undo racism at the community level."

As reported earlier, Stakeholders 2, 3, 4, 5, and 6 had similar Q-12 responses as to their potential roles as social workers in a south Whidbey EMHT service. (Stakeholder 8 did as well but was not included in this validation example since they reported no prior community organization experience.) This comparison of TIQ-1 and Q-12 answers suggests a consistent pattern of agreement among these respondents about their potential participation in a south Whidbey EMHT service. Their agreement indicates respondent validation for the data provided by these two questions.

Trustworthiness and Rigor Limitations

Action research is best understood as a systematic investigation of subjective data based on a continuum of definitions and philosophical principles. A critical feature of this approach is engaging the researcher and research participants as co-equals (Fenge, 2010). Trustworthiness in the context of an action research study is defined as inspiring a degree of trust in the study. Rigor refers to the way that action research principles are adhered to. Trustworthiness and rigor are concepts intended to validate the work of action researchers. Stringer (2014) outlines four further concepts that are essential to legitimizing a study: credibility, transferability, dependability, and confirmability.

However, action research theorists do not offer an explanation of what constitutes a necessary or sufficient degree of conceptual integration into a study in order to establish trustworthiness and rigor. Neither do they identify which of the four concepts carries greater or lesser weight than the others. This gap raises several questions: Must these concepts be engaged in equal degree of rigor for an action research study to be deemed trustworthy? Or does the researcher only need to meet one, two, or three of these attributes? If so, which one(s) and to what extent, and how does one quantify such assessments? Furthermore, how trustworthy is trustworthy: a lot, a little, or not very much? How much rigor is necessary to constitute sufficiency?

These questions point to a degree of ambiguity inherent to qualitative research. In quantitative studies, rigor refers to the way research principles are adhered to in a study; the more closely such principles are followed, the stronger the research findings are likely to be (Ivarsson & Gorschek, 2010). Although action research defines the use of rigor in a

similar fashion (Stringer, 2014), the similarities end there. Quantitative research uses statistical models to identify rigor. Qualitative research uses nouns. Therefore, subjective interpretation will be the final arbitrator as to whether the action research study was rigorous enough to qualify as trustworthy, which marks something of a limitation to both measurement concepts (Stringer, 2014; McNiff & Whitehead, 2010). However, such limitations are not to be considered significant to my project's conclusions. In this study, adherence to Stringer's (2014) four points of credibility, transferability, dependability, and confirmability successfully address this concern.

Findings

The project's database consisted of 21 questions; 15 of these were asked in the mailed questionnaire and six during telephone interviews. Nine questions from the questionnaire were closed- or semi-open-ended and six were open-ended. The six questions from the telephone interview were all open-ended.

The 15 closed and semi-open-ended questionnaire questions have been grouped into three topical categories: *residency*, *professional identity*, and *south Whidbey EMHT service knowledge*. Several of these topics are elaborated with sub-topics in order to clarify the data. These topical categories represent information from questionnaire Questions 1 through 15 (Appendix A, Sections 1 and 2).

The six open-ended telephone interview questions have been grouped into three topical categories: *community organization (CO) activities*, *knowledge about the social work community in south Whidbey*, and *research project feedback*. Two of these categories are accompanied by several sub-topics.

These six categories resulted in 12 topics used in the analytic coding process of the telephone interviews: *residence*, *professional identity*, *professional focus*, *employment status*, *EMHT knowledge*, *CERT knowledge*, *PFA knowledge*, *CO activity before relocation to Whidbey*, *CO activity since relocation to Whidbey*, *knowledge about south Whidbey social workers*, *awareness of a south Whidbey social work presence*, and *research project feedback*.

The following descriptive explanations define four of the 12 topics; the other eight topics are self-explanatory.

Residence: A full-time residence, as opposed to a summer place.

Professional identity: Attitudes, behaviors, decisions, and accomplishments that correlate positively with the social work profession.

Knowledge about 21 south Whidbey social workers: Knowledge that would exceed mere familiarity with social workers' names.

Awareness of a south Whidbey social work presence: Awareness of one or more public social work-sponsored activities or organizations in south Whidbey.

Stakeholder questionnaire and telephone interview data were analyzed according to these topics and their sub-topic headings (see Appendix G). In order to minimize repetition during the data analysis process, numbers assigned to the topic headings were used in place of the complete topic or subtopic name. Since Whidbey Island is a small rural community, some stakeholder data have been edited to protect participants' identities. To the best of my ability, I retained the essence of the stakeholder's

information without compromising their identity or the outcome of the data analysis process. "*WG*," notated in italics, represents my reflexive comments.

Case Example

The following questionnaire and telephone interview from Stakeholder 4 were selected to demonstrate principles of the descriptive coding model (Richards, 2015), including the three central aspects of the model: descriptive, topic, and analytic coding. These data also serve as a representative template for analytic coding of the other stakeholders' telephone interviews. Topics highlighted in this interview and reflected in the other stakeholders' information include knowledge about south Whidbey's EMHT and CERT services, the PFA intervention model, the need for psychological first-aid service, and stakeholders' willingness to participate in a service solution. Several additional topic commonalities are worthy of notice, such as previous community organization participation and professional identity commitments. I have quoted the other stakeholders in eight of the 12 topics found in Appendix G and integrated their comments throughout this account of my interview with Stakeholder 4.

Descriptive coding: Questionnaire data.

STAKEHOLDER: Stakeholder 4

SOUTH WHIDBEY RESIDENCE: Yes

LENGTH OF RESIDENCY: 23 years

MSW DATE: 1968

LICENSED: Yes

PROFESSIONAL FOCUS: Adult outpatient

EMPLOYMENT: Retired

SELF OR AGENCY EMPLOYED: Self-employed

AGENCY TYPE: N/A

ISLAND WORK TIME: Retired

SOUTH WHIDBEY EMHT SERVICE KNOWLEDGE: Nothing

SOUTH WHIDBEY EMHT SERVICE PARTICIPATION: None

SOUTH WHIDBEY EMHT SERVICE ROLE: Planning and help, when asked

COMMUNITY EMERGENCY RERSPONSE TEAM (CERT) KNOWLEDGE: Nothing

CERT PARTICIPATION: None

PSYCHOLOGICAL FIRST-AID (PFA) KNOWLEDGE: Somewhat

Analytic coding: Telephone interview. Prior to this formal telephone interview, Stakeholder 4 had asked me to call anytime for the interview. When I called and identified myself, I was told the stakeholder was expecting my call. Consistent with the telephone interview protocol, I had the stakeholder call me back on the 1-888 toll-free number. It turns out that the stakeholder had been engaged in a hobby that was one of the loves of the stakeholder's leisure-time. Even though I had been invited to call at any time, I was sensitive about priorities and this personal information, and so I wanted to stay on task. The interview remained pretty much on script: I received the information I asked for, and the stakeholder's answers were substantive, but it was clear as the interview continued that Stakeholder 4's attention was drifting elsewhere.

I stayed with the telephone interview protocol outlined in Appendix B and began the interview by asking about Stakeholder 4's previous CO experience. In the following transcript of our conversation, parenthetical numbers correspond to analytic coding topics (see Appendix G).

Q16: CO before moving to Whidbey. Stakeholder 4: Before moving to Whidbey, I worked in Detroit for the Red Cross (2). I was in the heart of the Detroit riots in 1967 serving as a crisis counselor (2, 7a, 8d), working alongside with what we now call first responders (2, 3a). Those were harrowing days. I was called on to do more than just try and reduce the stress of the workers. I was distributing food, finding places for people to sleep, coordinating services that allowed people to stay in touch with family. I just had my hand in anything that was needed (8acd).

Q17: CO after moving to Whidbey. Stakeholder 4: I have moved around Whidbey several times (1). From 1972 and for a number of years after that I lived in North Whidbey—out of Oak Harbor actually. If I understand your series of questions I would summarize my answer by describing my activities in founding the first community mental health center on the island (2, 3b, 8ac). I was instrumental along with several other mental health folks in writing and have funded an NIMH grant that got the clinic started (2, 3b). I was the director (2, 3b) of that clinic for a number of years, directing all aspects of the comprehensive clinic: day treatment, crisis service coordinating with Western state for involuntary commits, and running an outpatient clinic (2, 3b). I should say that I

was instrumental in getting it started and took over the directorship sometime in the mid-1970s (2, 3b).

WG: I loved the community mental health center movement. My first job was as the coordinator of emergency services at a CMHC. I hired community volunteers to provide some of the walk-in and evening crisis services. Published the results and loved the concept.

Stakeholder 4: I know what you are talking about. What was the name of your clinic? (*WG provided the name.*) Yes, I recall that name (2). I don't remember the name of the director, but weren't you over on the eastside somewhere? (2).

WG: Yes, we were. I was also connected to the hospital there for psychiatric beds.

Stakeholder 4: It was a great concept but never adequately funded by the states (2). I know I was always looking for funds (2, 3b, 9ace). In fact, there toward the end after many years as director, that's all I was doing, it seemed—looking for money (2, 3b, 9ace). That's kind of what burned me out there at the end (2). Since retirement (4a), I have not been too active recently (9b). But when I was the Island County's mental health director, I tried to establish a day treatment satellite down in Langley (2, 3b, 9ac). I met with several social workers at that time but if pressed today I don't recall their names. So I don't know what may or may not be happening anymore (5b, 6b, 7b, 9b, 10b, 11b).

WG: All this community mental health discussion revived memories: colleagues I met and still retain a friendship with to this day; shared experiences with a startup movement that we all believed would revolutionize psychiatric care; disappointments that

lack of funding was such a death knell for the concept; and on and on. I felt a real kinship with Stakeholder 4. He will be a wonderful professional to work with in the future.

Q18: Social work presence on the island. Stakeholder 4: Other than what I just said, I'm pretty much out of the loop (9b, 10b). Even though I have retained my NASW membership, I'm not really involved anymore (9b, 10b).

Q19: 21 island social workers. Stakeholder 4: I was surprised (9b). But as I mentioned, I'm just not involved (9b, 10b).

WG: As with so many other stakeholders, Stakeholder 4 has, in their own word, "zero" knowledge about current island colleagues and services. Retirement has meant stepping away from day-to-day professional issues such as the EMHT service. But this stakeholder has retained their NASW membership, answered and returned my questionnaire, and agreed to be interviewed. So the withdrawal has not been complete. Something about my project has caught this stakeholder's interest. What is it? A revived interest for having a "hand in everything" when operating as the CMHC administrator? A love of the community-based mental health philosophy never fully extinguished? It is not clear yet. What is clear is that this stakeholder still has some professional interest and is not ready to step away completely. All are interesting possibilities and, if appropriate, could be addressed when we meet again.

Q20: Thoughts about the project. Stakeholder 4: I would be very interested in contributing to your idea once you have finished your research project (12). As we discussed, I am very familiar with your ideas (7a) and think I could contribute (2). Just make sure you keep in touch with me (12).

Topic coding and frequency of references.

1. Residence: 1

2. Professional identity: 11

3. Professional focus:

    Direct service (3a): 3

    Administration (3b): 8

    CO (3c):

4. Employment:

    Retired (4a): 1

    Not retired (4b):

5. EMHT knowledge:

    Yes (5a):

    No (5b): 1

6. CERT knowledge:

    Yes (6a):

    No (6b): 1

7. PFA knowledge:

    Yes (7a): 1

    No (7b): 1

8. CO activity before Whidbey:

    Yes (8a): 2

    No (8b):

Public participation (8c): 2

Public emergencies (8d): 2

Social and political action (8e):

9. CO activity since Whidbey:

Yes (9a): 3

No (9b): 5

Public participation (9c): 2

Public emergencies (9d):

Social and political action (9e): 2

10. Knowledge about 21 south Whidbey social workers:

Yes (10a):

No (10b): 4

11. Awareness of social work presence:

Yes (11a):

No (11b): 1

12. Project feedback: 2

Key features. *WG: In my opinion, Stakeholder 4 is a highly skilled social worker: a professional to the core, and a real asset regarding the EMHT issue as a service provider/leader/consultant/trainer. This stakeholder is completely familiar with both the service and the need, with experience likely equal to mine. Together with the other stakeholders who have expressed a willingness to put something together, we will develop a plan to address this service issue. Though Stakeholder 4 is retired, I could*

sense the professional passion that was there once and may be possible to reenergize again with the EMHT issue.

Commonalities with other stakeholders. Stakeholder 4's coded telephone interview highlights the 12 topical categories from Appendix G and provides a framework for noting response similarities with the other telephone interviews. The substance of these similarities is outlined in Appendix I.

Summary of Descriptive Coding Analysis

This summary covers all coded analysis from stakeholders' telephone interviews (Appendix K). One of the most significant outcomes involved an offer from the research stakeholders to participate in a future EMHT service for south Whidbey (12). These social workers recognized that such action could not commence until I had completed the present project, but they were willing to wait (12). A second finding of almost equal importance and directly related to their offer to participate is the fact that 90% of the research participants had no idea that the community lacked such a service (5b); neither were they aware of the large number of their colleagues living in south Whidbey (10b). Given the fact that there is no local NASW chapter or social work organization (confirmed by a telephone conversation with the state chapter), it was not surprising to find that stakeholders had no awareness of a social work presence (10b). Another likely explanation is the retired and rural character associated with life in south Whidbey. Retired commonly means disengaged from a former profession; rural, as defined by the Island County Zoning code, refers to the county's land use patterns, the preservation of wild life habitat, and traditional rural lifestyles where open space is to be preserved and to

take precedence over built environments (Revised Code of Washington 36.70A.030). Even against this cultural backdrop and the number of years some stakeholders have been detached from active practice, I received considerable support for an EMHT resolution once respondents understood the nature of my research project. On reflection, I perceived these social work stakeholders to be waiting for a spark, a relevant community issue, to allow them to be collaboratively involved, and my action research study appeared to have given them that spark.

Related to this issue, all stakeholders expressed some degree of surprise that there were as many as 21 NASW members in south Whidbey. Their surprise mirrored my own when I first began this research study. After this project's completion, I would like to discuss that situation with all the project's stakeholders.

A third relevant outcome was the report by 90% of the respondents that they had little if any training in psychological first aid (7b). As a result, they felt they would be inadequately prepared to intervene if they were called on to provide some type of EMHT service. This was a shock to me. The lapse in preparation fits for those who identified as retired, since they had been away from an active practice for many years. But for those stakeholders who were still active, their response was surprising. However, all stakeholders were open to learning PFA (12), even those who identified with a career focus on administration or research (3b, 3d).

A fourth outcome was that 50% of the respondents were retired yet willing, even eager, to participate in the resolution of the EMHT issue (4a, 12). While admitting to not being clinically current, these retirees were nevertheless willing to sharpen their focus

with additional PFA training (12). This professional attitude was unmistakable with every telephone interview, even from those who had been long retired (2). After completing the current project, I will contact all stakeholders to reestablish their participatory interests.

Lastly, nearly 90% of the questionnaire respondents reported some degree of CO activity prior to moving to south Whidbey (8a, c, 9c). However, only 25% continued their involvement after moving to the island. I cross-checked these CO responses, active versus inactive, with respondents' retired or non-retired status and found no meaningful differences. Retired or not, all stakeholders were open to working toward an EMHT solution (12).

Appendix K summarizes the frequency of topic references from the seven telephone interviews. It represents the number of times I cited their telephone interview statements related to my research question. Added to data from the eight questionnaires, this frequency count provides additional material for my research question: How do social workers on south Whidbey Island perceive the issue of a rural emergency mental health trauma (EMHT) service in their community? The evidence to some of the topic data is significant; other topical questions remain to be addressed in the future. In every instance, the stakeholder's perceptions about the research question were illuminating and positive.

Learning Points

The process of carrying out this research project brought the following key lessons to the fore.

- Openness about professional identity, regardless of setting, can produce remarkable results. Because my golfing group knew I was a professional social worker with a background in crisis intervention, they asked me what I knew about an EMHT service in south Whidbey. This capstone project is the result of that inquiry.
- Following up on such an inquiry is an ethical responsibility, regardless of the outcome. I had no idea what I would find when I began looking for such a service. It turned into a three-year project with the potential for substantial, sustained, and positive community impact.
- It is critical to remain open to surprises. Numerous telephone calls and basic research strategies identified no current EMHT service for south Whidbey. That was not so much a surprise as a confirmation of some of my earlier research. The fact that there were 20 other professionally trained social workers living in south Whidbey was the surprise.
- A major research project needs to be separated into distinct components. For the first year of the project I tried to combine data collection and project implementation. This led to intense pressure to knit these two features together in a timely fashion. My faculty advisor's intervention helped me understand how unrealistic and unnecessary this approach was.
- The project's questionnaire reawakened something in each of the respondents. Some respondents had been away from community organization activities for

many years but were willing to become involved again for the sake of a community need. My project offered them a rallying point and some direction.

Clinical Practice Impact

Several significant findings will impact clinical practice in south Whidbey and beyond. First, my research data confirmed the supposition that there is no known EMHT service in south Whidbey, nor any plans for such a service. This absence leaves south Whidbey vulnerable to any community-wide disaster and would leave survivors with no mental health trauma resources. This lack of immediate service would expose survivors to chronic mental health issues extending far beyond the actual trauma event and incurring unnecessary costs on individuals, their families, and the south Whidbey community.

Second, I discovered the existence of a core of south Whidbey professional colleagues, who had no awareness of each other, though all were living within a 20-mile radius of each other. When the existence of this group was brought to the attention of the participants, they were universally “shocked” or “surprised.” In most instances, the respondents had had no known interaction with their peers, and those who had could not remember when that was or what had transpired conversationally. While perhaps not intentionally, respondents appear to have experienced some professional isolation that was not recognized until this action research project surfaced.

A third and perhaps most significant finding was the unanimous willingness of these respondents to collaborate in a future endeavor to address the lack of an EMHT service. There was no hesitation on this point, even though four individuals identified

themselves as retired from the clinical work force for some years. In spite of being out of practice, they were open to brushing up on whatever skills were necessary. During the course of the interviews, I noted a different quality in respondents' speech when they spoke about their willingness to participate. It was deeper in tone and more emphatic in pronunciation. From an action research perspective, these participants were not just giving lip service to a telephone interviewer's prompts, nor were they responding to transference issues (Racker, 1982). They appeared to mean what they said: they sounded and felt authentic to me, which left me with little doubt they would be ready when asked to participate. Actualizing these stakeholders into a professional presence would positively impact the lives of countless community members if a traumatic situation requiring professional intervention were to arise.

Unexpected Findings

As mentioned previously, I had no prior interaction with these social workers nor any idea how they might respond to either my research proposal or its implications. As a result, I was greatly pleased that so many colleagues agreed to participate and, beyond that, to assist in addressing the need. This was unexpected. My project identified a demonstrable need, and although I had hoped that my colleagues would see it as ready-made for their participation, I did not know whether my expectations might simply be the product of projection. For my own part, I was trained to participate, or at least be open to participating to some extent, in all aspects of the social work code of ethics, including evaluation and research as well as in responsibilities to the broader society (e.g., public

participation, public emergencies, social and political action), and not just in direct service (NASW, 2008). It was gratifying to find that I was not alone in this position.

Summary

My research question was: How do social workers residing on south Whidbey Island perceive the issue of a rural EMHT service in the community? Ninety percent of the respondents reported knowing nothing of such a service. However, 100% of respondents indicated a willingness to participate in a solution to this issue after the completion of the present project. I was also interested to know the extent of respondents' CO experience prior to taking residence on south Whidbey. Nearly 90% of the respondents had been very active prior to their move to the island and would willingly become active again, and the nearly 10% who had not previously been active were willing to get involved with this issue.

Stakeholder support to participate in a south Whidbey EMHT solution was unanimous, but it remains to be seen exactly what solutions may unfold, since such details were not part of my research design. The data make clear that this research project has identified a group of resident social workers who are waiting to be called into action for a worthy purpose. That purpose has now been defined; stakeholders have been located and surveyed, and all have agreed to participate in an EMHT solution. Following graduation, I will invite the stakeholders to convert their verbal commitment into collaborative action.

The initial motivation behind this action research project was to determine what sort of south Whidbey mental health services were available in the event of an

earthquake. The more I sought answers to the apparent lack of service, the clearer it became that there were other potential natural and man-made disasters for which the community was ill-prepared. I therefore constructed this research project to determine the full scope of the problem and, during the process, discovered a group of south Whidbey social workers who were willing to collaborate on a solution. The results of these research efforts provide a base for understanding and subsequently addressing this community-wide vulnerability. With such information in hand I can move forward confidently with recommended solutions.

Section 4: Recommended Solutions

Members of my community brought to my attention that south Whidbey lacked an EMHT service to deal with survivors of a catastrophe, such as a school shooting, earthquake, or terrorist attack. My action research study explored this issue. Among the significant data collected was the discovery of a cadre of 20 professional social work colleagues who have registered addresses within several square miles of one another, yet appear to have never met, personally or professionally. Furthermore, respondent data indicated a nearly universal lack of knowledge about south Whidbey's EMHT service vulnerability, combined with unanimous support for a collaborative solution to resolve this issue. Additional research data indicated that respondents had participated in a substantial degree of off-island CO, which could be readily transferred to south Whidbey if needed. Finally, despite having been disengaged from community organization on the island, social workers who participated in the study were more than eager to reverse this trend. What was lacking was a galvanizing issue and someone to help them get started, both of which this action research project provided.

Professional Practice Application

As outlined earlier in both narrative and graphic form, the social workers who participated in this research were unaware of south Whidbey's lack of an EMHT service for survivors of a natural or man-made disaster (Figure 1). When asked specifically what they knew, 75% of the respondents used words like "nothing," "not much," and "a bit"; and one stated, "Maybe a clinic?" These responses, while essential to establishing a baseline of knowledge about the EMHT service issue, offered only the first step to a

proposed course of action. The second step was ascertaining respondents' willingness to become involved and their capability to implement an EMHT service. This question was answered positively by 75% of the questionnaire respondents (see Q-12 and Figure 3), with elaboration in TIQ-5 of the telephone interviews. For example:

Stakeholder 3: "I want to be a part of it [the EMHT proposal]."

Stakeholder 4: "I am very interested in contributing."

Stakeholder 5: "Good luck…wonderful project…much needed. I'm interested."

Stakeholder 6: "I see the need"; "Your project is a good one"; "Count me in."

Stakeholder 7: "I like the idea."

Stakeholder 8: "I think it's great…would like to learn more."

The respondents' capability, which I determined by their previous clinical and CO experience, was answered clearly by their off-island community activities and clinical backgrounds. As noted earlier, Stakeholders 2, 3, 4, and 6 reported years of community activism. Furthermore, each participant had the commensurate clinical training to accompany their activist background, including providing direct services to individuals, couples, families, and geriatric populations (Appendix H). While only one respondent was familiar with the PFA model (Figure 6), all others expressed willingness to learn it.

As mentioned in the literature review, I found very few resources that bore direct reference to my research question. There was literature on action research (Bradbury & Reason, 2015), posttraumatic stress reactions (Bugge et al., 2015), rural social work (Ginsberg, 2011), psychological first aid (Everly, Barnett, & Links, 2012), and collaboration theory and practice (Dukes, Firehock, & Birkhoff, 2011). But my action

research integrated these fields with no one concept carrying greater importance than another. Therefore, my project is best described as extending knowledge within the social work profession through integrative, research-based leadership and outreach.

Situated 30 miles north of Seattle and accessible by a regularly scheduled ferry service, south Whidbey Island is a rural community of some 16,000 residents with an average per capita income of $36,000. As typical of a community of such modest size and means, south Whidbey relies on its own resources to address and solve its social service needs as much as possible. This has been true for the all-volunteer fire and emergency medical teams as well as the several community food and shelter services. While admirable and necessary, this ethos has certain drawbacks. The community's lack of *any* EMHT service program and the resources to serve should the need arise is one such example. My research project identified both the lack of service and a labor force capable of addressing the service need. As detailed previously, I identified both gaps following a diligent inquiry into need and available resources. Having uncovered the need for, but lack of, an EMHT service for the community, I had seriously considered proposing a para-professional service model based on the work of McCabe et al. (2011). Finding a community of social workers residing in south Whidbey provided me with a better option. Research data from the questionnaire and telephone interviews supported this conclusion. As a result, I have secured a group of professionally trained social work colleagues willing to commit their time and experience to address this situation. As demonstrated by the data, this outcome could prove to be an ideal solution to an otherwise significant community vulnerability.

I have every reason to believe the sincerity of respondents' commitment to participate in an EMHT solution. As I have argued, this statement finds support in both the questionnaire data and respondents' enthusiasm expressed during their telephone interviews. Until my recent contact, this group did not exist except as names and addresses on a mailing list. Shortly after graduation I will help organize this group into a social change agent poised to address a mental health service need. While that alone will be of significance, of equal importance will be the forging of eight social workers into a professional presence that previously had not existed in the south Whidbey community.

Solutions for the Clinical Social Work Setting

The solutions that have emerged from my research, while not agency-based, have in a very real sense reawakened dormant professional engagement in colleagues who described themselves as retired. Evidence of this is confirmed by my action research-based observations: I found them engaging, thoroughly open to all my research questions, and excited about the prospect of contributing again. They did not consider it prying when I asked about their past CO activities. In fact, several respondents provided details and insights about those experiences at great length. As they spoke about their involvement, I noted a genuine pride in what they had done, though it had been many years ago. As I thought about their histories, I realized my project was likely giving them a new chance to participate in a significant activity. This was not said outright, but listening with what Theodore Reik (1888–1969) called "the third ear," I was convinced that it was a significant element in their decisions to participate again.

For myself, the results of this project confirmed what I long suspected was needed but not yet available. The discovery of 20 colleagues, eight of whom have agreed to help, was an added bonus far exceeding my expectations for resource assistance. Their verbal commitment combined with an extraordinary array of CO experience bodes well for the future of my ideas. Before there was just me. Now there are multiples of me—a collaborative team in every sense of the word.

Implications for Social Change

Implementation of my action research recommendations would positively affect the micro, mezzo, and macro levels of south Whidbey's community should a natural or man-made disaster occur. To be sure, some levels would be more directly impacted than others, but each segment of community life that these practice levels represent would experience some immediate and long-lasting benefit.

Micro Level

At the micro level, the foremost beneficiaries would be individual disaster survivors who gained access to immediate mental health trauma services. Such access would mitigate the likelihood that symptoms related to PTSD transition from acute to chronic. Potential cost savings to survivors and the community alike would be incalculable (Goldmann & Galea, 2014; Kar, 2010; Liu et al., 2011; Zhang et al., 2012). Without such service, the economic, social, and medical costs would be especially difficult to bear for a rural community such as south Whidbey. As noted, such resources are already stretched thin, requiring many of the community's basic services to be handled by volunteers. Organizing a functioning social work presence to address this

EMHT need would strengthen such resources rather than overburden them with yet another demand in a time of crisis. A secondary benefit at the micro level would be strengthening the family unit, which has long been a goal of the social work profession. Timely and effective intervention with disaster survivors gives explanation and support to families that might otherwise have to fend for themselves during an emergency and beyond.

Mezzo Level

At the mezzo level of practice, a group of EMHT-focused social workers would interact with small- and medium-sized community groups, both informing them of the need for such a service and enlisting their collaborative support. Relevant groups would include the local school system, neighborhood churches, the south Whidbey business community, and service groups such as the Optimists, Habitat for Humanity, Good Cheer, and other local organizations. In south Whidbey, these organizations are the lifeblood of the community. Each group supports the activities of the others with considerable crossover participation, including fundraising for school activities, church-sponsored events, holiday parades, and children's events.

Also included at this practice level would be the island's first responders such as fire, police, and medical services—crucial organizations that would be invited to participate as collaborative partners and whose involvement would be key to making the program operational. I broached this issue in my earlier contact with south Whidbey's fire chief, who made it clear that he would welcome such a program (R. Palmer, personal communication, April, 14, 2015).

Island County is served by a three-member Board of Commissioners, who serve as the county's legislative and executive authority. The Commissioners are charged with overseeing county operations; financial and budgetary matters; and the adoption of laws that regulate county growth, health, safety, and the welfare of its citizens. South Whidbey is part of District 1 and currently represented by a commissioner who is very proactive in promoting mental health issues that improve the quality of life in the community. This individual is well regarded by the other commissioners and would be the first elected official contacted once the social work group had been formed. She would be a powerful voice if we could convince her to support the EMHT service idea.

Macro Level

At the macro level, contact with and approval from appropriate state and federal organizations that have jurisdiction over related emergency services would be necessary. For example, the Department of Homeland Security provides federal coordination in the event of a terrorist attack, natural disaster, or other large-scale emergencies. It would be the appropriate federal agency to contact in the process of establishing an EMHT service. At the state level, the Washington Military Department's Emergency Management Division addresses the impact of emergencies and disasters throughout the state (mil.wa.gov/emergency-management-division). To this end, it manages an Emergency Operations Center that coordinates emergency services in all 39 counties of the state, and a south Whidbey EMHT service would be tied in with them as well.

It will also be essential to involve federal bureaucracies in the planning and execution of an EMHT service. Not only do these agencies provide the legal mandate to

serve in an oversight capacity, but they coordinate all such emergency services down to the local level. Their support would be mandatory, and informing them early on about the EMHT service idea would be critically important.

Evaluation

As with any proposed social service program that is new, the question of evaluation must be included. The proposed EMHT service program would not be an exception. An evaluation would address such issues as need, cost, staffing, and effectiveness. As facilitator, I would place these issues before the eight social work stakeholders at the first meeting. Given the backgrounds of the members, these issues would be integrated into a formal proposal ready for presentation to the individuals, groups, or organizations we deemed appropriate to help launch the program.

Developing criteria to measure the program's effectiveness would depend on the type of program proposed. Johns Hopkins Bloomberg School of Public Health has developed a service model using community volunteers as crisis counselors in disaster situations. Their model is particularly well suited for underfunded rural communities, and extensive evaluations have demonstrated their likely effectiveness. Should the stakeholders choose this service option, there are ample research publications outlining their evaluation format (Everly, Barnett, & Links, 2012; Everly & Flynn, 2006; McCabe, Everly, et al., 2014; McCabe et al., 2012; McCabe et al., 2011; McCabe et al., 2010; McCabe, Semon et al., 2014). If the stakeholders decide to go in another direction than this paraprofessional model, there will be enough research expertise among the group to propose a solution equally significant.

Summary

From experience with this project, I can offer other rural researchers a frame of reference: When asked about a local community problem, research the issue. After all relevant information is available, organize whatever community resources are available to address it. In my case, I was asked about the existence of a mental health trauma service if an earthquake were to strike south Whidbey. This question led me to search for answers, only to discover that there was no such service. During this search, I located 20 other NASW-member social workers living in the area with no professional affiliation to one another, nor any active participation with the local NASW chapter. With a mailing list purchased from the NASW state chapter, I conducted an action research study requesting social workers' perceptions about the issue of a rural EMHT service in south Whidbey. Eight responded with a commitment to participate in a solutions-based group. Such a group could also transition into a voice for addressing a wide range of other service needs.

The findings from this project are unique in several important ways. As noted in the literature review section, I was unable to find anything similar to what I was proposing; therefore, I reasoned, I was likely breaking new ground. For example, instead of designating a single research focus, I identified four areas of interest: action research, collaboration, the profession's commitment to vulnerable populations, and EMHT relief efforts, all in a rural community. I argued that all four components would have to be addressed in order to solve the lack of a mental health service for survivors of a potential disaster in south Whidbey. The combination of these features, and the way my project

addressed them through careful research planning and execution, can serve as a template for other rural communities facing similar vulnerabilities. In narrative form, I have demonstrated the importance of a research-based decision-making process. This narrative has been followed by recommendations to form a collaborative work group of resident social workers committed to addressing the lack of a local EMHT service. I have offered guidelines to engage micro, mezzo, and macro levels of social work practice in order to be effective. Finally, I have maintained a high degree of transparency in how I arrived at my conclusions.

I intend to disseminate this project's findings in several ways. My first effort will be to demonstrate the soundness of my action research project by making it operational. I have the data to support the need. I have eight community stakeholders willing to collaborate to convert the research data into action. After graduation I will have the capacity to see the project through to completion. One of the keys to this approach is to enlist community support. To that end, I will approach the county commissioner who represents south Whidbey and who has a long and successful history of supporting needed community services. We know one another by sight, and that recognition gives me access to her that others might not have. She is widely known as a very strong advocate for expanded mental health services in the community, and was recently re-elected, according to newspaper reports, because of this advocacy. At the appropriate time, I will meet with her to show her the results of my project, including the recommendation for an EMHT service endorsed by my eight colleagues. I will follow

this first debriefing with additional meetings accompanied by other project stakeholders in order to demonstrate the breadth and depth of our professional commitment.

A second strategy is to pursue publication. After my extensive review of related literature, it became apparent that there was a paucity of academic material related to my proposal. This awareness underscored the significance of my research ideas and the importance of having my data published. My first choice of venue would be a journal that reflects the action research point of view, such as *Action Research*. Other journals to consider that are not focused on qualitative research but that reflect issues germane to my project would include *Disaster Health*, *The International Journal of Emergency Mental Health*, *Journal of Traumatic Stress*, *The Journal of Public Health*, and *Community Psychology*, to name a few.

A third means of dissemination would be presenting at regional and nationally sponsored conferences. Having presented at such conferences in the past, I am well aware of the value of this platform. Sponsors screen such presentations, selecting only those that have something unique and cutting edge to offer. I am confident that the results of my action research project would meet that standard.

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Appendix A

Survey Questionnaire

Dear social work colleague,

I am conducting a research project designed to understand local members' knowledge about south Whidbey's emergency mental health trauma (EMHT) service in the event of a natural or man-made disaster. For the purposes of this research project, south Whidbey encompasses the geographic areas from Clinton to Coupeville.

Would you be willing to participate? Please circle one: I *would* or *would not* be interested in participating in William Getz's research project.

Section 1

1. Is your south Whidbey residence your primary residence? *Yes* or *No* (circle one)

2. If *yes,* how long have you been a resident of south Whidbey?

   _____

3. If *no,* what proportion of time would you estimate that you spend at your south Whidbey residence, year-round? _____%

4. When did you receive your M.S.W.? _____

   a) Are you licensed? _____

5. What is your professional focus? _____

6. Are you employed full-time, part-time, or retired? (circle one)

7. If employed, are you self-employed or employed by an agency? (circle one)

8. If you are agency-employed, is it a nonprofit, for-profit, or governmental agency?

   (circle one)

9. What percentage of your work time would you estimate is on the island?

   _____%

Section 2

10. How much do you know about an EMHT service for south Whidbey?

11. Have you been involved in any aspect of an EMHT service for south Whidbey? *Yes* or *No* (circle one)

    A) If *yes*, please explain.

    B) If *no*, please explain.

12. What do you believe is the role that resident social workers could play in an EMHT service for south Whidbey?

13. What do you know of south Whidbey's Community Emergency Response Team (CERT)?

14. What do you know of resident social workers' participation in the (CERT) program?

15. How familiar are you with the World Health Organization / American Red Cross Psychological first-aid (PFA) model as an intervention with disaster survivors?

Section 3

Please identify the best method of contacting you to make a telephone interview appointment:
Email: _____
Telephone number: _____
Other: _____

Appendix B

Telephone Interview Protocol

These follow-up questions were asked in interviews following the return of the paper-based questionnaire. They were designed to provide additional data that may not have been provided by respondents in the questionnaire. These, like the research questions in Appendix A, were intended to secure information aligned with the definition of collaboration as a successful problem-solving process that addresses a specific need through mutually beneficial cooperation. In addition to this theoretical alignment, Questions 1 and 2 were based on sections of the NASW Code of Ethics (2008), having to do with social workers' responsibilities to the greater community.

Before the interview, I extended a thank-you for agreeing to participate. I also thanked the participant for giving me the opportunity to ask additional questions beyond the questionnaire. Finally, I asked respondents to feel free to ask me any question before, during, or after the interview.

As a 13-year resident on south Whidbey, I was able to project a level of comfort about the community, island culture, and the need for service. I conducted this interview process in way that was as unstilted and free-flowing as possible, while also retaining a professional attitude consistent with my role as researcher. I allotted up to 30 minutes for each interview.

1. Before you moved to south Whidbey:
    a) Tell me about your involvement in "public participation" in your community. (The following operational definitions will be provided as needed: For the purpose of this study, *public participation* is defined as assisting community members to engage in informed participation to improve social policies and institutions.)

    b) Tell me about your involvement in "public emergencies" in your community. (*Public emergencies* is defined as a natural or man-made disaster.)

    c) Tell me about your involvement in "social and political action" in your community. (*Social and political action* is defined as engagement in activities designed to improve the welfare of vulnerable populations.)

2. Since moving to south Whidbey:
    a) Tell me about any involvement you may have had in "public participation" in south Whidbey. (*Public participation* is defined as assisting community members to engage in informed participation to improve social policies and institutions.)

b) Tell me about any involvement you may have had in "public emergencies" in south Whidbey. (*Public emergencies* is defined as a natural or man-made disaster.)

c) Tell me about any involvement you may have had in "social and political action" in south Whidbey. (*Social and political action* is defined as engaging in activities designed to improve the welfare of vulnerable populations.)

3. Tell me what you may know about any professional social work presence in south Whidbey.

4. As mentioned in my introductory letter, there are 21 social workers with a listed residence in south Whidbey. Were you aware or unaware of this? In either case, please tell me more.

5. Overall what are your thoughts and feelings about my research project?

6. Are there any additional comments you would like to make before we end the interview?

Appendix C

Introductory Letter to South Whidbey MSW Social Workers

Dear colleague,

My name is William Getz, and I have been a resident in south Whidbey since 2003. I am an M.S.W. graduate (University of Washington, 1966) and currently a doctoral student in Social Work (D.S.W.) at Walden University (Minnesota). According to the Washington Chapter of N.A.S.W., you are one of 21 members with a listed address in south Whidbey Island.

I am conducting a research project designed to understand local social workers' knowledge about south Whidbey's emergency mental health trauma (EMHT) service in the event of a disaster. For the purposes of this research project, south Whidbey encompasses the geographic areas from Clinton to Coupeville.

If you would be willing to participate in this study, which includes filling out the attached questionnaire and consenting to a telephone interview, I would very much appreciate your return of the enclosed documents: a completed questionnaire and a signed *consent to participate* form, as required by the Institutional Review Board (IRB) at Walden University. These documents can be returned via the enclosed self-addressed envelope.

If you would like to learn more before committing, please contact me at my Walden University email account **william.getz@waldenu.edu,** or, if you prefer, through my confidential toll-free number 1-888-556-6272 or by post using the enclosed self-addressed return envelope.

If you are not interested in participating, I would be grateful if you would return the unanswered survey using the self-addressed envelope stating you do not wish to participate.

Thank you so much for your consideration.

Respectfully,

William Getz, MSW, LCSW

Committee Chair:

Pablo Arriaza, PhD, MSW, LICSW
Core Faculty Professor of Social Work
College of Social and Behavioral Sciences
Social Work Programs
Walden University
pablo.arriaza@waldenu.edu

Appendix D

Reflexivity Journal Format

The following format structured journal entries I wrote whenever I detected the possibility of personal bias entering the data entry, analysis, or conclusions process. These reflexivity entries included the date, the setting, the notation context, process notes, conclusions, and any additional relevant information.

Activity

What was the activity I was reviewing, recording, entering, or analyzing that caught my attention, indicating the possibility for bias? What was there about the activity that caused my associations to wander away from the task that was before me? Was it curiosity related or unrelated to the data? Or was it bias related to my agenda rather than that of the stakeholders?

Self-reflexivity

Openness to my unconscious process, as expressed in free-flowing associations, was an important element of this reflective process. This approach was similar to Freud's self-analysis and his use of free associations to determine the root cause(s) of his own biases (Freud, 1916/1966). Counter-transference (Racker, 1982) and projective identification (Klein, 1946/1975) are psychoanalytic constructs intended to detect and address personal bias arising from the psychotherapeutic hour. Theoretically, these concepts are also applicable to the data entry, analysis, and conclusion processes of my project. Therefore, I included them as part of my reflexivity journal.

Action

I relied on my committee chair for additional feedback. He was familiar with my thinking as a doctoral student and with my capstone project. Stringer (2014) advocates additional strategies such as triangulation and member checking, which were key elements in bias containment. Both strategies were incorporated throughout the project and noted in my reflexivity journal.

Appendix E

Summary Information Provided Upon Request

My name is William Getz. I am a University of Washington trained MSW and currently a doctoral student in social work (DSW) at Walden University. I have been a resident on south Whidbey since 2003. I am conducting a research project intended to understand local social workers' knowledge about south Whidbey's emergency mental health trauma (EMHT) service. Public records indicate that south Whidbey is without any such service in the event of a natural or man-made disaster. Since we are situated on a significant earthquake fault, this apparent lack of service leaves Whidbey Island trauma survivors vulnerable to PTSD-like symptoms. My Capstone research project is designed to engage the social work community as potential change agents to address this need. To accomplish this I must find out who are the social workers living here, their knowledge about this apparent unmet need, and their interest to participate. All information generated by this project would maintain respondents' confidentiality, meeting Walden University's Institutional Review Board (IRB) standards for human subject's research. I have secured your name and address from the Washington State Chapter of NASW, of which I am also a member.

Respectfully,

William Getz
Walden University
Whidbey Island, WA

Appendix F

Descriptive Coding Template

STAKEHOLDER:

SOUTH WHIDBEY RESIDENT:

LENGTH OF RESIDENCY:

MSW DATE:

LICENSED:

PROFESSIONAL FOCUS:

EMPLOYMENT:

SELF OR AGENCY EMPLOYED:

AGENCY TYPE:

ISLAND WORK TIME:

SOUTH WHIDBEY EMHT SERVICE KNOWLEDGE:

SOUTH WHIDBEY EMHT SERVICE PARTICIPATION:

SOUTH WHIDBEY EMHT SERVICE ROLE:

COMMUNITY EMERGENCY RESPONSE TEAM (CERT) KNOWLEDGE:

COMMUNITY EMERGENCY RESPONSE TEAM (CERT) PARTICIPANTS:

PSYCHOLOGICAL FIRST-AID (PFA) KNOWLEDGE:

Appendix G

Topic and Numerical Template

1. Residence:

2. Professional Identity:

3. Professional Focus:

    Direct service (3a):

    Administration (3b):

    CO (3c):

4. Employment:

    Retired (4a):

    Not retired (4b):

5. EMHT Knowledge:

    Yes (5a):

    No (5b):

6. CERT Knowledge:

    Yes (6a):

    No (6b):

7. PFA Knowledge:

    Yes (7a):

    No (7b):

8. CO Activity before Whidbey:

    Yes (8a):

No (8b):

Public participation (8c):

Public emergencies (8d):

Social and political action (8e):

9. CO Activity since Whidbey:

Yes (9a):

No (9b):

Public participation (9c):

Public emergencies (9d):

Social and political action (9e):

10. Knowledge about 21 south Whidbey Social Workers:

Yes (10a):

No (10b):

11. Awareness of a social work presence:

Yes (11a):

No (11b):

12. Project feedback:

Appendix H

Descriptive Coding Data

Stakeholder 1

SOUTH WHIDBEY RESIDENCE: Yes

LENGTH OF RESIDENCY: 1.5 years

MSW DATE: 2013

LICENSED: Yes

PROFESSIONAL FOCUS: Infant Mental Health

EMPLOYMENT: Part time

SELF OR AGENCY EMPLOYED: Agency

AGENCY TYPE: Governmental

ISLAND WORK TIME: 100%

SOUTH WHIDBEY EMHT SERVICE KNOWLEDGE: None

SOUTH WHIDBEY EMHT SERVICE PARTICIPATION: No

SOUTH WHIDBEY EMHT SERVICE ROLE: Don't know

COMMUNITY EMERGENCY RESPONSE TEAM (CERT) KNOWLEDGE: Not a bit

COMMUNITY EMERGENCY RESPONSE TEAM (CERT) PARTICIPANTS: My boss?

PSYCHOLOGICAL FIRST-AID (PFA) KNOWLEDGE: Not very

Stakeholder 2

SOUTH WHIDBEY RESIDENCE: Yes

LENGTH OF RESIDENCY: 5 years

MSW DATE: 1966 (Berkley)

LICENSED: Yes

PROFESSIONAL FOCUS: Individual and couple therapy; Mediation

EMPLOYMENT: Retired

SELF OR AGENCY EMPLOYED: N/A

AGENCY TYPE: N/A

ISLAND WORK TIME: N/A

SOUTH WHIDBEY EMHT SERVICE KNOWLEDGE: Not much

SOUTH WHIDBEY EMHT SERVICE PARTICIPATION: Up until now low interest

SOUTH WHIDBEY EMHT SERVICE ROLE: Situational help in crisis

COMMUNITY EMERGENCY RESPONSE TEAM (CERT) KNOWLEDGE: Very little

COMMUNITY EMERGENCY RESPONSE TEAM (CERT) PARTICIPANTS: Very little

PSYCHOLOGICAL FIRST-AID (PFA) KNOWLEDGE:

Stakeholder 3

SOUTH WHIDBEY RESIDENCE: Yes

LENGTH OF RESIDENCY: 1.5 years

MSW DATE: 1979

LICENSED: Yes

PROFESSIONAL FOCUS: Geriatrics

EMPLOYMENT: Part time

SELF OR AGENCY EMPLOYED: Self

AGENCY TYPE: N/A

ISLAND WORK TIME: 0%

SOUTH WHIDBERY EMHT SERVICE KNOWLEDGE: Some sort of clinic?

SOUTH WHIDBEY EMHT SERVICE PARTICIPATION: No

SOUTH WHIDBEY EMHT SERVICE ROLE: Moral and ethical obligation

COMMUNITY EMERGENCY RESPONSE TEAM (CERT) KNOWLEDGE: Nothing

COMMUNITY EMERGENCY RESPONSE TEAM (CERT) PARTICIPANTS: None

PSYCHOLOGICAL FIRST-AID (PFA) KNOWLEDGE: Very little

Stakeholder 4

SOUTH WHIDBEY RESIDENCE: Yes

LENGTH OF RESIDENCY: 23 years

MSW DATE: 1968

LICENSED: Yes

PROFESSIONAL FOCUS: Individual therapy

EMPLOYMENT: Retired

SELF OR AGENCY EMPLOYED: N/A

AGENCY TYPE: N/A

ISLAND WORK TIME: Retired N/A

SOUTH WHIDBEY EMHT SERVICE KNOWLEDGE: None

SOUTH WHIDBEY EMHT SERVICE PARTICIPATION: No

SOUTH WHIDBEY EMHT SERVICE ROLE: Planning and help when needed

COMMUNITY EMERGENCY RESPONSE (CERT) KNOWLEDGE: Not aware of it

COMMUNITY EMERGENCY RESPONSE (CERT) PARTICIPANTS: Nobody

PSYCHOLOGICAL FIRST-AID (PFA) KNOWLEDGE: World Health Organization (WHO) familiar

Stakeholder 5

SOUTH WHIDBEY RESIDENCE: Yes

LENGTH OF RESIDENCY: 10 years

MSW DATE: 1979

LICENSED: Yes

PROFESSIONAL FOCUS: Divorce, parenting, couples, depression, anxiety

EMPLOYMENT: Full time

SELF OR AGENCY EMPLOYED: Self

AGENCY TYPE: N/A

ISLAND WORK TIME: 0%

SOUTH WHIDBEY EMHT SERVICE KNOWLEDGE: A bit

SOUTH WHIDBEY EMHT SERVICE PARTICIPATION: Yes (Whidbey CareNet)

SOUTH WHIDBEY EMHT SERVICE ROLE: Volunteer

COMMUNITY EMERGENCY RESPONSE TEAM (CERT) KNOWLEDGE: Zero

COMMUNITY EMERGENCY RESPONSE TEAM (CERT) PARTICIPANTS: Zero

PSYCHOLOGICAL FIRST-AID (PFA) KNOWLEDGE: Could learn more

Stakeholder 6

SOUTH WHIDBEY RESIDENCE: Yes

LENGTH OF RESIDENCY: 12 years

MSW DATE: 1979

LICENSED: Yes

PROFESSIONAL FOCUS: Families

EMPLOYMENT: Retired

SELF OR AGENCY: N/A

AGENCY TYPE: N/A

ISLAND WORK TIME (VOLUNTEER): 100%

SOUTH WHIDBEY EMHT SERVICE KNOWLEDGE: Nothing

SOUTH WHIDBEY EMHT SERVICE PARTICIPATION: No

SOUTH WHIDBEY EMHT SERVICE ROLE: Service for our community

COMMUNITY EMERGENCY RESPONSE TEAM (CERT) KNOWLEDGE: Zip

COMMUNITY EMERGENCY RESPONSE TEAM (CERT) PARTICIPANTS: Zero

PSYCHOLOGICAL FIRST-AID (PFA) KNOWLEDGE: Not at all

Stakeholder 7

SOUTH WHIDBEY RESIDENCE: Yes

LENGTH OF RESIDENCY: 33 years

MSW DATE: 1968

LICENSED: No

PROFESSIONAL FOCUS: None at this time

EMPLOYMENT: Retired

SELF OR AGENCY EMPLOYED: N/A

AGENCY TYPE: N/A

ISLAND WORK TIME: N/A

SOUTH WHIDBEY EMHT SERVICE KNOWLEDGE: Nothing

SOUTH WHIDBEY EMHT SERVICE PARTICIPATION: No

SOUTH WHIDBEY SERVICE ROLE: No idea

COMMUNITY EMERGENCY RESPONSE TEAM (CERT) KNOWLEDGE: Nothing

COMMUNITY EMEREGENCY RESPONSE TEAM (CERT) PARTICIPANTS:

Nothing

PSYCHOLOGICAL FIRST-AID (PFA) KNOWLEDGE: Not familiar

Stakeholder 8

SOUTH WHIDBEY RESIDENCE: Not full time any longer

LENGTH OF RESIDENCY: Several years before recently moving off island

MSW DATE: 2015

LICENSED: Not yet

PROFESSIONAL FOCUS: Substance abuse

EMPLOYMENT: Full time

SELF OR AGENCY EMPLOYED: Agency

AGENCY TYPE: Governmental

ISLAND WORK TIME: 0%

SOUTH WHIDBEY EMHT SERVICE KNOWLEDEGE: Not a thing

SOUTH WHIDBEY EMHT SERVICE PREPERATION: No

SOUTH WHIDBEY EMHT SERVICE ROLE: Psychiatric first aid and trauma service

COMMUNITY EMERGENCY RESPONSE TEAM (CERT) KNOWLEDGE: Not a thing

COMMUNITY EMERGENCY RESPONSE TEAM (CERT) PARTICIPANTS: No one

PSYCHOLOGICAL FIRST-AID (PFA) KNOWLEDGE: Very little, name only

Appendix I

Topic Analysis Data

Topic 2: Professional Identity

Earlier I described criteria I used to code for professional identity. For the purposes of this study, I have included any comment or activity that reflected the stakeholder's adherence to the profession's code of ethics (NASW, 2008). Stakeholder 2 stated, "I was drawn to community organization with a great deal of empathy for the neighborhoods that were being torn apart . . . I was right in the thick of it." Speaking on behalf of previous client work, Stakeholder 3 said, "I have run the gamut of doing what the old style social workers were known for . . . . You name it, I have done it." Stakeholder 5 stated, "In the past I have been on several boards. The most important one was the Washington State Coalition of Mental Health Professionals and consumers . . . . I was on that board for 8 to 10 years." Stakeholder 6 stated, "Before I moved to Whidbey, I was employed by the city of Seattle to undo racism through early childhood development education programs . . . . I worked at that for over 6 years." Stakeholder 7 addressed professional identity by commenting that "my first love was always clinical." Finally, Stakeholder 8 mentioned their first field placement "at the VA . . . where I just kept my head down and focused on what I was there for." All stakeholders spoke with authenticity about their professional identity examples.

Topic 3: Professional Focus

This topic included possible specializations in direct service, administration, research, and community organization. Stakeholder 2 identified their first social work

job: “After I graduated my career really took off. I took a job as more or less an administrator,” which remained a professional focus for the next 25 years or so. Stakeholder 3 had been a career-long private practitioner: “Couldn’t do all these crazy out of the box things working for an agency.” Stakeholder 5’s heavy private practice load was evident from the fact of having to squeeze in our telephone interview between an ongoing family medical emergency and a full schedule of appointments, saying, “again, another spur of the moment thing . . . I’m free until 8:30 this morning”; and, on another day, “I just had a cancellation so I am free now.” Stakeholder 6 stated, “I was instrumental . . . in founding a free of charge service . . . that . . . had served 33 families and 65 or 68 children.” Stakeholder 7 described their first job after graduation at “a psychiatric clinic in New York,” which continued for nearly 15 years. Stakeholder 8 described a quantitative background, “where you study something, try and get it published, and if you get it published you hope someone will read it.” Despite their nonclinical background, Stakeholder 8 was emphatic about becoming involved in an EMHT solution.

Topic 5: EMHT Knowledge

Stakeholder 2 remarked, “I don’t really know much about anything like that [EMHT] here.” Stakeholder 3 stated, “I have zero information about any mental health services in case of an emergency on Whidbey.” Stakeholder 5 acknowledged having “a bit” of EMHT knowledge, but it was related to a specific nonprofit organization offering meditative services for first responders rather than a direct service for disaster survivors. Due to pressure to keep the interview brief, I did not ask further about Stakeholder 6’s

EMHT knowledge, which had already been addressed in the returned questionnaire, where Stakeholder 6 stated, “Nothing.” Similarly, Stakeholder 7 indicated knowing “nothing” about an EMHT service on south Whidbey but did mention a social worker on another part of the island who had “some kind of involvement with helping people in crisis,” but could not remember their name. Stakeholder 8’s questionnaire reply was the same as Stakeholder 6’s: Stakeholder 8 knew “nothing” about an EMHT service, admitting “I know we live on an earthquake fault that I think is a pretty big one.”

Topic 6: CERT Knowledge

Stakeholders’ lack of knowledge about emergency mental health services repeated in the question about CERT. Stakeholder 2 replied, “None” on the questionnaire and “I don’t really know much about anything like that” in the telephone interview. Stakeholder 3 replied, “Not familiar” on the questionnaire and in the interview mentioned it once with the catch-all response, “I have zero information about any mental health services in case of an emergency on Whidbey.” Stakeholder 5 answered, “Nothing” on the questionnaire and did not mention it during the telephone interview. Likewise, Stakeholder 6 said, “Nothing” on the questionnaire but in the interview followed up with, “Until I read your questionnaire I really did not know what was available.” Stakeholder 7 stated in their questionnaire that they knew nothing about CERT and in the interview followed up with reference to a social worker who “helps people in crisis.” Stakeholder 8 stated on their questionnaire that they knew “not a thing” about CERT but commented in the interview, “I have really thought about what might happen if something did happen.”

Topic 7: PFA Knowledge

Only Stakeholder 4 was able to admit to some familiarity with the term, having worked for the Red Cross early in their career, "serving as a crisis counselor." None of the other stakeholders were even familiar with the concept, much less knowledgeable about its value for disaster survivors. As reported earlier, seven of eight stakeholder responses were similar: "None," "Name only," "Zero," "Not at all," "Not familiar," "Name only," and "Not very."

Topic 8: Community Organization Activity Prior to Whidbey

All but one stakeholder reported some degree of CO activity in their past. Stakeholder 2 reported "being out in the community . . . working out of a neighborhood church" during the mid-sixties in the midst of widespread campus activism. Stakeholder 3 reported a 20-year career of advocating for seniors, with "almost all of my time out in the field . . . being an advocate." Stakeholder 5 reported a long-term and consistent presence in the community through temple activity about "issues of discrimination." Similar to Stakeholder 5, Stakeholder 6 described temple activity as community-based, "and in 1978 [Stakeholder 6] helped organize an African American/Jewish coalition for Justice Committee." Stakeholder 7 reported being "very much into the anti-war movement back in Philadelphia." Stakeholder 8 identified as "more a talker than a doer" and, therefore, having done "very little public participation other than my vocal activities as a graduate student."

Topic 9: Community Organization Since Relocating to Whidbey

CO activity since becoming an island resident had been greatly reduced for many stakeholders, especially those who declared themselves retired. This group's activities have been limited to volunteer functions and church and temple participation. Stakeholder 2 reported "being pretty much retired." Stakeholder 3 commented, "So, in answer to the question I would have to say nothing." Stakeholder 5 remarked, "Other than Whidbey CareNet I have had no involvement in any community organization activities . . . though I have always been active through my temple." Stakeholder 6 stated, "I am retired now," but reported some volunteer work as a clinician with drug and alcohol abuse issues. Stakeholder 7, also retired "for a long time now," reported continued volunteer work through their church. Stakeholder 8 replied, "My partner has been involved in our local town's efforts to incorporate, but I don't think that qualifies."

Topics 10 and 11: Knowledge About 21 Social Workers and Awareness of Social Work Presence

Stakeholders were consistent in their reactions to these two questions. Stakeholder 2 stated, "That seems like a lot [of social workers]," and "I don't really know anything about [a social work presence]." Stakeholder 3 remarked, "wow"; "way more than I would have thought." Stakeholder 5 reported knowing nothing of a social work presence on the island by saying, "None that I know of." (The telephone interview was interrupted at this point before Stakeholder 5 was able to provide any information about 21 island social workers.) Stakeholder 6 stated, "I can't think of anything that says to me there are a group of social workers meeting or having read anything in the newspaper"; "21 social

workers? I didn't know there were that many on the island." Stakeholder 7 reported knowing of a social worker "up on the island . . . but can't remember her name," and "[I] didn't know anything about them [the 21 social workers]." Stakeholder 8 said, "I did not know there were that many," and, regarding a social work presence, "I tried job networking my last year of school . . . and met a couple of social workers . . . , but . . . nothing turned up for me."

Topic 12: Project Feedback

Stakeholder comments across the board were positive about the project's purpose. Furthermore, all stakeholders expressed a wish to be kept in the loop about an EMHT solution once this research project was completed. Stakeholder 2 stated, "I would like to learn more . . . but I caution you . . . I'm pretty rusty clinically." Stakeholder 3 was more emphatic: "You obviously see the necessity of looking at what we as professional social workers can and should do. I see it as our moral and ethical responsibilities . . . and I do want to be part of that action." Although limited by a family illness, Stakeholder 5's interview gave every indication that, time permitting, they could be included as a solution-based participant. Stakeholder 6 was somewhat vague regarding a participatory commitment but clearly understood the need: "It is important we have as much knowledge about crisis services as we can . . . . Your project should help improve our knowledge about the need . . . so I thank you." Stakeholder 7 stated, "I like the idea of social workers coming together for an emergency counseling service." Stakeholder 8 was unequivocal: "I think it is great. I have really thought about what might happen if

something [like an earthquake] happened . . . . So when I got your questionnaire I was really excited."

It is important to note that during the course of the interviews I noted an upturn in the stakeholders' affect when I asked about the project's impact. Some responses, such as those of Stakeholders 2 and 6, were tempered. Others, such as Stakeholders 3, 4, 7, and 8, were far more animated, and their enthusiasm was palpable over the telephone. I felt that the project had inspired them, and they were ready to take action immediately. It should also be remembered that Stakeholders 4 and 7 were both retired, yet they were as motivated as Stakeholders 3 and 8, who were still active in the profession.

Appendix J

Questionnaire Demographic Summary

Section 1

1. Is your south Whidbey residence your primary residence? *Yes* or *No* (circle one)

   Yes: 8

   No: 0

2. If yes*,* how long have you been a resident of south Whidbey?

   6 answered: 18 months, 5 years, 10 years, 12 years, 23 years, 33 years

   2 did not answer

3. If *no,* what proportion of time would you estimate that you spend at your south Whidbey residence, year-round? _____NA_____%

4. When did you receive your M.S.W.?

   7 answered: 1966, 1968, 1968, 1979, 1979, 1979, 2015

   1 did not answer

   a) Are you licensed?

      5 answered yes

      1 answered no

      1 answered "Not yet"

      1 did not answer

5. What is your professional focus?

   7 answered with some form of direct service, including individual, couple, family, substance abuse, parenting, divorce, depression, and geriatrics.

   1 answered administration

6. Are you employed full-time, part-time, or retired?

   2 answered full time

1 answered part time

5 answered retired

7. If employed, are you self-employed or employed by an agency?

3 answered self-employed

1 answered agency-employed

4 gave no answer

8. If you are agency employed, is it a nonprofit, for-profit, or governmental agency?

0 answered

9. What percent of your work time would you estimate is on the island?

8 answered 0%

Appendix K

Telephone Interview Responses Summary

1. Residence: 12

2. Professional identity: 112

3. Professional focus:

    Direct service (3a): 16

    Administration (3b): 24

    CO (3c): 1

    Research (3d): 2

4. Employment:

    Retired (4a): 6

    Not retired (4b): 9

5. EMHT Knowledge:

    Yes (5a):

    No (5b): 8

6. CERT Knowledge:

    Yes (6a):

    No (6b): 7

7. PFA Knowledge:

    Yes (7a): 1

    No (7b): 8

8. CO activity before Whidbey:

Yes (8a): 14

No (8b): 6

Public participation (8c): 11

Public emergencies (8d): 8

Social and political action (8e): 8

9. CO activity since Whidbey:

Yes (9a): 7

No (9b): 17

Public participation (9c): 9

Public emergencies (9d): 2

Social and political action (9e): 6

10. Knowledge about 21 south Whidbey social workers:

Yes (10a):

No (10b): 19

11. Awareness of a social work presence:

Yes (11a):

No (11b): 9

12. Project feedback: 30