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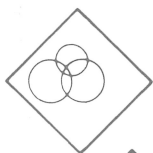
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Impact of Social Capital on Employment and Marriage among Low Income Single Mothers

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The 1996 Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, P. L. 104–93) called primarily on women to achieve two goals: work and/or marriage. For low income single mothers with limited access to capital, the PRWORA presents a quagmire in that the public safety nets previously guaranteed by the policies of the New Deal were abruptly supplanted by policies with obligations that require various forms of capital. Using longitudinal data from the Fragile Families and Child Wellbeing dataset, we examine the impact of social capital on the chances of marriage and employment among single, unemployed mothers. We find that social capital increases a woman's chances of both marriage and stable employment, but the social capital must be expansive in order to challenge significant social disadvantage. We conclude with a discussion of the importance of social capital as a precursor to upward social mobility for low-income mothers as opposed to simply getting 'off of welfare.'

Key words: PRWORA, single mothers, unemployed mothers, social capital, marriage, employment, welfare leavers

The passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, P. L. 104–93) was a response to the notion that we were a ‘nation in crisis’ (Hays, 2003), evidenced by declining marriage rates, a perceived erosion of the traditional work ethic, and high levels of cyclical welfare dependency amongst single mothers (Mead, 1997; Murray, 1984; Putnam, 2000). The PRA legislated goals that would oblige the poor to reverse these trends through the practice of ‘personal responsibility’ by replacing Aid to Families with Dependent Children (AFDC) with Temporary Assistance for Needy Families (TANF). The TANF program emphasizes the goals of work and marriage as avenues off of welfare and supposedly out of poverty.

These political concerns, both liberal and conservative alike, were influenced by the functionalist assumptions of Coleman (1988) and Putnam (2000), who argue social capital, defined as networks, norms and trust, is in decline in the American society. Putnam points to declines in civic participation and Coleman to the changing structure of the American family, i.e., the increase in the numbers of single parent households, as evidence of this decline. Both argue these changes have led to a reduction in the trust, norms and values that constitute a civil society. Furstenberg (2005), in his theory of ‘social capital lost’ argues that this decline is a result of state policies which create a climate of dependence in which individuals will ‘lose their spontaneous ability to work for the greater good of society.’ Therefore, as Fukuyama (2000) argues, the state must change policies to set limitations and obligations that will force individuals to comply with the social contract of bearing children within a marriage and working outside of the home to support their families.

For low-income single mothers with limited access to capital, the PRWORA presents a quagmire in that the public safety nets previously guaranteed by the policies of the New Deal were abruptly supplanted by policies with obligations requiring various forms of capital. Finding and keeping work requires access to networks of information and support (Ciabattari, 2007; Schneider, 2006; Voydanoff, 2005; Woolcock, 1998). Stable marriages are best achieved through access to networks of care and trust (Carbonaro, 1998; Lareau, 2003). These

networks represent what researchers describe as social capital, a term that attempts to explain how some people gain more success in a particular setting based on the nature and qualities of their connections to others. Social capital can provide both social leveraging, allowing individuals to 'get ahead' or social support, allowing individuals to 'get by' or stay afloat (Briggs, 1998; Putnam, 2000). The literature provides evidence of the rich source of social support-type capital traditionally found among low-income single mothers, particularly among women of color (Edin & Kefalas, 2004; Stack, 1974) is becoming more scarce and difficult to maintain in the face of stagnating or eroding economic capital (Ciabattari, 2007; Domínguez & Watkins, 2003; Nelson, 2000). Considering their current social capital reserves, are low-income women in a solid position to successfully navigate the new PRWORA requirements by achieving work and/or marriage?

Using longitudinal data from the Fragile Families and Child Wellbeing Survey, we conduct empirical analyses of the relationship between social capital, defined here in terms of social support (Ciabattari, 2007) and measures of success as prescribed by the PRWORA—work and marriage. Using Wellman and Wortley's (1990) dimensional framework outlining the dimensions of social support found in networks, we constructed two social capital scales—a 4-item and a 9-item scale—to measure the level of social support availability. We hypothesize social capital facilitates marriage such that single women with higher levels of social capital will have a greater chance of getting married. We also hypothesize that this relationship will hold true for work, as well; low-income single women with high levels of social capital will have a greater chance of maintaining stable employment. Our results show that in order for social capital to enhance a low-income woman's chance of PRWORA success, she must have deep reserves of social capital; a shallow pool of social support does not help.

First introduced by Bourdieu (1986), and elaborated on by Coleman (1988), Putnam (2000), Lin (2001) and Fukuyama (2000), social capital is a term used to make assumptions regarding the role of social networks and connectivity. Bourdieu (1986) defines social capital as "the aggregate of the actual or

potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance or recognition" (p. 248). Social connections—who we know and who they know—have value to both the individual and to the community at large. According to Coleman (1988), social capital facilitates certain actions and makes possible certain achievements that in the absence of social capital would not be possible. Family, friends, and neighbors provide access to information such as what businesses are hiring workers, what free daycare programs have openings, and which agencies are providing the best training and job placement services. As Putnam (2000) notes, social capital resides in the network structure, but is activated by the individual; in the process, both the individual and the collective benefit through personal gain and positive externalities. The people in an individual's network provide connections to other networks. Information is passed through networks, and when reciprocation is understood, networks grow exponentially. Ideally, through this growth, social trust and mutual obligation deepen, norms are strengthened, and values are more widely shared, all of which sustains stronger communities and healthier individuals (Putnam, 2000).

At the individual level, social capital produces two different types of positive externalities—social support and social leverages, or what Putnam (2000) calls 'bonding' and 'bridging' respectively. Social support, or 'bonding' social capital, is good for building solidarity and facilitating reciprocity; it bonds people together by providing mutual access to social, economic and cultural resources. Bonding social capital helps people cope with the demands and stressors of everyday life by providing emotional support, rides to work, babysitting, monetary loans, etc. (Domínguez & Watkins, 2003). As Briggs (1998) describes, bonding social capital allows people to 'get by' and manage their daily lives. Social leverage, or 'bridging' social capital, on the other hand, helps people 'get ahead' by providing a more diverse array of social contacts outside one's inner circle, thus providing access to more information and diverse resources (Briggs, 1998). While bonding social capital brings together people of similar social locations, bridging social capital provides access to different kinds of people,

which in turn provide access to different kinds of information and resources.

Research has consistently documented a deep pool of bonding social capital among low-income women, especially among ethnic minority populations (Edin & Keflas, 2005; Hogan, Hao, & Parish, 1990; Scott, Hurst, & London, 2003; Stack, 1974) and a relatively shallow pool of bridging social capital (Schneider, 2006; Smith, 2005). Low-income women have historically looked to each other, kin and other close neighbors for critical social support as they navigate economic insecurity. Low-income women have exchanged babysitting services, small loans, temporary housing and other forms of emotional and social support, all of which are regulated by norms of reciprocity (Nelson, 2000). However, research also documents how this rich pool, while enabling daily survival, can become insular, restricting and draining (Domínguez & Watkins, 2003; Nelson, 2000; Wilson, 1996). For example, Briggs (1998) found that women who relied on neighbors for information regarding employment earned less than those who sought information outside their immediate network. Furthermore, research shows that the norms of reciprocity critical to the governing and maintenance of bonding social capital are beginning to fray under the stress of increasingly insecure and hostile economic conditions (Domínguez & Watkins, 2003; Menjivar, 2000; Roschelle, 1997). Low-income women are having a difficult time reliably paying back social support efforts, thus threatening the mutual benefits of participating in the network. In sum, while low-income women generally have access to a pool of social capital which enables them to get by, it comes at a cost to upward mobility and is itself becoming an unreliable resource.

This erosion in reliable social support among low-income women is particularly troubling considering the self-reproducing nature of social capital. Social capital begets more social capital; the more it is used, the stronger and richer it becomes (Bourdieu, 1986). Like financial capital, social capital expands with use but disappears without continuing investment (Burt, 1997). The 'use-value' of social capital therefore depends on prior access and continuing development of social capital. Social capital also provides access to other forms of capital

such as cultural capital (knowing the appropriate cultural and behavioral cues in a particular setting), institutionalized capital (merits, certificates or degrees), or sheer economic capital (Bourdieu, 1986). In other words, not only does it take social capital to make social capital, but it takes social capital to make other forms of capital.

Social capital therefore represents the opportunity an individual has to realize goals, i.e., work and marriage. The more the individual exercises his or her social capital, the more effective, stable and useful it becomes. Thus, the loss or diminishment of social support networks so vital to low-income women not only threatens their social capital reserve, it impacts their ability to acquire other forms of capital as well, including economic and cultural capital. How, then, do social support networks, as the most available form of social capital to low-income women, impact their achievement of goals set forth by the PRWORA—work and marriage?

Beginning with the landmark article by Granovetter (1973), research has consistently shown social capital to be a pivotal resource in acquiring employment and expanding economic capital. Low-income women rely heavily on mutual networks of social support to achieve and maintain employment (Edin & Lein, 1997; Garfinkle & McLanahan, 1986; Stoloff, Glanville & Bienenstock, 1999). For example, Scott, Hurst and London (2003) found that low-income women make heavy use of informal networks of care to meet the work requirements of the PRWORA. The networks varied in quality; some informal systems were flexible and preferable, while others were very erratic and often times dangerous. However, all were less reliable than formal, institutionalized systems of child care, thus leaving women vulnerable to job loss. Ciabattari (2007) finds that stable social support networks reduce work–family conflict and enhance low-income women’s ability to maintain stable employment. Women with strong networks providing financial, emotional and logistical support are less likely to drop out of the labor force (Blalock, Tiller, & Monroe, 2004; Jarvis, 1999; Voydanoff, 2005). Finally, as Bourdieu (1986) points out, social capital is self-reproducing, such that once individuals land jobs using their current reserves of social capital, they now have extended access to a wider array of social

connections that offer the potential to advance employment success and acquire other forms of capital, including both economic and cultural capital (Lin, 2001; McDonald & Elder, 2006).

However, like Briggs (2000), Schneider (2006) finds that tight social networks most characteristic of the social capital available to low-income women can exert negative pressures on employment as well. Low-income workers with a narrow set of strong ties were less likely to find a job than those who had a broad range of ties to individuals and institutions such as churches, schools, and agencies. This fits with Granovetter's (1973) 'strength of weak ties' argument that weak ties connect people across networks and increase an individual's chances of finding out about a job opportunity, whereas strong ties facilitate closeness but limited diversity in information flow. Access to networks of information provides leads to jobs and job training (Baron, 2000; Henly, Danziger, & Offer, 2005; London, Scott, Edin, & Hunter, 2004). For example, Smith (2005) found that the strength of one's referral network plays a role in job seeking success and that these referral networks were limited or circumscribed among the urban poor. Not only are the urban poor less likely to be connected to individuals or institutions that offer job opportunities, individuals guarded the limited referral opportunities they did possess and were reluctant to provide a referral for fear that the person being referred would not be reliable and would harm the reputation of the individual who provided the referral (Smith, 2005). Therefore, job seekers have more success in obtaining paid employment when they are attached to networks with reliable reputations (Smith, 2005).

While not as extensively investigated as work, research does show that social capital plays a role in an individual's chances of getting married as well as staying married. Lareau (2003) found that the stable marriages require an extensive external support network that provides mutual care and relationships of trust. Research also shows that social networks of family, friends, coworkers, and associates offer a pool of resources that can be drawn on in times of need to protect married couples and their families from the stress and depression that is associated with marital conflict and divorce

(Buchel & Duncan, 1998; Carbonaro, 1998). However, research also shows that dense, homogenous networks can negatively impact chances of marriage, particularly for African American women. Edin and Keflas (2004) found that finding the 'right man'—employed, not in prison/on parole, sober—requires the social capital that affords access to networks where the right men can be found. The crucial social support networks which allow low-income women to get by also connect them to poor men with limited economic capability to contribute to a stable life for them or their children, and as such, women will defer marriage until they can 'find the right man' in order to cope with this 'marriage squeeze' (Crowder & Tolnay, 2000). James R. Flynn (2008) calculated that for every 57 marriageable black men, there are 100 black women, and 70% of educated black women remain single. In light of these demographic realities, the policy mandate of marriage is particularly problematic for low-income and/or black women because it encourages dependence on economically insecure men.

In sum, social capital, defined here as social support, plays an important supporting role in finding the 'right man,' providing logistical support in maintaining a work-family balance, as well as providing emotional support and assistance to family in stressful times, which helps to prevent divorce and high marital conflict. However, the social networks in which low-income women are typically embedded, while crucial for 'getting by' can also limit their ability for upward mobility, growth and development. Furthermore, the social capital coffers from which low-income women can typically draw are becoming increasingly tenuous as their ability to maintain norms of reciprocity diminish in the face of increasingly hostile economic conditions. All of this creates a quagmire for low-income women; does the social support on which they rely and the level to which they have access enable them to achieve the institutionally compelled obligations of work and/or marriage mandated by the PRWORA?

Methods

The data for our analysis were drawn from the Fragile Families and Child Wellbeing Study (FFCWS), a longitudinal

study that follows a cohort of nearly 5,000 children born in large U.S. cities between 1998 and 2000. The FFCWS consisted of three waves of in-home interviews beginning just after the birth of the child (Birth) with subsequent interviews when the child was approximately 12 months (Year 1) and 36 months old (Year 3). The parent interviews collected information on attitudes, relationships, parenting behavior, demographic characteristics, health (mental and physical), economic and employment status, and neighborhood characteristics. See Reichman, Teitler, Garfinkel, & McLanahan (2001) for further information about the Fragile Families and Child Wellbeing study design and sampling techniques.

Our analyses were conducted on a subsample of low-income women who were unmarried and had not been stably employed in the previous 12 months, as determined in the interviews conducted at child's birth ($n = 659$). We considered respondents not to be stably employed if they had not worked for pay at a regular job lasting two consecutive weeks or more in the previous 12 months. We considered respondents to be "low-income" if they fulfilled at least one of four criteria: (1) did not have any income from earnings in the last year; (2) received income from public assistance, welfare, or food stamps during the last year; (3) received federal, state, or local government assistance in paying rent; and (4) lived in a public housing project.

Social Capital Measures

We used Wellman and Wortley's (1990) dimensional framework for defining social capital. These dimensions include: (1) emotional aid; (2) small services (i.e., informal babysitting help); (3) large services (i.e., long term care in illness); (4) financial aid; and (5) companionship. This framework of social capital measurement is the most comprehensive, for it encompasses both expressive forms of social capital, such as emotional aid, as well as instrumental forms, such as financial assistance. We also followed Van der Gaag and Snijder's (2003) recommendation of assessing perceptions of social capital when possible, rather than actual use of social capital. Modeled after Ciabattari's (2007) social capital scale and using questions asked in the Fragile Families dataset, we constructed

a 4-item social capital scale that includes the following yes/no questions (yes = 1, no = 0):

1. During the next year, if you needed help, could you count on someone in your family to loan you \$200?
2. During the next year, if you needed help, could you count on someone in your family to provide you a place to live?
3. During the next year, if you needed help, could you count on someone in your family to help with babysitting or child care?
4. In the last 12 months, did you have any income from family and friends?

These four questions were asked in the all three waves of the survey, birth, year 1, and year 3. Though the first three questions referred to a narrower social group in the birth year ("someone in your family") than in years 1 and 3 ("someone"), we treated them as sufficiently similar to include in the 4-item index. In addition, we constructed an enhanced 9-item social capital scale that included the items in the shorter index and five additional items that were available only in the year 1 and year 3 interviews, as follows:

5. If you needed help during the next year, could you count on someone to loan you \$1000?
6. If you needed help during the next year, could you count on someone to cosign a loan for \$1000?
7. If you needed help during the next year, could you count on someone to cosign a loan for \$5000?
8. How many days a week do you usually take (child) to visit relatives?
9. Could you trust anyone else to look after (child)?

We dichotomized the question about visiting relatives as 1 = two or more days a week and 0 = less than two days a week. We used the question about trusting anyone else to look after the child instead of similar questions about the child's father, because some women in the study did not have contact with the father, and the 'anyone else' question indicated availability of help in a broader social group. In the tables that include data on the 9-item social capital index, the number of cases is

lower than for the 4-item index, because these last two questions were asked in only 18 of the study cities.

Dependent Variable: Marriage

The FFCWS includes the question of whether or not the respondent is married to the baby's father at all three waves. We used this question to determine marital status of the mother at birth of the child. In years 1 and 3, women were additionally asked whether they were married to a new partner. We counted a woman as being married in years 1 and 3 if they were married to either the baby's father or a new partner.

Dependent Variable: Stable Employment

This measure was based on the question: 'In what month and year did you last work at a regular job lasting two consecutive weeks or more for which you received a regular paycheck, either full- or part-time?' We considered women who indicated they had worked for two consecutive weeks in the last 12 months to be stably employed.

Additional Variables

We measured educational level at child's birth by the question: 'What is the highest grade or year of regular school that you have completed?' We used the following levels: less than high school, high school or GED, some college or technical/vocational training, college graduate. For years 1 and 3, women were asked if they had completed listed types of additional schooling. We adjusted their initial baseline educational level upward if they had completed appropriate forms of additional schooling. We measured race with the question asked at child's birth, 'Which of these categories best describes your race?' For our analyses using race, we coded Black/African-American as 1 and others as 0. We also controlled for age, as determined at child's birth, divided into five age groups: 14-19, 20-24, 25-29, 30-34, 35 or older.

Procedures

We followed our subsample of 659 low-income, unmarried women who were not stably employed at the birth of their child across all three FFCWS waves. Using logistic regression,

Table 1. Distribution of Demographic Characteristics and Selection Criteria in Analysis Subsample and Total FFCWS Sample

| | Subsample (Percent) | Total Sample (Percent) |
|--|------------------------|---------------------------|
| Educational level | | |
| Less than HS | 62.1 | 34.6 |
| HS or GED | 26.4 | 30.3 |
| Some college or technical | 10.7 | 24.3 |
| College grad | 0.8 | 10.7 |
| (N) | (655) | (4887) |
| Racial identity | | |
| Black | 57.4 | 49.7 |
| White | 18.7 | 30.8 |
| Other | 23.9 | 19.5 |
| (N) | (641) | (4808) |
| Hispanic origin or descent | | |
| Yes | 34.6 | 27.4 |
| No | 65.4 | 72.6 |
| (N) | (648) | (4861) |
| Age | | |
| 14-19 years | 28.2 | 17.4 |
| 20-29 years | 53.1 | 59.1 |
| 30-39 years | 16.7 | 21.2 |
| 40-49 years | 2.0 | 2.3 |
| (N) | (659) | (4895) |
| Mean age (s.d.) | 23.93 (6.22) | 25.28 (6.05) |
| Other biological children | | |
| Yes | 69.5 | 61.7 |
| No | 30.5 | 38.3 |
| (N) | (656) | (4882) |
| Income from earnings in last year | | |
| Yes | 5.5 | 68.3 |
| No | 94.5 | 31.7 |
| (N) | (657) | (4865) |
| Income from public assistance, welfare, food stamps in last year | | |
| Yes | 57.4 | 35.7 |
| No | 42.6 | 64.3 |
| (N) | (658) | (4862) |
| Live in a public housing project | | |
| Yes | 16.2 | 10.4 |
| No | 83.8 | 89.6 |
| (N) | (656) | (4879) |
| Government assistance paying rent | | |
| Yes | 22.1 | 12.3 |
| No | 77.9 | 87.7 |
| (N) | (656) | (4877) |

we examined the effects of social capital on marriage and employment stability, controlling for educational level and race. We hypothesized that social capital facilitates becoming stably employed and marrying.

Results

In the total FFCWS sample, 76% of women were unmarried, and 75% had been stably employed in the past year. Comparisons between the total sample and our subsample on other selected demographic characteristics and the selection criteria are displayed in Table 1. Women in our subsample were younger, more likely to be black or Hispanic, more likely to have other biological children, more likely to receive some form of government assistance in the past year, and less likely to have income from earnings in the past year or to have high educational levels. Compared to women in the total Fragile Families sample, our subsample tended to be more disadvantaged.

Table 2. Marital and Stable Employment Trajectories for Low Income, Unmarried Women Who Were Not Stably Employed at Birth Interview

| | Percent (N) |
|--|----------------|
| <i>Marital status trajectories</i> | |
| Unmarried (birth, year 1, year 3) | 84.5 |
| Unmarried (birth, year 1), Married (year 3) | 6.2 |
| Unmarried (birth), Married (year 1), Unmarried (year 3) | 1.7 |
| Unmarried (birth), Married (year 1 and year 3) | 7.6 |
| (N) | (659) |
| <i>Stable employment trajectories</i> | |
| Not stable (birth, year 1, year 3) | 39.1 |
| Not stable (birth, year 1), Stable (year 3) | 15.8 |
| Not stable (birth), Stable (year 1), Not stable (year 3) | 22.2 |
| Not stable (birth), Stable (year 1 and year 3) | 22.9 |
| (N) | (645) |

Our dependent variables were marital status and stable employment status. Marital and stable employment trajectories for the women in our subsample are displayed in Table 2. Relatively little change was observed in these women's marital status across the three survey waves. All were unmarried as of the birth interview, and the great majority (85%) remained unmarried across all waves. Only about eight percent exhibited the pattern encouraged by the PRWORA, being married in both year 1 and year 3. An additional six percent were unmarried in the first two waves, but married by year 3. Employment trajectories were more variable. Almost 40 percent were not stably employed in any of the three survey waves. An

additional 22 percent gained stable employment in year 1, but returned to unstable employment in year 3. However, 38 percent transitioned to stable employment at some point and remained stably employed in the third survey wave.

Table 3. Means and Standard Deviations for Social Capital Indexes

| | At birth | Year 1 | Year 3 |
|--|------------------|------------------|------------------|
| Social capital 4-item index | | | |
| Mean (s.d.) | 2.947 (1.084) | 2.687 (1.210) | 2.480 (1.201) |
| N | 659 | 659 | 659 |
| Percent "Yes" for component variables: | | | |
| Count on loan \$200 | 83.0 | 72.5 | 72.5 |
| Count on place to live | 87.1 | 77.2 | 72.8 |
| Count on child care | 88.8 | 81.9 | 79.4 |
| Income from family/friends | 35.8 | 37.0 | 23.2 |
| Social capital 9-item index | | | |
| Mean (s.d.) | | 5.226 (2.317) | 4.947 (2.342) |
| N | | 545 | 544 |
| Percent "Yes" for component variables: | | | |
| Loan \$200 | | 72.5 | 72.5 |
| Place to live | | 77.2 | 72.8 |
| Child care | | 81.9 | 79.4 |
| Income from family/friends | | 37.0 | 23.2 |
| Loan \$1000 | | 34.7 | 35.5 |
| Cosign \$1000 loan | | 48.7 | 44.6 |
| Cosign \$5000 loan | | 25.2 | 23.1 |
| Trust to look after child | | 65.1 | 66.5 |
| Visit relatives often | | 71.4 | 72.2 |

Our 4-item social capital mean index scores decreased somewhat from child's birth to year 3, due largely to decreases in the percentage of women who could count on someone for emergency child care and who received income during the past year from family or friends (Table 3). However, the *counting on child care* variable decreased more between child's birth and year 1 than between year 1 and year 3, while the reverse is true for income from family or friends. For the 9-item index,

in addition, the percentage of women who thought they could find someone to cosign a loan for \$1,000 or \$5,000 decreased slightly from year 1 to year 3.

Table 4. Odds Ratios for the Effects of Social Capital 4-Item and 9-Item Indexes and Demographic Factors on Stable Employment

| | Time Period | | | |
|--------------------------|--------------|--------------|---------------|---------------|
| | Birth-Year 1 | Birth-Year 3 | Year 1-Year 3 | Year 1-Year 3 |
| Education level | 1.704*** | 1.455*** | 1.457*** | 1.444** |
| Race (Black=1) | 1.795*** | 1.033 | 1.019 | 1.013 |
| Age | 0.671*** | 0.846* | 0.841* | 0.800 |
| Social Capital (4 items) | 1.047 | 1.023 | 0.996 | |
| Social Capital (9 items) | | | | 1.102* |
| N= | 646 | 650 | 650 | 540 |
| -2LL (Intercept only) | 889.965 | 868.924 | 868.924 | 684.726 |
| -2LL (Full model) | 835.746 | 855.598 | 854.529 | 662.286 |
| χ^2 | 54.219*** | 13.325** | 14.395** | 22.343*** |
| df | 4 | 4 | 4 | 4 |

Notes: $p < .001$ ***, $p < .01$ **, $p < .05$ *; Age is grouped as 14-19, 20-24, 25-29, 30-34, 35+.

As shown in Table 4, as measured by the 4-item index, an increase in social capital did not significantly increase the odds of having stable employment over any of the time periods examined. However, as measured by the 9-item index, the higher the woman's social capital in year 1, the more likely she would be to have stable employment in year 3 (OR = 1.102, $p < .05$). Educational level at child's birth and race were also related to the likelihood of obtaining stable employment when entered with the 4-item index. More highly educated women and blacks were more likely to be stably employed from child's birth to year 1. Education, but not race, continued to play a role from child's birth to year 3. Likewise, in the equation with the 9-item social capital index from year 1 to year 3, educational level was a statistically significant predictor of stable employment, and race was not.

Though the 4-item social capital index did not increase the likelihood of marriage across any of the three time periods (Table 5), the 9-item year 1 social capital index increased the likelihood of marriage in year 3 (OR = 1.164, $p < .05$). Race was a statistically significant predictor of the likelihood of marriage in all time periods (black women were significantly less likely to be married) and in the equations including both social capital indexes. Educational level acts as a statistically significant predictor of marital status only in the birth to year 1 and birth to year 3 equations.

Table 5. Odds Ratios for the Effects of Social Capital 4-Item and 9-Item Indexes and Demographic Factors on Marital Status

| | Time Period | | | |
|--------------------------|--------------|--------------|---------------|---------------|
| | Birth–Year 1 | Birth–Year 3 | Year 1–Year 3 | Year 1–Year 3 |
| Education level | 1.454* | 1.426* | 1.317 | 1.156 |
| Race (Black=1) | .262*** | 0.189*** | 0.186*** | 0.211*** |
| Age | 1.120 | 0.896 | 0.905 | 0.965 |
| Social Capital (4 items) | 1.157 | 1.125 | 1.171 | |
| Social Capital (9 items) | | | | 1.164* |
| N= | 655 | 655 | 655 | 544 |
| -2LL (Intercept only) | 401.163 | 520.606 | 520.606 | 406.017 |
| -2LL (Full model) | 373.542 | 469.458 | 469.576 | 367.608 |
| χ^2 | 26.620*** | 51.148*** | 51.031*** | 38.409*** |
| df | 4 | 4 | 4 | 4 |

Notes: $p < .001$ ***, $p < .01$ **, $p < .05$ *; Age is grouped as 14-19, 20-24, 25-29, 30-34, 35+.

Summary and Conclusions

The 1996 Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, P. L. 104–93) called primarily on women to achieve two goals: work and/or marriage. The onus for independence from welfare shifted towards the individual woman and away from collective responsibility that historically characterized public assistance to women with

children (Rank, 2004). In doing so, individual forms of capital, including social capital, came into focus as a mechanism for achieving the new markers of success—work and marriage. Low-income women found themselves in a dilemma—they were now required to achieve goals that were, in part, facilitated by social capital, a resource that is not readily available to poor women (Conley, 1999; McLanahan & Sandefur, 1994; Simons, Beaman, Conger, & Chao, 1993).

In this study, we find that social capital is a predictor of work and marriage but only at the higher levels. In our analysis, the 4-item social capital index did not predict stable employment in any of the three time periods. However, the 9-item index was statistically significant over the year 1-3 interval. In addition, the 4-item index was not predictive of marriage in any interval, whereas the 9-item index was. When the reserve of social capital is shallow, the payoff may not be as robust. Women with higher levels of the broader 9-item index were more likely to be married and employed three years after giving birth. Women with higher levels of the narrower 4-item index were not more likely to maintain employment or transition to marriage.

Our findings call into question the practicality and feasibility of the goals of the PRWORA. The women in our study required a deep pool of social capital to reap returns in seeking and maintaining employment, meaning that the women who are in the greatest economic need did not see positive returns. The same was true with regards to marriage. Women with connections to other individuals with expanded economic capital were able to find acceptable marriage partners, while women with economically poorer social capital were not. The 9-item scaled measured literally a richer form of social capital; women with high capital on the 9-item scale had access to people with a greater amount of economic capital. These results fit with Bourdieu's (1986) discussion of the reciprocal and mutually reinforcing nature of various forms of capital. For Bourdieu (1986), social networks containing more material or economic capital are more beneficial because they transmit advantageous cultural capital relative to institutional norms. These forms of capital construct the 'habitus' of the individual, which is the totality of the immediate environment whereby the person learns the cultural skills necessary to navigate the norms of

the institutions. An individual with a habitus containing more economically advantaged persons will have more success, because he or she will have access to more institutionally successful cultural skills. For the women in our study, more social capital reflects a more economically advantageous network, which led to more success as defined by the PRWORA.

This suggests that social capital may be a 'trojan horse' masking the real culprit—culture. Somers (2005) argues sociologists have bought too deeply into the myth of social capital in the misguided hopes of capitalizing on the academic love affair with the market model and the logic of rational-choice. Somers argues that society and the social cannot be completely rationalized into market-type exchange transactions. The concept of habitus suggests an osmosis-like process whereby what is transmitted through social capital is not tangible resources (i.e., an emergency ride or babysitting) which can be reciprocated through rational exchange, but rather the breathing in of the cultural tools necessary to be successful inside social institutions. For example, Lareau's (2003) work shows how economically successful parents transmit a sense of institutional entitlement to their children, teaching them how to customize the institutional fabric to best suit their needs. It may be that the women in our study who have access to more economically enriched social capital find it beneficial not because they receive more actual exchange-type resources (i.e., small loans), but that they are embedded in a cultural habitus more in line with the institutional norms. If so, the overall success of the PRWORA will be limited to only those who can best play the institutional game. Thus PRWORA becomes another tool to culturally marginalize a group of women (Hays, 2003).

The narrow scope of our social capital measure is a limitation of our study. The social capital index we constructed narrowly focuses on bonding social capital, or emergency support, which logically would be drawn from close contacts. This type of social capital is most readily available to low-income women (Edin & Keflas, 2004; Stack, 1974). However, research shows that both finding a job and finding a mate are more likely when women are embedded in diverse, expansive networks—in other words, those consisting of more bridging capital (London et al., 2004; Lowndes, 2004; Parks-Yancey,

DiTomaso, & Post, 2006). As previously mentioned, bonding social capital, or strong ties, keeps us connected to our intimate contacts and provides sources of support, both financial and emotional, whereas bridging social capital, or weak ties, take us out of our close network and into contact with other, more varied social networks. Edin and Keflas (2004), among others, have noted that poor women, particularly poor African American women, have limited choices when it comes to marriageable men because there are so few economically stable men in their social networks. Furthermore, research also shows that white social networks contain more bridging social capital than black social networks (Smith, 2005). Along with our findings, this research suggests that the chances of marriage may be related to a woman's level of bridging social capital. Women with more bridging social capital may have a greater chance of getting married because they are embedded in networks with a greater reach. This would make it easier for white women to marry, since they are already embedded in more expansive networks.

Bonding social capital works well to facilitate employment because, unlike bridging social capital, which diversifies ties, bonding social capital provides stability and balance that enables women to negotiate a work-family balance (Ciabattari, 2007; Furstenburg, 2005). Social capital in the form of emergency funding and child care, both large and small, provides women the support necessary to manage multiple roles and cope with unexpected crises that, as Hays (2003) showed, could easily derail a low-income woman's employment pattern. However, our results show that it may take a broader pool of social capital to produce long-term positive employment outcomes.

Our findings also raise a question about the overarching objective of the PRWORA. The goal of the 1996 welfare reform act was to 'end welfare as we know it' and reduce the welfare caseloads. On this score, the PRWORA has been very successful, with a 50% reduction in the number of people receiving welfare. However, the objective of reduced caseloads is very different from a goal of financial independence for women. While most of the women who have left welfare have done so through employment, as Hays (2003) points out, most of the jobs are unstable and low paying with no benefits. These

are not the sorts of jobs that produce financial independence. While we cannot ascertain where the women in our sample are employed, our research suggests that policy that is oriented towards achieving stability and financial independence for low income women must take into account more than just their human and financial capital. Future work should take into consideration how low-income women are embedded in larger social networks and how those networks provide avenues for economic mobility, financial independence, and opportunities to find eligible partners.

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Emergency Room Use by Undocumented Mexican Immigrants

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This study examined emergency room use by undocumented Mexican immigrants and their sources of health care information. Thirty-eight percent of the respondents reported that they would use a hospital emergency room (ER) for primary medical care. ER use rates declined with time spent in the United States. Emergency room use rates varied significantly by region. Respondents receiving information from a church reported less ER use, compared to all others; respondents receiving information from U.S. newspapers reported higher ER use rates. Lack of health care access for undocumented immigrants remains a public health issue as well as a social justice concern.

Key words: Emergency room use, undocumented immigrants, Mexicans, health care services

In 2008, there were approximately 12.7 million Mexican immigrants living in the United States, up from only 760,000 in 1970. Thirty-two percent of all immigrants living in this
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country are Mexican, and of that number, more than half (55%) are undocumented. "Overall, Mexicans comprise about six-in-ten (59%) of the estimated 11.9 million unauthorized immigrants in the U.S." (Pew Hispanic Center, 2009, p. 1).

As citizens, we must be concerned about those in our midst who may need health and human services. This is especially true in the matter of health and should be of special concern with respect to Latinos. While new Latino immigrants tend to be healthier than the general population (the Latino paradox), their health deteriorates in time with acculturation (Zsembik & Fennell, 2005). This is often attributed to the fact that Latino immigrants and their children often lack health insurance and access to health care services (Prentice, Pebley, & Sastry, 2005). In addition, it has been found that many immigrants are unaware of the health and community resources available to them (Yu, Huang, Schwalber, & Kogan, 2005).

The purpose of this study is: (1) to examine patterns of emergency room (ER) use among undocumented Mexican immigrants who choose this rather than usual sources of care; and (2) to describe sources of health care information among these immigrants, as the lack of such information constitutes a major barrier to accessing appropriate care.

Conceptual Framework and Literature Review

As we consider health-seeking behavior of undocumented Mexicans which results in use of an emergency room rather than a clinic or private physician, we use here an ecosystems perspective as a theoretical framework for our analysis (Bronfenbrenner, 1979). In this framework, behavior is seen as resulting from reciprocal transactions between the continually developing person and a multivariate, multidimensional environment. Bronfenbrenner's four transactional levels between person and environment—macro, meso, exo, and micro—here frame the context for health-seeking behavior of Mexican immigrants. While it is not the purpose of this paper to explore each of such factors at each level in depth, they are presented here to facilitate a better understanding of immigrant health-seeking behavior within the context of a reciprocal ecosystems environment.

Macro and Exo Level Factors

At the *macro*, or societal/cultural level, and the *exo*, or distal institutional level, there are many factors that may be viewed as influencing immigrant health behavior. These include economic factors, such as the desire for work, which often results in immigrants working at jobs that have no health benefits (Chavez, Flores, & Lopez-Garza, 1992), and immigration policies. The Immigration Control Act of 1996, among others, denied some benefits to legal immigrants, not just undocumented ones, and precluded legal immigrants from receiving public benefits for five years after they had become legal residents (Berk & Schur, 2001). Other critical factors are social welfare policies, such as The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), which has limited access to health care in some states for undocumented immigrants except for treatment of an emergency medical condition and immunizations (National Immigration Law Center, 2005) and the structure of the health care system. Those who do not have the resources to purchase health care insurance are, in most cases, excluded from accessing this system (Berdahl, Kirby, & Torres Stone, 2007). Other factors include societal attitudes towards immigrants, with many viewing immigrants as “undeserving outsiders” and a “problem” (Horton, 2004; Pew Hispanic Center, 2006); institutional discrimination, as “stereotyping, biases, and uncertainty on the part of healthcare providers can all contribute to unequal treatment” (Smedley, Stith, & Nelson, 2003); and cultural attitudes regarding health and illness. As an example of the latter, Borrayo and Jenkins (2003) have asserted that the concept of prevention is meaningless in traditional Mexican culture. There, in order to receive attention, one’s health problem must show symptoms.

Meso and Micro Level Factors

At the *meso*, or proximate institutional level, and at the *micro*, or individual and familial levels, there are also numerous factors affecting immigrant healthcare behavior, including accessibility of healthcare, social support networks, demography, knowledge of available health care resources, individual/familial resources, and perceptions/attitudes regarding care.

In addition to the structural barriers encountered at the macro and meso levels, the immigrant in this country may face

other issues relating to accessibility, for example, lack of transportation to healthcare facilities and lack of childcare, which would deny a parent the opportunity to use such facilities. New immigrants often do not know of health and community resources that may be available to them (Yu et al., 2005). Newcomers have to learn how to navigate a complex health-care system from which they are often excluded (Chavez et al., 1992; Smedley et al., 2003). New immigrants are often better able to access health systems with social support (Derose, 2000).

Individual demographic characteristics, such as length of residence in the United States, immigration status, and language ability, all contribute to access to care, or lack thereof, for Latino immigrants. Thamer, Richard, Casebeer, and Ray (1997) found that the longer one resides in the United States, the more likely one is to have health insurance. Similarly, LeClere, Jensen, and Biddlecom (1994) found length of residence to be a significant factor in whether and how often a person saw a physician in the last year.

Language ability can also be a significant barrier to accessing care, as many facilities have no Spanish-speaking translators and many new immigrants are not bilingual in English (Hu & Covell, 1986). Ku and Matani (2001) state that language problems are cited by Latino parents as the leading barrier to child health services. In addition, many Latino patients, even those with proficiency in English, have difficulty communicating in English when they are ill (Documet & Sharma, 2004).

Studies have shown that immigrants are more likely to be uninsured than U.S. born persons (Mohanty et al., 2005). This is particularly true for Hispanics, who have the highest percentage of uninsured of any immigrant group (Dey & Lucas, 2006). In particular, immigrants who are not U.S. citizens are more likely to lack health insurance, although the number decreases with length of time in U.S. In the case of immigrant families, U.S.-born children are eligible to receive SCHIP (State Children's Health Insurance Plan), but often undocumented parents are less likely to enroll their children in such programs (Ku & Matani, 2001).

Undocumented immigrants not only tend to lack health insurance, but also report more difficulty in obtaining health care

than others (Hubbell, Waitzkin, Mishra, Dombink, & Chavez, 1991). In many hospitals, doctors' offices, and clinics, eligibility requirements often screen out undocumented immigrants (Smedley et al., 2003). Some studies have shown that immigrants are fearful to access health services because they are afraid they will be asked their immigration status and denied service, or even worse, be deported (Berk & Schur, 2001).

In addition, some immigrants may mistrust the medical system and their treatment by healthcare providers. Many Latinos feel that they receive lesser care, have been discriminated against in the health care system, and have been treated with disrespect based on their ethnicity and English-speaking ability (Johnson, Saha, Arbelaez, Beach, & Cooper, 2004; Schur, Berk, Good, & Gardner, 1999).

Given these myriad, interacting forces affecting immigrants' lives, it is readily apparent that decisions to seek primary medical care, or routine care from other usual sources of care, are not isolated events but rather take place in a dynamic, sociopolitical/cultural context. Within this context, we wanted to know where Mexican immigrants choose to receive health care, particularly at what rate they would choose an ER as the source of medical care, rather than other sources of primary care or other types of care. The authors focused on emergency room use because health care obtained in this way is a public concern due to its high cost and also due to the consequent overcrowding of emergency rooms with non-emergency issues, placing great strains on hospital systems. A secondary aim of the study is to describe where immigrants obtain information about health care resources and how such information sources may impact the choice of care setting.

Methods

This study is a secondary analysis of the Mexican Migrant Worker Survey conducted by the Pew Hispanic Center (Pew Hispanic Center, 2005). The survey comprised a convenience sample of nearly 5,000 Mexican migrants in the United States who were interviewed while applying for a "Matrícula Consular," an identity document issued by Mexican diplomatic missions. As the immigrants had no legal papers

authorizing them to be in the United States, they were assumed to be undocumented or unauthorized. Data were collected at consulates in seven large American cities known to have high numbers of Mexicans: Los Angeles, New York, Chicago, Atlanta, Dallas, Raleigh, and Fresno, from July 12, 2004, to Jan. 28, 2005. In each location, data collection was conducted for five to ten business days, depending on the estimated size of the target population in each city.

Potential participants were identified in the consulate waiting rooms where they received announcements regarding the survey and its content, the nature of the questions and the length of time needed to fill out the survey, as well as a detailed explanation of the anonymity and confidentiality of their responses. Data were collected with a self-administered questionnaire in Spanish. Because the targeted sample is characterized by a high rate of illiteracy, special attention was paid to the potentially illiterate or semi-literate people in the sample by emphasizing that reading and writing were not a prerequisite to participation and that interviewers were available to provide assistance and to conduct as much of the survey as necessary. In return for filling out the questionnaire, respondents received a telephone card to be used to call Mexico.

The Pew Hispanic Center made the data publicly available after the surveys were completed. These data were downloaded from the Center's website. The dependent variable in this study was the binary variable of choosing ER for medical care. The independent variables were age, sex, education, income, employment status, length of residence in U.S., number of children, and having family in the same town. In order to learn more about the health-seeking behavior of this undocumented population, researchers here utilized descriptive statistics to ascertain demographic characteristics of the sample. Inferential statistics were used to determine the correlates and predictors of choice for health care and sources of health care information. We also described the sources of information regarding health care and investigated whether information sources independently affect the choice of setting for medical care.

The sample characteristics in this study are comparable to estimated characteristics of undocumented Mexican migrants living in the United States (Passel, Capps, & Fix, 2004; Suro,

2005). The survey captured a distinctively young and recently arrived segment of the Mexican-born population living in the United States: nearly half of the sample was aged between 18 and 29 years, or had been in the country for five years or less. In addition, respondents showed a higher level of educational achievement than the adult population of Mexico at large (Suro, 2005).

Of the sample of 4,836, the majority were male (58.7%) and 41.3% were female. Slightly over 50% of the sample were 29 years of age or younger. About a third had not completed high school, while 59.5% were either secondary/technical school graduates or high school graduates. About six percent (6.3%) were college graduates. These findings are similar to those of Cuecuecha (2005), who found that Mexico was losing its middle-range educated workers, not its uneducated campesinos.

Almost fifty percent of the immigrants (45.9%) had been in the country for five years or less, while twenty percent (20.9%) had been in the country for more than fifteen years. Related to this residency is fluency in English, with over fifty percent (54.8%) of the respondents able to speak "only a little" or no English, as compared to 13.6% who said they spoke "a lot" of English.

A majority of the respondents were married (55.9%) and had three or more children in the United States (54.7%). Most of them lived in a town or city where they had relatives (67.1%). Of those who worked, 76% worked full-time. And unlike findings in other studies, the majority of them (59.5%) stated that they had health insurance.

Respondents were asked, "Which of these would you be most likely to use if you were seeking medical care?" Responses included: (i) hospital emergency room; (ii) clinic; (iii) private doctor; and (iv) consult with a friend. Multiple responses were allowed. The dichotomous dependent variable of the current study, emergency room (ER) use for medical care, indicated all respondents that choose hospital ER for medical care. Potential predictors of ER use included gender, age, education, level of English, marital status, number of children in the U.S., presence of relatives in town/city, working full-time, time in the U.S. and the city where the data was collected. In addition, analyses controlled for presence of health insurance.

Respondents were asked about the two most important sources from which they receive medical and health information. Analyses included a binary variable indicating that the respondent received such information from church, a second binary indicator for receiving information from medical care providers, and two other binary indicators for receiving information from Mexican and U.S. newspapers.

For purposes of analysis, an acculturation index was created from three variables found to be associated with acculturation: English-speaking ability, time in the U.S., and level of education. A number of acculturation scales have used these proxy measures and these scales have been tested and validated to some degree (Arcia, Skinner, Bailey, & Correa, 2001; Lara, Gamboa, Kahramanian, Morales, & Bautista, 2005). Those with better facility in English (self-reported), longer residence in the U.S., and higher levels of education were assumed to be more acculturated.

The proportion of immigrants choosing ER for medical care was tabulated across covariates, and chi-square tests were used to identify bivariate associations between the outcome measure and the potential predictors. Multivariate logistical regressions were used to model the relationship between ER use and explanatory variables. Estimates were converted to odds ratios. Because the acculturation index is a composite of time in the U.S., education, and level of English, two separate models were estimated. The first model included the acculturation index and did not control for items that make it up, in order to avoid multicollinearity. The second model controlled for the items that compose the acculturation index individually, and excluded the index. Data management and statistical analyses were conducted using Stata software (StataCorp, 2006).

Results

Thirty-eight percent of the respondents reported that they would use hospital ER for medical care (Table 1). Males were more likely to use ER for care, compared to females (39% vs. 35%). Those youngest (aged 29 or younger) reported higher ER use rates (41%) compared to those aged 30-39 (36%) or older (aged 40+, 31%). Those with one or two children reported the

Table 1. Bivariate Associations between Emergency Room (ER) Use for Medical Care and Respondents' Characteristics

| | % | p-value |
|---|------|---------|
| All | 37.6 | |
| Gender | | |
| Male | 39.1 | 0.007 |
| Female | 35.2 | |
| Age | | |
| Under 30 | 40.6 | 0.001 |
| 30-39 | 36.4 | |
| 40+ | 30.7 | |
| Education | | |
| Did Not Complete High School | 36.7 | 0.283 |
| Secondary/Technical School Graduate | 39.3 | |
| High School Graduate | 37.0 | |
| College Graduate | 35.0 | |
| How much English does the respondent speak? | | |
| A Lot | 37.0 | 0.752 |
| Some | 38.5 | |
| A Little | 36.7 | |
| None | 37.4 | |
| Is the respondent married (including common law)? | | |
| No | 38.9 | 0.069 |
| Yes | 36.3 | |
| Number of children in the U.S. | | |
| None | 34.5 | 0.050 |
| 1 or 2 | 39.7 | |
| 3 or more | 36.6 | |
| Any relatives in town/city? | | |
| No | 36.0 | 0.232 |
| Yes | 38.5 | |
| Does respondent work full-time? | | |
| No | 38.6 | 0.856 |
| Yes | 38.3 | |
| Time in the U.S. (Years) | | |
| 5 or Less | 39.0 | 0.003 |
| 6 to 10 | 40.1 | |
| 11 to 15 | 37.2 | |
| More Than 15 | 32.7 | |
| Does respondent have health insurance? | | |
| No | 36.1 | 0.023 |
| Yes | 39.3 | |
| Market [City] | | |
| Los Angeles, CA | 33.1 | <0.001 |
| New York, NY | 45.7 | |
| Chicago, IL | 34.2 | |
| Fresno, CA | 36.2 | |
| Atlanta, GA | 45.6 | |
| Dallas, TX | 37.4 | |
| Raleigh, NC | 46.3 | |
| Information Sources (number & % receiving information from) | | |
| Church | 32.5 | 0.043 |
| Doctors or Other Medical Service Providers | 36.3 | 0.231 |
| Mexican Newspaper | 36.4 | 0.762 |
| US Newspaper | 41.3 | 0.065 |

highest ER use rates (40%), compared to the subgroup with no children, or respondents with three or more children. ER use rates declined with time spent in the U.S., especially for those who have been in the U.S. for more than 15 years. There were no statistically significant bivariate subgroup variations in ER use by education, level of English, presence of relatives in town/city or full-time employment status. Reported ER use rates varied significantly according to the data collection site: lowest rates were observed in Los Angeles (33%); whereas in New York, Atlanta, and Raleigh, rates were above 45%.

Contrary to expectations, and the literature studying non-immigrant or documented immigrant populations, those with some insurance coverage reported slightly higher ER use rates compared to the respondents that lack health insurance coverage (39% vs. 36%). It should be noted that respondents were simply asked "Do you have health insurance?" and there were no inquiries on quality or source of coverage.

Of the 4,836 respondents, 345 of them (7%) reported that they receive health care related information from churches; 1,415 (29%) reported receiving information from medical care providers, 162 respondents (3%) reported Mexican newspapers as a source, and 511 of them (11%) reported U.S. newspapers as a source of information for medical care (these choices were not mutually exclusive). Respondents who receive information from a church reported less ER use, compared to all others (Table 1), whereas respondents receiving information from U.S. newspapers reported higher ER use rates (the difference reached borderline statistical significance, $p = 0.065$).

Observed variations in age remained in the multivariate analyses: the odds of using ER declined with age (Table 2). However, the gender difference was no longer significant once all other covariates were controlled for. The findings on number of children, insurance, education or employment status remained in the multivariate analyses. Variations by location also remained after other characteristics were controlled for: compared to the respondents surveyed in Los Angeles, those surveyed in New York, Fresno, Atlanta or Raleigh had significantly higher odds of reporting ER use. Respondents that use churches or medical providers as a source of information had lower odds of reporting ER use for medical care, whereas those

that use Mexican or U.S. newspapers for information were no less likely to report ER use, compared to those that do not rely on newspapers as an information source.

Table 2. Multivariate Predictors of Emergency Room (ER) Use for Medical Care

| | MODEL 1 | | MODEL 2 | |
|-------------------------------------|------------|---------|------------|---------|
| | Odds Ratio | p-value | Odds Ratio | p-value |
| Gender: Female | 0.89 | 0.131 | 0.90 | 0.189 |
| Age: 30-39 | 0.86* | 0.061 | 0.83** | 0.038 |
| Age: 40+ | 0.65*** | <0.001 | 0.65*** | 0.001 |
| Married | 1.00 | 0.956 | 0.98 | 0.811 |
| 1-2 children in the U.S. | 1.36** | 0.021 | 1.27* | 0.086 |
| 3+ children in the U.S. | 1.18 | 0.195 | 1.14 | 0.330 |
| Working full-time | 0.99 | 0.881 | 1.02 | 0.774 |
| Possessing Health Insurance | 1.20** | 0.010 | 1.21** | 0.010 |
| Residence: New York, NY | 1.58*** | <0.001 | 1.67*** | <0.001 |
| Residence: Chicago, IL | 1.04 | 0.696 | 1.10 | 0.379 |
| Residence: Fresno, CA | 1.45*** | 0.009 | 1.55*** | 0.003 |
| Residence: Atlanta, GA | 1.74*** | <0.001 | 1.81*** | <0.001 |
| Residence: Dallas, TX | 1.21* | 0.069 | 1.24* | 0.055 |
| Residence: Raleigh, NC | 1.80*** | <0.001 | 1.88*** | <0.001 |
| Information from: Church | 0.75** | 0.042 | 0.76* | 0.059 |
| Information from: Medical Provider | 0.84** | 0.027 | 0.83** | 0.026 |
| Information from: Mexican Newspaper | 0.84 | 0.345 | 0.84 | 0.398 |
| Information from: U.S. Newspaper | 1.02 | 0.871 | 1.00 | 0.984 |
| Acculturation index | 1.00 | 0.881 | ... | ... |
| Education: Secondary/Technical Sch. | ... | ... | 1.12 | 0.349 |
| Education: High School Graduate | ... | ... | 1.00 | 0.996 |
| Education: College Graduate | ... | ... | 1.19 | 0.254 |
| English: some | ... | ... | 1.18* | 0.088 |
| English: a little | ... | ... | 1.25* | 0.070 |
| English: none | ... | ... | 1.04 | 0.742 |
| Time in US: 6-10 years | ... | ... | 1.07 | 0.484 |
| Time in US: 11-15 years | ... | ... | 1.01 | 0.905 |
| Time in US: 15+ years | ... | ... | 0.95 | 0.754 |

Reference categories are male, aged 30 or younger, did not complete high school, spent less than 5 years in the US, speaking a lot of English, single, no children in the U.S., working part time, not covered by health insurance, residing around Los Angeles, CA, not receiving information from church, medical providers, U.S. or Mexican newspapers.

***p < 0.01, **0.01 <= p < 0.05, *0.05 <= p < 0.10

The acculturation measure was insignificant in multivariate analyses (Table 2, model 1). In the second model, where components of acculturation were entered independently to the estimation, we observed that level of English was associated with ER use, at a borderline significance level. Those who

rated their level of English "some" or "a little" were more likely to report ER use compared to the respondents that reported speaking "a lot" of English. An important deviation from the bivariate findings was related to time in the U.S.: spending 15 or more years in the U.S. was no longer associated with ER use, once all other covariates were controlled for.

Discussion and Conclusion

For all population groups in this country, some conditions do require ER care, including such urgent care as that required for a heart attack, in which case primary care physicians send the patient immediately to the ER. Other conditions may need immediate attention at night or on weekends. If a person, although having a source of routine care, does not have access to it (due to time, location), she or he may be channeled to the ER. However, some ER visits are "preventable," resulting from untreated or under-treated conditions that may lead to acute events requiring an emergency visit; limited access to routine health care is likely to be the root cause of such visits. In other cases, however, the ER is the immigrant's "preference" because he or she fears discrimination in doctors' offices and clinics, or simply cannot afford such services and perceives ER care as free. While the survey does not inquire as to why the person chooses ER for medical care, the questionnaire is most likely to capture the preference-based visits, thus reflecting the problem of access to care.

One of the limitations of this study, however, was the questionnaire instrument itself. While the question was asked, "Do you have health insurance?" no follow-up question was asked as to type or source of the insurance. Contrary to the literature, a high percentage (60%) of the undocumented immigrants responding to the survey reported having health insurance. As Mexico has universal health care coverage, it is possible that some of those who responded affirmatively, when interviewed in the consulates prior to receiving documentation, may have been referring to coverage in their former homeland. Given that this is a retrospective secondary analysis of an existing survey, it is beyond our capacity to investigate the validity of the insurance coverage variable. Still, we opt to report the findings-related insurance variable, since the literature shows that

it is the most influential factor that impacts health care access in the United States.

Another limitation of the study was that no question was asked about the health status of the respondents or whether they had a regular health care provider. A recent study has found that undocumented Mexicans in New York City who reported having health insurance, but not a regular source of care, were more likely to use the emergency room if they reported more health care needs (Nandi et al., 2008). ER use declines by age, even after controlling for acculturation and other factors. It is likely that older people with chronic conditions are more connected to usual sources of care, and younger people with acute problems are more likely to use ER rather than other providers. Families with one to two children were more likely to use the ER, compared to families with three or more children. It is also possible that families with more children were more informed about the outpatient health care services available for children, or more likely to insure their children with SCHIP, thus less likely rely on the ER for medical care.

The finding that younger immigrants tend to use emergency rooms in higher numbers is consistent with the literature, as is the finding that ER use declines with time in the U.S. Younger immigrants may not have as much knowledge about other health resources available, and they are less likely to be working at jobs that offer health care coverage. Therefore, they would be more likely to seek care at a hospital emergency room.

One of the interesting findings had to do with location. As indicated above, this survey was conducted in seven major cities known to have high numbers of Mexicans: Los Angeles, New York, Chicago, Atlanta, Dallas, Raleigh, and Fresno. The highest rates of ER use were found in New York City, Atlanta, GA, and Raleigh, NC. We can only conjecture what the reasons for the differences by area may be. Some of these may be due to issues discussed previously, such as access, fear, and lack of knowledge of resources, particularly in locations where this population has only recently migrated. The areas with the lowest rates of ER use, Los Angeles, Fresno, Dallas, and Chicago, have very large Mexican populations of long standing. The Mexican neighborhoods in these areas may have developed better formal and informal systems of communication

regarding health care resources. In some cases, the Mexican population may have become, over time, better accepted by the population at large and thus be better positioned to access available resources and services than are Mexican immigrants in cities like Atlanta and Raleigh, where this population has much more recently begun to settle.

Another reason for the difference in reliance on ER use may be the structure of health care systems from location to location. Large numbers of Latinos are now moving into rural (non-metro) areas and small towns that often have limited healthcare facilities and personnel, especially bilingual ones (Berdahl et al., 2007). Some dentists and physicians in these areas may be reluctant to participate in Medicaid and in the State Children's Health Insurance Program (SCHIP) (Casey, Blewett, & Call, 2004).

Another factor related to location is transportation. Cities in the U.S., including the ones used in this study, have varying degrees of quality public transportation. Even such public transportation as is available may be difficult to navigate for an immigrant with limited English-speaking ability. And whatever the locale, emergency rooms, as components and functions of hospitals, are often more visible than are neighborhood offices or clinics. The differential use of emergency rooms by location is an area for future study. While our data do not allow us to investigate the reasons for regional variations, our findings suggest that macro and meso factors, such as health care structure and transportation, are highly significant predictors of ER use by Mexican immigrants for health care, and explain a larger proportion of the variation compared to the variables we controlled at the micro level (e.g., language, education).

Another area for future research is the question of sources of health care information. It was found that those immigrants who received information from churches were less likely to use emergency rooms, perhaps because they were provided abundant information on other health care sources, and possibly even assistance in accessing such sources. The majority of Mexican immigrants are Catholics. Catholic social service organizations in the United States have long provided social services to this immigrant group as well as many others. It is possible that these organizations provide the local parishes

with information and assistance regarding other sources of health care for immigrants. As to that percentage most likely to use the ER according to source of information, those persons relying on U.S. newspapers as a source for information on health care, one can perhaps speculate that the information presented through this medium was either not sufficiently specific to resources, or that those reading the information did not feel those resources would be accessible, but more research in this area is needed.

This paper looked at a specific population in the United States, undocumented Mexican immigrants, who are of concern for many reasons. Because of their undocumented status and the realistic fear it may engender among them, it can be a difficult population to find or even to persuade to participate in research studies. Further, the use and overuse of emergency rooms is a complex issue, and one not confined to this one group. Also, in the survey utilized for this study, the survey instrument had some shortcomings, at least for our purposes, including the lack of follow-up questions to those immigrants indicating they had health insurance, and not including other factors of interest at both the macro and micro levels. Even given the shortcomings of the data, the survey did open a window onto a crucial policy question: that is, how many undocumented immigrants use emergency room services and what may be some predictors of that use?

Regardless of immigrant status, and whether one is documented or undocumented, health care access is critical to each individual. And at the societal level this issue confronts both human rights and public health considerations. When public policies leave undocumented immigrants with few choices for health care, they may find that the emergency room becomes their only choice. Further research may help solve the dilemma of how to help ameliorate health care problems of immigrant populations caused by disparate policies and health care systems across the country.

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If Not Welfare, Then What?: How Single Mothers Finance College Post-Welfare Reform

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The article follows previous work on TANF and AFDC by asking if not welfare, then what social programs and financial aid programs are low-income women using to support their college attendance, and what is the impact of these programs on the college-going decisions of low-income women? The study is based on case studies of 10 low-income women attending a community college. Results indicated that EITC, food stamps, and subsidized housing are stable sources of funding. However, each of these programs requires different application processes and compliance regulations. Only the Pell Grant was viewed as a dependable source of funding for college costs. Participants expressed confusion and frustration over the many varying regulations amongst programs.

Key words: welfare reform, social programs, postsecondary education, poverty, mothers, parenting

Prior to 1996, Aid to Families with Dependent Children (AFDC) gave some low-income mothers an opportunity to attend college by providing direct-cash subsidies to finance living expenses. However, critics of the program believed the unlimited time frame for receiving the aid and the loose work requirements resulted in a general work disincentive. In 1996, criticism reached critical mass and the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) was passed; the resultant direct-cash subsidy program replacing

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AFDC was Temporary Assistance to Needy Families (TANF). AFDC was regulated and administered through the United States Department of Health and Human Services (HHS); however, PRWORA changed the administration of the direct-cash subsidy by giving regulatory discretion to states with oversight and funding from HHS. The cost of the welfare entitlement grant was cut in half, the number of recipients using the program was cut in half, and the monetary support for women seeking postsecondary education was largely eliminated. Since the passage of PRWORA, researchers have argued that the reform is a disincentive for college attendance. Specifically researchers have argued the work-first rules in TANF pressure poor women to find low-paying, inflexible jobs in lieu of education (e.g., Adair, 2001; Christopher, 2005; Kahn & Polakow, 2002; London, 2006; Shaw, 2004).

Before and since PRWORA, when studying college participation by low-income mothers, researchers have largely focused on a single program, TANF (or AFDC), rather than studying the entire policy environment (e.g., London, 2006; Pandey, Zhan, & Youngmi, 2006; Shaw, 2004; Zhan & Pandey, 2004). For example, using the National Longitudinal Survey of Youth (NLSY) data, which spans from 1979 to 1998 or pre-welfare reform, London (2006) studied welfare spells for women and found that many women cycle on and off welfare, and welfare spells corresponded with college attendance for only a small percentage of women. London (2006) noted that most women attending college while on welfare only received welfare for one spell and not for the entire college enrollment period, and few women were still receiving welfare aid at the time they graduated from college.

Despite the educational disincentives in TANF and the evidence that women enrolled in college are not receiving welfare, low-income mothers are attending college in significant numbers, especially community colleges (Goan & Cunningham, 2007; Wei, Nevill, & Berkner, 2005). Therefore, I wondered how low-income single mothers are financing college and living expenses in the post-welfare reform era.

This article follows previous work on TANF and AFDC by asking if not welfare, then what social programs and financial aid programs are low-income women using to support their

college attendance, and what is the impact of these programs on the college-going decisions of low-income women? In order to answer these questions, I collected case studies of 10 low-income women attending a community college. Specifically, the study's purpose is to illustrate which government and institutional programs low-income, single mothers used and which programs were important to their individual decision making while attending college. Operating from a pragmatist paradigm, including the assumption that findings are historically situated, this research combined a three-interview series with extensive document analysis to illustrate the complex policy environment for low-income women attending college (Creswell, 2007; Denzin & Lincoln, 1994; Seidman, 2006; Stake, 1995).

Low-Income Mothers' Participation in Higher Education

The largest poverty sector in the United States is women with school-aged children (Brady & Kall, 2008; Current Population Survey [CPS], 2007), and poverty is especially severe in rural areas (Fisher, 2007). Part of the rationale behind PRWORA was that having a job, any job, would help women become self-supporting (Shaw, 2004). Yet, research has demonstrated that poverty is associated with low educational or low skill levels, low-wage occupations, and a lack of economic opportunities in rural areas (Fisher, 2007; Lichtenwalter, 2005), all suggesting that employment alone will not substantially or permanently improve the economic condition of poor women. However, when low-income women earn a college degree, their economic condition improves significantly (Attewell & Lavin, 2007; London, 2006; Pandey, Zhan, & Youngmi, 2006; Zhan & Pandey, 2004), so understanding how programs influence the college-going decisions of low-income mothers is an important aspect of reducing female poverty in the United States.

One clear aspect of mothers' college decision-making is that their primary motivations revolve around their children. Specifically, they want to provide a better life economically and they want to role-model college attainment (Attewell & Lavin,

2007; Bloom, 2009; Christopher, 2005; Jennings, 2004; Luttrell, 1997). However, once enrolled in college, women struggle to manage the conflict between care-giving and studying. Part of this conflict is in negotiating their program-related obligations while attending classes and studying (Bloom, 2009; Christopher, 2005; Kahn & Polakow, 2002), illustrating the need for more research on the policy environment for these women.

Case Study Methods and Data Sources

Case Study

In general, this is an illustrative multiple case study operating from a pragmatist paradigm (Denzin & Lincoln, 1994; Stake, 1995). Researchers operating from a pragmatist paradigm are focused on “what works” thinking and see research as historically located (Creswell, 2007; Stake, 1995). Stake (1995) noted that the pragmatist paradigm operates well with case study methods. In their books on case study methods, Yin and Stake noted that case study researchers seek to understand “a complex social phenomena” (Yin, 2003, p. 2) or “a complex functioning thing” (Stake, 1995, p. 5), such as policy environments. A policy environment was understood to be the value-laden societal response to a public problem often enacted through public programs, like TANF or AFDC (Fowler, 2004). For this study, the policy environment is the collection of public programs, both financial aid and income-related programs, used by low-income, single mothers attending college. The policy environment for low-income women is historically located, complex, and both a social phenomenon and a functioning thing. In addition, both Stake and Yin view case studies as appropriate for studying people or individual decision making, as it is in the purpose of this study.

Because low-income women have a significant amount of personal choice regarding which programs they will use, each woman was viewed as an individual case. As a multiple case study, the policy environment and decision-making for each woman was analyzed as a separate case before conducting cross-case analysis (Stake, 2006).

Data Sources

Initially, I constructed a list of 36 low-income women whose circumstances were known to me through my work as a faculty member at the community college these women were attending. I then reduced the list to women I knew to be mothers. The women were contacted and asked questions related to the criteria for the case study. Fourteen women signed informed consent letters; however, four of the women dropped out of the study after one or more interviews. Ten women completed the three-interview series (Seidman, 2006) and provided the necessary documentation to triangulate criteria and to understand their policy environment. All of the names used in this study are pseudonyms.

Boundaries or Criteria

In defining the case to be studied, researchers should name the boundaries around the case (Creswell, 2007; Stake, 2005), the unit of analysis (Yin, 2003), or, more generally, the criteria for inclusion in the study. Yin suggested relying on the research questions to define boundaries or criteria for inclusion in the case. For this study, the research questions are related to low-income, single mothers attending college. As a result, the boundaries or criteria for the cases are: (1) low-income; (2) single mothering; and, (3) college attendance (see Table 1).

Table 1. Boundaries

| Name | Age | Marital status | # of Children | Pell | EITC | Poverty |
|----------|-----|---------------------|---------------|------|------|---------|
| Kate | 30 | never married | 2 | Yes | Yes | Yes |
| Rose | 38 | 1 divorce | 3 | Yes | Yes | Both |
| Nicole | 26 | never married | 1 | Yes | Yes | Yes |
| Anne | 28 | married/separated | 1 | No | Both | No |
| Charlene | 21 | never married/cohab | 1 | Yes | Yes | Yes |
| Carol | 29 | never married/cohab | 1 | Yes | Yes | Both |
| Betrice | 22 | never married/cohab | 2 | Yes | Yes | Yes |
| Chelcy | 42 | 2 divorces | 3 | Yes | No | Both |
| Helen | 48 | married/separated | 2 | Yes | Yes | No |
| Marie | 33 | 2 divorces/cohab | 3 | Yes | Yes | Yes |

*Both indicates that during part of the college enrollment period under study the boundary was met and during part of the enrollment period the boundary was unmet.

The criterion of low-income was measured in three ways: (1) the poverty threshold; (2) receiving an Earned Income Tax Credit (EITC); and (3) receiving a Pell grant. In 2006, the United States poverty threshold for a mother and two children was \$16,242 a year (CPS, 2007), and 36% of single female householders lived at or below the poverty threshold (CPS, 2007). However, the poverty threshold is based on the notion that households spend one-third of their income on food, although modern households spend much less than this; therefore, many researchers view the poverty threshold as too low (CPS, 2007). Nonetheless, five of the participants were living under the poverty threshold during the entire college enrollment period under study and three of the participants were living under the poverty threshold for part of the college enrollment period under study (see Table 1).

EITC is a tax credit directed at supplementing the income of low-wage workers (Internal Revenue Service [IRS], 2009) and the legislation for this credit was passed soon after the enactment of PRWORA. It has replaced AFDC as a source of income for low-income Americans (Christopher, 2007); however, in order to receive the tax credit, you must earn some income and file income tax forms. Given the research demonstrating that one outcome of PRWORA was to force women into low-wage employment (e.g., Shaw, 2004), using EITC as a criterion for low-income was important. Whenever possible, tax forms or IRS refund/credit check stubs were collected to confirm this boundary. In other cases, the participant's Adjusted Gross Income (AGI) was taken from the Institutional Student Information Record (ISIR), or the report the institution receives after the student completes the Free Application for Federal Student Aid (FAFSA) was compared to the IRS' EITC tables for the appropriate year. Eight of the participants received an EITC during the entire college enrollment period under study and one participant received an EITC during part of the college enrollment period under study (see Table 1).

Finally, the Pell Grant is a federal college grant program directed at reducing the cost of college for low-income Americans (U.S. Department of Education, 2009). Pell status was confirmed by reviewing the ISIR and a report generated by the financial aid department at the institution called, "Session

Billing Information for [Semester and Year]." This report detailed charges including tuition, fees, and bookstore charges, payments, all grant and loan aid listed by type, and refunds per semester. Nine of the participants received the Pell Grant during the college enrollment period under study (see Table 1).

Although defining *mothering* was a fairly simple matter of deciding that the women studied would need to be the biological mother and primary caretaker of a school-aged child, defining *single* was more complicated (Yin, 2003). As I spoke with the women over the phone, I found a number of differing living circumstances, including cohabitating and sharing household resources and married but living separately and not sharing household resources. These phone conversations revealed that at times the decision to cohabitate rather than marry had social program implications, as did the decision not to divorce, and often the decisions were related to income, the second boundary. As a result, I chose to study this criterion by choosing cases along the wide spectrum of single (see Table 1). Two of the women included were legally married, but financially separated from their spouse at the time of the study.

The final criterion for this study was being enrolled in the same rural community college in a Midwestern state. Most of the participants enrolled in postsecondary education right after high school. Specifically, seven participants, Kate, Rose, Anne, Charlene, Nicole, Carol and Beatrice, were college-ready upon high school graduation. Three of the participants, Chelcy, Helen, and Marie, were not college-ready upon high school graduation; rather, they considered college a possibility only after many other life experiences. Table 2 depicts the academic standing of the participants.

Data Collection

Patton (2002, p. 245) wrote, "the validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the *information richness* [emphasis added] of the cases selected ... than with sample size." For each case, I combined interview data with document analysis to create a rich case study of the policy environment for the women. I used Seidman's (2006) three interview series: focused life

history, details of the case, and personal meaning, especially as it related to decision making.

Table 2. Academic Standing of Participants

| Name | ACT | GPA | Complete credits | Developmental credits | Degree earned |
|----------|-----|-----|------------------|-----------------------|---------------|
| Kate | n/a | 3.2 | 64 | X | Yes |
| Rose | 23 | 3.6 | 57 | X | |
| Nicole | 15 | 1.7 | 28 | X | |
| Anne | 21 | 3.2 | 59 | | |
| Charlene | 17 | 3.1 | 45 | | |
| Carol | 16 | 2.6 | 45 | X | |
| Beatrice | 18 | 2.3 | 73 | X | Yes |
| Chelcy | n/a | 3.7 | 77 | X | Yes |
| Helen | 21 | 3.3 | 42 | X | |
| Marie | n/a | 2.3 | 32 | X | |

After receiving informed consent, I began working with the financial aid office and the registrar's office to collect documents related to college attendance (i.e., transcripts) and financing (e.g., see Table 3). A public database for court records was utilized to find information related to divorce settlements (including child support awards), default lawsuits related to healthcare bills, and criminal records. Prior to the second interview, I contacted participants and asked them to bring documents that they felt were particularly relevant to their case. The women provided documents such as tax forms, health provider bills, insurance bills, communications with social services case officers, and food stamp award statements. Not all of the participants agreed to have these documents copied; however, in those instances I was able to take notes from the documents. During the second interview, the women were asked about many of the documents and records collected. Each participant was asked about her decision-making relative to program participation.

By collecting documentation in addition to interviewing, I was able to identify complexities and evolutions in the policy environment for these single mothers. Many of the mothers found their policy environments changed significantly during college enrollment. For example, Rose's year one ISIR listed an AGI of \$25,573, while her year two ISIR listed an AGI of *negative* 1,451 dollars. She moved from above the poverty threshold for a mother with three children to significantly

below the threshold in a matter of months. Marshall (1999, p. 64) observed that “[p]olicy formulations seldom incorporate complexity,” and researchers often study individual programs isolated from other programs, rather than studying a policy environment. One of the great strengths of combining document analysis with interviewing through case study methods was that I was able to study the complex policy environment of 10 single mothers attending college.

Table 3. College Financing for Participants During Their First Year of College

| Name | AGI | EFC | Tuition/ fees | Pell | Student pay | Other non- loan | Loan aid | Cash |
|----------|----------|---------|------------------|---------|----------------|-----------------------|-------------|---------|
| Kate | \$4,358 | \$0 | \$3,327 | \$3,949 | \$0 | \$708 | \$5,864 | \$7,195 |
| Rose | \$25,573 | \$9 | \$2,355 | \$2,431 | \$0 | \$450 | \$4,162 | \$4,688 |
| Nicole | \$10,815 | \$0 | \$2,566 | \$2,025 | \$1,230 | \$150 | \$0 | \$839 |
| Anne | \$42,958 | \$4,081 | \$2,802 | \$0 | \$2,502 | \$300 | \$0 | \$0 |
| Charlene | \$1,649 | \$0 | \$3,275 | \$4,050 | \$0 | \$300 | \$0 | \$1,075 |
| Carol | \$16,679 | \$47 | \$1,370 | \$1,500 | \$560 | \$0 | \$0 | \$690 |
| Betrice | \$2,990 | \$0 | \$2,227 | \$0 | \$124 | \$2,122 | \$0 | \$19 |
| Chelcy | \$22,680 | \$0 | \$2,749 | \$3,916 | \$100 | \$200 | \$0 | \$1,468 |
| Helen | \$18,548 | \$0 | \$1,286 | \$2,025 | \$50 | \$100 | \$0 | \$889 |
| Marie | \$12,927 | \$0 | \$3,176 | \$4,050 | \$100 | \$800 | \$0 | \$1,774 |

Data Analysis

All of the interviews were transcribed verbatim and analyzed from a single-case perspective and from a cross-case perspective. Program participation was triangulated through document analysis. Because I was interested in decision-making, I analyzed cases by building explanations of decision-making for each participant (General Accounting Office [GAO], 1999; Yin, 1994, 2003) within the context or historicity of that participant's life. Individual case analysis occurred at all stages of the research process. Before interviewing began, I studied common programs used by low-income mothers. As document analysis revealed a new program, I sought to understand how the program goals were translated into compliance

regulations at the local level and whether these compliance regulations influenced the college-going decisions of low-income single mothers. All the participants were asked about all the programs captured whether they participated in the program or not, and worksheets that tracked program influence were developed for each case. When gaps arose between interviews and documentation, the participant or the appropriate social services agency was contacted to resolve the gap by explaining a program guideline or by providing an additional document. In sum, individual case analysis was an intuitive and recursive process that was focused on explanation building. Why and how did the participant make the college-going decisions she made?

For cross-case analysis, I developed a matrix combining case findings and cross-case themes. I relied on rival explanations to understand the prevalence of themes across cases (Stake, 2006; Yin, 1994, 2003). I did not approach cross-case analysis of themes from a quantitative perspective, rather I sought to maintain historicity or situationality. As such, some cross-case themes were present in few cases (Stake, 2006).

Findings: The Complex Lives of Low-Income Mothers

The 10 participants were enrolled in 20 different program initiatives at the federal, state, and institution level during college enrollment: nine were non-education programs, and 11 were education programs. Program participation is illustrated in Table 4 and Table 5.

Illustrating Work and Income-Related Programs

Across cases, the women's decisions related to non-education programs involved a complex mix of values and circumstance. Although all of the women appeared to be trying to make informed and deliberate decisions that supported their educational goals, I found that many of the women were confused and/or wrongly-informed about program guidelines. The complexity of the policy environment was overwhelming. In addition, because non-education program benefits are largely guided by income calculations, the decisions the women made concerning paid employment were important to whether they would qualify for non-education programs.

In no case did a participant generate a living-wage using social programs without working at paid employment. In this section, I discuss work motivations and illustrate the non-education programs captured in the study by discussing important program guidelines, the extent to which the women used the program, and whether the program affected educational decision-making.

Table 4. Program Participation

| Non-education Programs | | Education Programs | |
|------------------------|---|----------------------------|---|
| TANF | 2 | Pell Grant | 9 |
| EITC | 9 | Federal SEOG | 6 |
| Food Stamps | 7 | Federal Loan | 4 |
| Subsidized Housing | 2 | Work Study | 4 |
| WIC | 5 | Access (State) | 5 |
| Medicaid | 3 | New Traditions Scholarship | 2 |
| MC+ | 9 | TEACH Scholarship | 1 |
| Head Start | 3 | HRSA Scholarship | 1 |
| Childcare Subsidy | 1 | Presidential Ambassador | 2 |
| | | WIA | 3 |
| | | GAMM | 3 |

Table 5. Program participation listed by participant

| | Non-ed Programs | Education Programs | Total Programs |
|----------|--------------------|-----------------------|-------------------|
| Kate | 8 | 4 | 12 |
| Rose | 6 | 10 | 16 |
| Nicole | 5 | 2 | 7 |
| Anne | 1 | 3 | 4 |
| Charlene | 4 | 1 | 5 |
| Carol | 3 | 1 | 4 |
| Betrice | 5 | 4 | 9 |
| Chelcy | 3 | 2 | 5 |
| Helen | 4 | 7 | 11 |
| Marie | 2 | 6 | 8 |
| Average | 4 | 4 | 8 |

Work. All of the women were employed during college enrollment; however, while enrolled they changed jobs and had

periods of unemployment. Although four of the women were employed for some period of time in a work-study position, Rose was the only participant who relied on work-study as her only source of income. Reasoning that off-campus employment would generate more income, the other nine women sought employment off campus.

Across cases, the women interviewed were motivated to work, and, at times, their decision-making stemmed from a desire to generate a living wage or to avoid the use of social programs. Anne, who worked full-time while attending college said, "Hard work is very important to me." However, she worried "that I'm going to be replaced at any moment by anybody off the street." Earning a college degree was tied to her desire to earn a living wage and have secure employment.

I also found that sometimes the participants' work decisions stemmed from a desire to gain specific work experience or to contribute to an organization or a cause. Generating an income was only one aspect of the motivation to work and not always the most important aspect. Anne and Rose sought out work-study positions that gave them an opportunity to tutor students, reasoning that the tutoring experience would be helpful in accomplishing their goals of becoming teachers. In addition, Rose volunteered at her children's school reading books to children in an after school program, and she was actively involved in her church. These activities did not generate a substantial wage, yet all of them contributed to her accomplishing her educational goals.

At times the decision not to work was connected to college requirements. For instance, Helen was the oldest participant in the study at 47, and has lived most of her adult life struggling to earn enough income to meet her family's needs, which often meant using social programs. At the time of the study, Helen lived in subsidized housing and relied on food stamps to buy groceries for herself and her teen-aged daughter. During the interview series, she quit her school-bus-driving position because it conflicted with the clinical requirements for her nursing degree.

Department of Social Services. Each county's Department of Social Services (DSS) administered five social programs: TANF, Food Stamps, Medicaid, MC+, and the Childcare Assistance

Program. However, each program is administered through separate divisions of DSS. With the exception of Medicaid and MC+ which use a common application form, the programs had different application forms, and all of the programs had different income calculations and different compliance regulations.

Two of the women received TANF briefly (i.e., less than 6 months) while enrolled in college, and TANF provided the estimated amount of child support while the state took legal action against the father to collect child support. For three of the women in the study, the risk to their child's well-being was too great, and the benefit too little. As noted by other researchers, I found that TANF funding did not provide a pathway to college for low-income mothers.

All of the women in the study had applied for food stamps at some point in their lives, and seven of the participants received food stamps during college enrollment. However, the awards varied greatly from \$522 a month to \$86 dollars a month. To receive the aid, participants had to re-apply every six months, and case workers verified income amounts through employer paycheck stubs, child support enforcement officials, or statements directly from fathers verifying how much child support they provide. In addition, if a woman cohabitates, the income of the cohabitating partner is considered part of the household income and reduces food stamp benefits. Beatrice chose to indicate that she did not cohabitate, although she did, in order to maximize her food stamp benefits.

Food stamps proved to be an important aspect of managing living expenses while attending college and without them many of the women felt the pressure to work more hours would make managing college enrollment difficult. Kate said:

It would be very difficult to be going to school and concentrating, keeping the focus until I'm done with school, knowing that even if some other things, if you're failing in some other areas, you have food there to feed your kids. That's a huge stress not to have to think about.

Across cases, the women relied on food stamps to buy groceries for themselves and their children.

MC+ is a Medicaid program for children which is administered by the state, and although nine of the participants used MC+ for healthcare insurance for their children, only three of the women were on Medicaid while enrolled in college. One of the three women (Beatrice) received Medicaid for her pregnancy-related expenses only. Importantly, paid employment at a for-profit enterprise counts as income in the income calculation for Medicaid, while income earned through a work-study position at a college does not. Earning more than \$350 per month from a for-profit enterprise makes the mother ineligible for Medicaid. Rose managed to obtain healthcare for herself through Medicaid by working at a work-study position.

Eight of the women spent all or some portion of their college enrollment period without healthcare insurance. For Helen, the lack of health care will prove to be a significant barrier to degree attainment, because a newly-passed regulation requires student nurses to have health insurance while taking clinical courses. Yet, for most of the women, not having health care insurance was the norm. Beatrice told this story:

When I had a car wreck this semester 'cause I fell asleep driving, I didn't go to the hospital 'cause I knew I wasn't insured. So the next day I was ... my neck and back was hurting really bad, so I went to the walk-in place at [college town]. They wouldn't accept me unless I could pay. I just didn't have the money, so I couldn't see a doctor. I didn't have any insurance.

Six of the women in the study had healthcare-related debt, and two of the women were sued by hospitals to collect healthcare bills. Many of the women reported having poor credit because of healthcare-related debt.

The Childcare Assistance Program is based on income and a sliding fee scale. Participants must locate a childcare provider who participates in the program and re-apply annually, including having their income verified. Only Rose used this program to pay for daycare for her youngest child. This study was conducted at a community college without daycare facilities. However, the women who participated in the study had school-aged children and obtained daycare through Head Start, friends or family.

EITC. EITC provided a maximum of \$4,000 per year (at the time of the study) depending on the amount of income generated from working. This credit is administered through the IRS and is based on AGI and the number of dependents. It is commonly dispersed through employer paychecks, so women may apply to receive the tax credit at the beginning of the year and have the money added to their paycheck by their employer throughout the year. Importantly, the amount of the credit increases as wages increase in low-income brackets and decreases as wages increase in higher income brackets. I found that EITC was an important mechanism for supplementing income, and many of the women related EITC to college-going expenses. Charlene likened it to “savings” saying, “if my car breaks down, I’ll have money to fix it.” Marie called EITC “extra money for gas to get back and forth to school.” Nine of the participants received EITC; only Chelcy did not because she did not file income tax forms, not because she did not met the income guidelines.

Subsidized housing. Only two women used subsidized housing, which is administered through the Housing Authority. This service requires participants to re-apply annually and have home inspections performed annually. Inspections include housekeeping, compliance with fire codes, and maintenance issues. The Housing Authority verifies income eligibility by contacting employers and/or government agencies. Once approved to move into subsidized housing, the resident must attend a briefing session where the compliance regulations are covered. When asked if she would be in college without subsidized housing, Helen replied, “No, I couldn’t afford to live right now without that, because if our income changes, it goes down. It goes according to your income.” Kate said, “It helps financially because you’re provided with a roof over your head and you know that at least the rent’s going to be paid. So you have food and a place to be.” While only two of the women used subsidized housing, for them it was an important aspect of managing work, college, and family.

WIC. WIC is administered through the Health Department and is available for women with infants. Of the five women who had received WIC, only three received WIC while enrolled in college. WIC requires an annual application process

with income verification through employers or government agencies. In addition, participants must attend monthly nutritional training sessions. WIC closely stipulates what can be purchased. Five of the participants used WIC while enrolled in college, however, none of them connected WIC to college-going decisions or talked about WIC as critical for obtaining food for their children. Charlene said, "I don't know if it helped [with college attendance]. It didn't help. I mean it's money that I have extra. I guess it helped in a way." Charlene went on to indicate that WIC is perceived more positively than food stamps, saying, "Teachers and stuff have been on WIC."

Head Start. The final income-related program captured in the study was Head Start, which is administered through the Department of Health and Human Services. Three participants used the program, which requires an annual re-application form including income verifications. Kate said,

They provided me with a family resource advocate who was very supportive. They did home visits, educational materials. A lot of what she did with me was reassuring me that it's okay that you're taking your kid to somebody else, because you're doing a good thing. Day care is extremely expensive. And that made that part free.

Although few participants used the program, the ones who did felt the program helped them attend college and parent simultaneously.

In sum, nine non-education-related programs were captured by the study. TANF and EITC provide cash assistance; EITC, food stamps, and subsidized housing are potentially permanent sources of aid. The participants positively connected their ability to maintain college enrollment with food stamps, EITC, subsidized housing, and Head Start. However, each of these programs has a different application process and compliance regulations, and the participants frequently expressed confusion or frustration about program guidelines. For Kate, who was enrolled in eight income-related social programs, she filed separate forms annually or bi-annually to enroll and re-enroll in seven of them, including a yearly inspection of her housekeeping and monthly meetings at the WIC office.

The women did not articulate a connection between college-going decisions and healthcare. However, I noted two important connections. First, the women in the study did not seem to be aware that earning a few hundred or a thousand dollars more a year at a nursing home position, rather than through work-study, meant that they were choosing income over healthcare. Only Rose understood the income calculation for Medicaid and understood that she could obtain Medicaid by working at a work-study position. However, Rose also understood that this decision decreased the amount of her EITC. Second, as will be discussed again in the section on education programs, although the education loans were available to the participants, even if they had bad credit scores, the women were not willing to take on additional debt to finance college. Part of this reluctance seemed to stem from past experiences with healthcare related debt.

Illustrating Education Programs

As with most colleges, the formula for student financial aid is to take the estimated cost of attendance, subtract the expected family contribution (EFC), grants and scholarships to arrive at the need for aid. If the student desires a loan, this difference is extended to the student in the form of federal loans. Table 3 illustrates the education-related finances for the participants in their first year of college enrollment. The Adjusted Gross Income (AGI) for the participant is income from the year previous to college enrollment. The exception to this is Chelcy, who did not report her income on her FAFSA because she did not file taxes, so her EFC may have been higher had she reported this income. Beatrice filed as a dependent in her first year of enrollment; in her second year, she lost her music scholarship, filed as an independent, and began receiving the full Pell Grant. All of the women except Anne received added income over and above their tuition and fees, and only two of the women took out federal loans, although all of them qualified.

Pell Grant

The Pell Grant was the most important program mechanism for individual decision-making about college. For the

community college in this study, the maximum Pell Grant award was more than enough to pay for all tuition and fees. Nine of the 10 participants received a Pell Grant, and all nine indicated that attending the community college would either have been impossible or difficult without the Pell Grant. Rose said, "If I didn't have Pell, I wouldn't be in school." Likewise, Kate indicated, "Absolutely it [Pell Grant] has helped me. It [attending college] would just not even be possible."

However, because the Pell Grant is not sufficient to pay for the tuition and fees at a baccalaureate institution, the women in this study were unsure how they would finance the rest of the baccalaureate degree. They were unwilling to take on additional debt. A few of the participants had academic records that would make them competitive for scholarships, but they did not see scholarships as a dependable avenue of access to baccalaureate completion.

Educational Loans

Many of the women were reluctant to view loans as a means for financing college. For example, I asked Carol, "If the only way would have been loans, do you think you would have gone?" She replied, "It would have been less likely because it would be just another bill to have to pay. I didn't really need that." In commenting on the Pell Grant and loans, Charlene said, "Pell Grants definitely made me want to go to college a little more because I don't have that worry about loans like everybody else," and Chelcy said, "I really didn't want something to pay back later." Several of the women named their existing debt load as a reason for not taking out student loans, and there was evidence of financial strain, including criminal charges for passing insufficient funds checks.

The Federal Supplemental Educational Opportunity Grant (SEOG) and Access

Six women received the Federal Supplemental Education Opportunity Grant (SEOG) and five women received the Access (State) grant. However, because neither are a significant amount of money and both are awarded after the start of semester, the women receiving the grant either did not know they had received it or did not know why they had received

it. Rose said, "That one just kind of showed up. I actually had asked them [financial aid] what it was. This keeps showing up. What is it? I like it. Don't take it away," and Anne commented, "I'm not even sure how I got that. I mean I didn't ... I was shocked when I got it. I didn't even know I had it until I got my bill, and I was like where did this come from?" Both grants were distributed through an in-house process after the start of the semester.

Institutional Scholarships

There were four small scholarships captured in the study: New Traditions, TEACH, HRSA, and Presidential Ambassador Award scholarships. All of the mothers applied for the scholarships or were aware they were a possibility. However, the awards were small, ranging from \$100 to \$500, and like SEOG and the state grant, they were awarded after the participant had already made college-going decisions. Across cases, the participants indicated that the awards were helpful. Comments like "It all helps to make it work" were typical. However, they did not influence the decision to enroll in college or the decision to re-enroll in subsequent semesters, because the women did not view them as dependable sources of aid.

Workforce Investment Act (WIA) and GAMM

As with SEOG, Access (State), and scholarships, WIA money was not substantial and was awarded after college-going decisions were made. However, Helen viewed the money as important because it paid for unexpected education-related expenses. She said, "It pays for things that had to like come out of pocket money, like my nursing uniforms, shots that we had to get, shoes we had to get, stethoscopes, all that kind of stuff." Likewise, Kate felt the money was important. However, she did not view it as dependable. She said:

For awhile they did provide funding for my books. They provided me with gas for mileage. They were going to provide so much for tuition and books and they would do a needs assessment type thing. If you were needing vehicle repair or you got a shut off notice or something like that, they were going to be able to

help with that. I didn't see any of that. And I did need vehicle repair.

In sum, only the Pell Grant was viewed as a dependable source for college tuition, fees, and expenses and part of college related decision-making. Although all of the women received other forms of aid that amounted to thousands of dollars, it was generally dispersed a few hundred dollars at a time, and the women were either unaware the money was available or unaware of the guidelines for receiving it.

The Case of Rose

Because Rose participated in the greatest number of programs, she provides an ideal way to view enacted programs. In her second year of college, Rose's adjusted gross income (AGI) in 2006 was negative \$1,451. This number is the basis for her FAFSA calculations for the 2007-2008 school-year, so her estimated family contribution (EFC) was zero, meaning Rose was eligible for the maximum amount of student aid. Table 6 depicts Rose's financial aid status during the calendar year of 2007, during which time Rose was enrolled as a full-time student during the spring, summer, and fall. It seems Rose benefited financially from college enrollment. Not only did she receive more than enough aid to pay for tuition and fees, she received enough aid to have \$10,703 in income to pay for living expenses.

As well as income from school-related programs, Rose was enrolled in a number of non-education related programs in 2007. Table 6 depicts her benefits from these programs. TANF and child support were grouped together because the state was willing to pay TANF in the amount of her expected child support award until she settled in court and began receiving the child support money (3 months).

Rose's non-education related aid amounted to \$14,112, including \$4,098 dollars of cash aid and child support. Her non-education aid added to her education aid amounts to \$28,940. This sum does not include the cost of Medicaid and MC+ for her and her three children; it does not include a tuition deferral for the private elementary school that two of her children attend or the free and reduced lunch benefit the children

receive at school; and, it does not include her EITC. At first glance, it appears the system generously supported Rose while she attended school.

Table 6. The Case of Rose

| | | |
|----------------------------------|-----------|----------|
| Financial Aid Revenue | | |
| Grant and Scholarship Aid | \$ 5,971 | |
| Loan Aid | \$ 5,934 | |
| Work-Study Income | \$ 2,923 | |
| Total revenue from financial aid | | \$14,828 |
| Less Tuition and Fees | \$(4,125) | |
| Cash refund from financial aid | \$10,703 | |
| Non-Education Aid | | |
| Food Stamps | \$ 6,264 | |
| TANF and Child Support (cash) | \$ 4,098 | |
| Child Care Subsidy | \$ 3,750 | |
| Total Non-Education Related Aid | | \$14,112 |
| Total Aid | | \$28,940 |
| Total Cash Aid | | \$14,801 |

However, from Rose's perspective the financial struggle to attend college was almost insurmountable. Rose had two major outlays each month: her mortgage and car payment. Her mortgage payments amount to \$10,392 a year. Rose did not intend to sell her house because there were several repairs that needed to be made, and in the existing poor real estate market, she was afraid she could not cover her mortgage loan by selling. As well, Rose paid \$3,960 a year in car payments. The total of these two outlays for 2007 was \$14,352, and the total cash income available to her in 2007 was \$14,801, leaving Rose \$449. Rose received the maximum EITC for the 2006 tax year of more than \$4,000 that helped pay living expenses, so Rose's cash monies for gas, utilities, clothing, and other expenses (e.g., extra-curricular activities for her children) was \$4,475 for the year or about \$373 per month. When Rose explained to her children that she could not buy Christmas presents, her food stamp benefit of \$522 a month acted as the proxy for presents.

She said,

In November, I had been warning them that we probably wouldn't have a Christmas with gifts. We were going to do decorations, and we were going to bake because I had food money. We can do anything with food. We can feed everybody, but we can't do gifts.

The Case of Carol

In contrast, Carol participated in very few programs while enrolled in college. From fall 2003 to spring 2007, Carol maintained part-time enrollment at the community college accumulating 45 credit hours. Table 7 depicts her financial award circumstances during this time frame, including her adjusted gross income (AGI). In 2003-2004, Carol earned above the federal poverty threshold for a single mother with one child. During the remaining years, she lived under the poverty threshold. Carol was eligible for social programs, like food stamps and housing vouchers, throughout this timeframe. As discussed in the earlier section on financial aid awards, unmet need is calculated by adding the cost of tuition and fees to average living expenses in the college's area and subtracting the student's estimated family contribution, an amount derived from the FAFSA. The second column of Table 7 shows Carol's unmet need during the four years she was enrolled in college courses. In all but one year, her Pell grant award exceeded the cost of tuition and fees, so it was refunded to her to be applied to living expenses. The final column, "Unmet Need less Pell," shows the amount she could have borrowed in subsidized student loans, but opted not to borrow.

While attending college, she worked full-time with no health benefits at a nursing home; she worked on Tuesdays, Thursdays, Saturdays, and Sundays, while taking classes on Mondays, Wednesdays, and Fridays. When I asked about healthcare, she said, "Paid for it or didn't go." Her income was largely dependent on the number of overtime hours she worked, as determined by her employer. Typically, she and her daughter could live on between \$1,000 and \$1,300 a month.

Carol lived in a trailer on her grandmother's land in a remote part of the community college's service region. She commuted

more than two hours a day or 60 miles to and from the community college, so her commuting costs, including a car payment, car insurance, and gas, were a large part of her monthly budget. Her grandmother provided a significant amount of additional support, from living expenses to child care. The father of her daughter paid no child support. However, Carol was unwilling to seek it, given he might also receive visitation rights. At the time of the study, he was serving a sentence in the state penitentiary for a drug conviction.

Since Carol enrolled in only four programs during her college enrollment period (i.e., Head Start, MC+, Pell grant and EITC), I asked why she did not make greater use of social services or educational loans in order to manage college attendance. She replied, "Because I think that it's important to me that I bring in the money. I can pay my bills myself. It makes me feel good that I'm doing that. I'm a mom." However, Carol was unable to manage her work responsibilities and successfully complete her coursework, so she had opted to drop out of college. During our final interview, she expressed an interest in enrolling in an online program at a for-profit college, although she had no definite plans. Her new position was full-time with health insurance. She said, "Oh yea, I have wonderful insurance. Excellent. It pays for everything." Depending on the number of hours she worked, she expected to earn between \$19,000 and \$24,000 for the year. For Carol, this was a substantial increase in her yearly income. However, she will still qualify for the EITC, an indicator of financial strain. When I asked her about EITC, she said, "Yea. I should still get it this year too." Carol's refusal to use social programs and financial aid programs to pay living expenses while attending college appears to be an important aspect of her drop-out decision.

Table 7. The Case of Carol

| Academic year | AGI | Unmet Need | Tuition & Fees | Pell award | Difference (refund) | Unmet Need less Pell |
|---------------|----------|------------|----------------|------------|---------------------|----------------------|
| 03/04 | \$16,679 | \$ 9,907 | \$1,370 | \$1,500 | (130) | \$ 8,407 |
| 04/05 | \$13,456 | \$ 9,330 | \$1,138 | \$1,013 | 125 | \$ 8,317 |
| 05/06 | \$13,049 | \$ 9,112 | \$1,561 | \$2,025 | (464) | \$ 7,551 |
| 06/07 | \$11,943 | \$14,122 | \$2,090 | \$2,535 | (445) | \$11,587 |

Discussion and Conclusion

Related to non-education programs, the overarching finding of this study was the overwhelming complexity of the policy environment. One participant said, "It's just such a hassle," while another commented on compliance regulations by saying, "yadda, yadda, yadda." In this study, I reported eight different income calculations with nine different sliding scales for benefits and nine different sets of compliance regulations. Contained in all the complexities are important choices related to the quality of life for the participants, like income or healthcare.

Related to education programs, the overarching finding of the study was that the mothers were unaware of the aid available to them through federal programs like SEOG and WIA. These hidden initiatives benefited the participants like a gift, but they did not influence enrollment decisions. The result of both complexity and gift-giving was that mothers were not empowered with the information necessary to make knowledgeable and deliberate program choices.

Low-income mothers do not need another program initiative that pays for the occasional broken muffler or a new printer; rather, they need policy leaders to clean out the pathway to college by reducing the complexity of financing and informing mothering students of potential college-related financing before the decisions related to enrollment are completed. Neither case workers nor financial aid advisors were aware of the complex array of programs that applied to low-income mothers in this study. It is likely that uncluttering the pathway to college will mean collaborations between federal departments, state and local social services agencies, community colleges, and universities. Such collaborations might enable the institution of higher education to assert a democratic influence in the struggle against poverty in the United States.

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Health Service Access for Rural People Living with HIV / AIDS in China: A Critical Evaluation

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The increasingly serious HIV/AIDS epidemic creates a significant burden for the public health system; however, little attention has been paid to the issue of health service access in rural China. Based on a qualitative study of 34 Chinese rural People Living with HIV/AIDS (PLWHA) and 13 health providers, this study fills a gap by examining health service access from both the demand and supply-side. Utilizing access theory, this study explores the availability, affordability and acceptability of health services in rural China. Moreover, this study focuses on access barriers and institutional obstacles that PLWHA meet during their illness and considers the influence of the current Chinese political philosophy of marketization and privatization of the health care systems.

Key words: HIV/AIDS, access, PLWHA, health care, China

The HIV/AIDS epidemic is a growing social problem in China. As of the end of October 2009, the number of people living with HIV/AIDS (PLWHA) in China was reported to be a total of 319,877 (Chinanews.com, 2009). The estimated population at the end of 2009 was 1.334 billion (Juan, 2011), meaning that 2.396% of the population were reported as living

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with HIV/AIDS. Since it is estimated that only 20% of the total number of PLWHA was reported, the actual number of people affected by HIV is likely to be much greater than indicated in the above statistics (UNAIDS China, 2006). Even if China is able to keep new infection rates to 2-3%, similar to that of Thailand's success during the 1990s, the total size of the infected population would still be around 27.5 million by 2020 (Saich, 2006).

Measures dealing with the HIV/AIDS epidemic rely heavily on the health system for effective prevention and treatment programs, and this creates significant additional burdens for health service provision, health education, monitoring, logistics supply, and manpower specialization (Liu & Kaufman, 2006). Existing studies demonstrate how the marketization and privatization of health reform have weakened the Chinese public health system and have failed to provide high-quality, affordable, and equitable health services for the majority of the rural population (Farmer, 2006; Liu, 2004a, 2004b; Saich, 2006; Wang, 2004). More than 70% of PLWHA live in rural areas. However, there has been little evaluation of the capacity of China's weakened rural public health system to meet the pressing needs to offer an effective medical response to the AIDS epidemic, either in terms of prevention or treatment.

This study attempts to fill a research gap by examining health service access in two provinces in rural China (Anhui and Henan), from both supply- and demand-sides, and describes the challenges and access barriers that are faced by rural public health infrastructures in dealing with HIV/AIDS. The sheer size of the country and the different characteristics of different regions make it impossible to adopt only one strategy to deal with the epidemic in all different areas. This study critically evaluates the drawbacks, ineffectiveness, and unreliability of the existing rural public health system in combating HIV/AIDS under the guidance of "marketization/privatization" and "decentralization" of China's health policy.

Rural Health System in a Chinese Socio-historical Context

China was the first large nation in the world to develop a

nationwide rural health insurance system, in the Maoist Era. The township public health center, together with the Rural Cooperative Medical System (RCMS) and the barefoot doctor, were praised by the World Health Organization (WHO) as the “three magic weapons” in meeting the needs of rural populations, and received much publicity in the West. The RCMS was a community-based rural health financing and provision system which functioned as collective medical insurance in villages. Although schemes varied, families were usually asked to contribute about 2% of their annual income, and this was matched with money from the village’s welfare fund (Liu, 2004b; Zhang & Chen, 1996). ‘Barefoot doctor’ was a term that emerged in the mid-1960s, referring to a paramedical worker with basic medical training who worked in a rural district in China. Under the RCMS, barefoot doctors provided both Western and traditional Chinese medical care and many public health services (Blumenthal & Hsiao, 2005), and were subsidized by the government. By 1980, about 90% of production brigades (comparable to the present-day administrative villages) were implementing RCMS, forming part of a three-tiered (county, township, and village) health services network that combined prevention, treatment, and health maintenance with a formal bottom-up referral process for patients. This health revolution in the Chinese countryside basically realized the goal of “treating minor diseases in the village, and major diseases in the township.” The WHO and the World Bank praised the “Chinese model,” which allowed the greatest health benefits for the smallest inputs (Hillier & Shen, 1996; Liu, 2004a; Wang, 2004).

In 1985, a State Council document set out regulations allowing for “diversity of provision” in health care and licensed private medical practice, and promoted a multiplicity of types of ownership of facilities and methods of payment for health care. In rural areas, when China transformed its system of collective agricultural production to private production in the late 1970s, the RCMS collapsed immediately: vaunted barefoot doctors became unemployed and stopped providing public health services, for which they were no longer compensated. Nine hundred million rural peasants, mostly poor citizens, became, in effect, uninsured overnight. Under this situation,

some of the barefoot doctors became private health care practitioners with licenses, renamed "rural doctors" and "village doctors." Drug prescriptions are their main source of income, and obtaining fee-for-service is their daily practice.

The last twenty years have witnessed remarkable economic growth in China. However, China's performance in the field of public health has been disappointing. Though China's primary health care system was held up as the model in the call for "health for all by the year 2000" at the WHO's Alma Ata conference in 1978, China ranked 188 out of 191 countries in terms of fairness of financial contribution to health in 2000; in 2001, 21.6% of poor rural households fell below the poverty line as a result of medical expenses (Liu & Kaufman, 2006; Saich, 2006). As the financing and operation of hospitals in China has become increasingly privatized and marketized, inequalities in health care and health status have increased between rich and poor, rural and city, and between different regions. Moreover, health care providers have become less interested in public health work, as there is little or no remuneration for preventive service (Liu, 2004a). The three-level network of county-township-village health units for rural people has also been weakened because of twenty years of underinvestment in health in rural China (Saich, 2006), thus public health in rural areas has been neglected. For example, in some poor rural areas infant mortality has recently increased, while it has continued to fall in urban centers, and there has been a resurgence of some infectious diseases such as schistosomiasis, which was nearly brought under control in the past (Blumenthal & Hsiao, 2005).

The outbreak of SARS in the winter/spring of 2002-2003 alerted the Chinese government not only to the relative weakness of its rural medical system, but also to the dangers of epidemic, life-threatening infectious diseases that could undermine economic growth (Kaufman, Kleinman, & Saich, 2006; Saich, 2005; Wang, 2004). In late 2003, the Chinese government officially took a more practical and realistic stance than previously and announced a new national policy, "Four Frees and One Care," which includes the provision of: free antiretroviral (ART) drugs for all rural residents and poor people in cities; free counseling and testing services; free treatment for pregnant women and testing for their babies; free school fees for

children affected by HIV/AIDS; and financial support for affected families (State Council AIDS Working Committee Office & UNAIDS China, 2004). This policy indicated that the government squarely recognized the need for treatment and care, not only for improving the lives of people and the functioning of communities affected by HIV/AIDS, but also for preventing further transmission of the disease.

With the Ministry of Health at the apex of the pyramid for monitoring the health system, accountable to the State Council, two types of health provision institutions are now available for PLWHA and the general public. One of these is the Center for Disease Prevention and Control (CDC), which is mainly responsible for testing and preventive institutions; the other consists of the hospitals, health stations, and private clinics, which are mainly curative and treatment institutions. Shortly after the SARS epidemic in 2003, the establishment of the China CDC was approved by the State Council; later, the former Epidemic Prevention Stations (EPS) all over China were renamed as CDC, although their capacity, staff, facilities, and functions, etc., remained virtually the same as those of the former EPSs. However, the national infrastructure of the public health surveillance and response system has yet to be established, and this comprises CDC at different administrative levels (province, city, and county, with the county as the lowest level). The concrete task of the CDC is to prevent communicable disease, chronic non-communicable disease, and other kinds of harm. AIDS is listed as the most serious communicable disease, with the highest mortality rate, and therefore the CDCs have become the most important institutions of HIV/AIDS prevention and treatment. Besides offering HIV/AIDS testing, CDCs are also in charge of health surveillance, information collecting and reporting, and offering guidance on disease prevention for health units in hospitals and clinics at the same administrative level or lower. Routine testing in health care settings and detention centers was introduced in 2005; behavioral surveillance began in 2004, and there were already 159 sites in 27 provinces by the end of 2006 (Sun et al., 2007).

China's National Free Antiretroviral Treatment (ART) Program began in 2003 in Henan province and was then

extended to Anhui Province. The care model is designed to be community-based, which involves the provision of ART at the county level with routine follow-up, monitoring, and care at the village or township level. County- and prefecture-level clinicians address serious opportunistic infections (OI), adverse reactions, and other complications, with consultative referral to the provincial and national level as required (Zhang et al., 2007). Later, this article will discuss how the design of the surveillance and referral system is transformed and adapted according to local situations.

Theoretical Framework

Drawing on Donabedian (1973), access is the “degree of fit” between the health system and those it serves—a dynamic process of interaction between health system (supply-side) issues and individual or household (demand-side) issues. Access has a number of dimensions (Gulliford, 2002; Liu & Kaufman, 2006; Penchansky & Thomas, 1981):

Availability refers to whether or not the appropriate health services are in the right place and at the right time. For example, availability includes the location of services; hours during which care is provided and the type; range, quantity and quality of service; and each is considered relative to the health needs of the population served (Gilson & Schneider, 2008).

Affordability refers to the “degree of fit” between the cost of health care and individuals’ ability to pay. *Acceptability* refers to the social and cultural distance between health care systems and their users. The concept of acceptability goes beyond patient-provider interaction, and includes three central elements (Gilson, 2007): (1) the fit between lay and professional health beliefs—covering both patients’ perceptions of the effectiveness of treatment and the extent to which their constructions of health and healing match health care providers’ understandings on these issues; (2) patient-provider engagement and dialogue—with particular emphasis on the communication practices of providers, the extent to which patients are themselves given opportunities and are able to discuss their own care, and whether or not providers demonstrate

prejudice towards patients, perhaps simply by stereotyping them and their needs rather than listening to each patient; and (3) the ways in which health care organizational arrangements influence patient responses to services—for example, fees for service systems often generate patient concern that the provider is more interested in making money than in addressing their needs fully.

The concept of access is helpful for linking rural PLWHA's experiences of illness and medical care-seeking behavior within the context of the rural public health system under the influence of marketization and the privatization of health reform in China, with special focus on how the individual's access to health service is shaped by institutional barriers. The concept of access also provides a conceptual perspective from which to measure differences in health care utilization, to assess inequalities in utilization, and to examine the interaction between PLWHA and health providers and the integration of various dimensions of access—namely, availability, affordability, and acceptability—within the Chinese socio-historical context.

Methods

Study Setting and Procedures

This study is part of a larger research project that includes both a large-scale household survey and qualitative interviews aimed at understanding the determinants and impacts of the HIV epidemic on the social and economic conditions of rural households. Because of space constraints, this article presents only the qualitative data collected from the larger project. Ethical approvals were obtained from the research ethics committees at the project implementing university.

For this study, qualitative data were collected from Henan and Anhui provinces of China at sites including two cities, five counties, 10 townships, and 19 villages. The main reasons for having selected these two provinces are that: (1) they are both epidemic-hit areas, where the dominant transmission was through illicit blood and plasma donation in the mid-1990s. The rate of infection among blood/plasma donors has reached an average of 10-20%, with rates as high as 60% in some communities (UNAIDS China, 2003); and (2) both provinces are

involved in the National Free ART program and have community-based state-funded ART Clinics.

The research team included three research professors and 10 postgraduate students. The implementation of this study included two phases. The first round of data collection was carried out between December 2006 and April 2007, when 36 PLWHA from the two provinces were interviewed. After analyzing the first round of data, we felt that we could not understand PLWHAs' illness experience deeply without examining the viewpoints of health providers. Therefore, a second round of data collection was conducted between August and September 2008, during which 13 health service providers from the two provinces were interviewed. After informed consent was obtained, each confidential interview was conducted in a private room on a one-to-one basis and lasted for one to two hours. During these in-depth semi-structured interviews, PLWHA participants were asked open-ended questions about their illness experience and utilization of health services; service providers were asked about their HIV knowledge, attitudes and interactions with PLWHA, and their personal practices, difficulties and challenges at work.

To allow flexibility and spontaneity as new content emerged during interviews, interview questions were not necessarily asked in the same order or wording as in the interview guide, however, all questions in the interview guide were covered during each interview. At the end of each interview, demographic information was collected with a standardized background questionnaire. Audiotaping was avoided in order to ease informants' possible unwillingness to respond and in consideration of the sensitivities of the topic. The researchers took detailed notes during the interviews and made field notes, recording dialogues, observations, and self-reflections in a timely manner, as part of the compilation of data for analysis. In order to protect the participants' privacy, all names remain anonymous and have been replaced by figures. Within the text, "A" and "H" represent Anhui and Henan provinces, respectively.

Study Participants

As shown in Table 1, the thirteen health service provider participants included 11 males and 2 females. Their ages

ranged from 20 to 61, with an average age of 37.9. In terms of educational background, only three had graduated from university; the others had graduated from college ($n = 1$), senior high school ($n = 1$), vocational nursing school ($n = 7$), or junior high school ($n = 1$). Eleven of them were doctors and two were nurses. All provided HIV/AIDS related services. They served in different types of medical institutions, including village clinics ($n = 5$), township hospitals ($n = 5$), and county hospitals ($n = 3$). Ten of the 13 had received some HIV-related training; the other 3 had received none.

Table 1. Demographic Characteristics of Provider Participants ($n=13$)

| Characteristics | Frequency / range (mean) |
|---------------------------|--------------------------|
| Gender | |
| Male | 11 |
| Female | 2 |
| Age | |
| Range (mean) | 20 - 61 years (37.9) |
| Education | |
| Junior high school | 1 |
| Vocational nursing school | 7 |
| Senior high school | 1 |
| College | 1 |
| University | 3 |
| Level of care | |
| ART clinic | 5 |
| Township hospital | 5 |
| County hospital | 3 |
| Occupation | |
| Doctor | 11 |
| Nurse | 2 |
| Contact with PLWHA | |
| Yes | 13 |
| No | 0 |
| HIV training | |
| Yes | 10 |
| No | 3 |

As shown in Table 2, the thirty-six PLWHA participants included 17 males and 19 females. Their ages ranged from 23 to 67, with an average age of 42.8 years. Their educational background was generally low: 16 participants were illiterate, and others were junior high school ($n = 9$) or primary school ($n = 11$) graduates. At the time of the interviews, the length of their HIV diagnosis averaged 4.6 years. Twenty-five participants were married, 10 were widowed through the death of their HIV-infected spouses, and 1 was currently single,

never having been married. Their infection modes are divided between "commercial blood donation" (n = 34) and "heterosexual behavior" (n = 2).

Table 2. Demographic Characteristics of Chinese PLWHA (n = 36)

| Characteristics | Frequency / range(mean) |
|--|-------------------------|
| Gender | |
| Male | 17 |
| Female | 19 |
| Age | |
| Range (mean) | 23 - 67 years (42.8) |
| Education | |
| Junior high school | 9 |
| Primary school | 11 |
| Illiterate | 16 |
| Current relationship status | |
| Married | 25 |
| Widowed | 10 |
| Single and never married | 1 |
| Infection modes | |
| Commercial blood donation | 34 |
| Heterosexual practice | 2 |
| Time of being diagnosed as HIV positive (mean) | (1 - 9)/4.6 year |

Data Analysis

The data analysis process included three main phases: identifying significant statement for coding; categorization; and theming. In order to attain better inter-coder reliability, the four authors read through the texts of all transcripts and field notes, brought tentative coding into team meetings and discussions, and then assigned category labels (e.g., "location of service," "quantity and quality of service," "individual's ability to pay," and "prejudice towards patients"). Statements with similar category labels were later grouped into clusters, which allowed easier examination of consistency of experience and the diversity of perspectives. Based on data analysis, we were able to develop a comprehensive synthesis of HIV/AIDS health service access in rural China. To avoid the loss of nuance within original narratives, the data were not translated into English until the stage of writing-up the research.

Results

Availability: Can PLWHA receive health service in the right place and at the right time? In Henan and Anhui,

community-based, state-funded ART Clinics have been established, to which health care workers are assigned. They are paid by the local government. The ART Clinics not only distribute antiviral drugs free of charge, but also provide some amount of free medicine to cure opportunistic infections. Usually, these ART clinics were located where infected groups and communities were highly concentrated. For example, one ART Clinic we visited was established in May 2007 in Anhui Province in A village, which had 155 PLWHA; also close to B village (three miles away), which had 117 PLWHA; and to C village (two miles away), which had 40 PLWHA.

An AIDS patient from B village told us how the establishment of the ART Clinic within the community had brought convenience to her life.

In the past, I had to pick up the medicine from County CDC, which is 20 miles away. Since last May, I came to A village to pick up the medicine, which is much closer to my home, as it only took 20 minutes by bicycle. (A3, F, 55)

In general, physical access was not a big issue for PLWHAs in these communities in both Henan and Anhui. Some villages of Henan even had a special distribution arrangement plan that used the services of PLWHA.

Here County CDC distributes ART drugs to the clinic. We selected one from every ten PLWHA to be in charge of distributing free ART drugs, [and this person] got 60 RMB from the government as monthly stipend. Most AIDS patients here can receive medicine without leaving home. (ART Clinic doctor)

For some patients not living in high-rate communities, however, physical access to health service remains a huge problem. We interviewed one AIDS patient who lived more than 30 kilometers away from an ART Clinic. However, instead of complaining about the long distance, A2 thinks that it was good for her to keep her illness secret from other villagers, since she was the only HIV-infected person in the village and she was afraid of isolation and discrimination associated with HIV stigma.

At the time of the interviews, we also noticed a phenomenon wherein migrant workers only returned to their hometown villages to seek health care after having been diagnosed as HIV positive, since rural PLWHA can usually obtain free (or reimbursable) medical services at the particular ART Clinics at the location of their *Hukou* registration. If they do not go to ART Clinic where their *Hukou* registered, they cannot get any medical assistance at all. On the one hand, this policy improves availability of health service for PLWHA within their community of origin; on the other hand, it limits PLWHAs' mobility and flexibility of health care seeking in order to control the spread of the HIV/AIDS epidemic.

Every resident of China was classified as either a rural or urban household (sic) through a household registration certificate (*hukou*). Although analysts differ on the motivating factors that led to these decisions, the effect was to create a "caste-like system of social stratification" (Potter & Potter, 1990) between urban dwellers and the rural peasantry. As Solinger (1999) describes in great detail, a Chinese person's classification as a rural or urban *hukou*-holder not only determined place of residence, but also the benefits she or he would receive from the state (as cited in Woronov, 2004, p. 291).

According to the original design of the health system, ART clinics can only provide simple ART treatment; as for OI treatment, patients can be transferred to township and county hospitals. However, the research confirmed that the health system adopts different strategies in order to keep the PLWHA's treatment within the ART clinics. In one county, if a patient was transferred from an ART clinic to a higher level hospital, he or she needed to pay 15% more than the cost of treatment at the ART clinic from his or her own pockets. This decreases PLWHAs' incentives to seek health care at a higher level hospital. In another county, the county hospital had been sending doctors to clinics since June 2008, so that, as the director of the ART clinic put it, "the ART clinic provides 'one station for all' service."

Our patients can receive as high-quality treatment here as in the county hospital, since their doctors were sent here. The ART clinic can provide the highest quality

of treatment in the county, and there is no need of transfer. If we cannot cure here, nowhere can. (ART clinic director)

This story sounds encouraging and promising—PLWHA can receive high-quality care in their own communities. However, we heard another side of the story from the doctor sent to the ART clinic by the county hospital, which shows that the arrangement per se has the function of excluding PLWHA from obtaining proper and better treatment.

I did not receive any kind of HIV-related training. Sometimes I think that I cannot make any difference, since I treat their OI just as [I treat] ordinary patients, and the only difference is that I prescribe them bigger doses of medication. I am here just because my boss did not like me. The other reason is that the county hospital does not like PLWHA going there and scaring other patients off. (Doctor sent by the county hospital)

Moreover, the arrangement makes it difficult for PLWHA to be transferred to higher-level hospitals. It is very complicated to get the paperwork done and to go through all the official procedures. Sometimes, in Anhui, one PLWHA needs to get the county CDC and county bureau of health approvals to move to a higher-level hospital. The so-called convenient availability within a community thus actually deprives PLWHA's freedom and rights to pursue high-quality medical care.

We found that it was always difficult for people to decide whether to take an HIV test or not. At the time of the interviews, many PLWHA told us that their spouses and children have not been examined. For example, A9 and her husband both are HIV infectors, but they did not send their children for examination. "I am afraid of the influence on the children if they are diagnosed as AIDS-infected. They are so young. My husband and I would not be able to bear it if we found out they are infected" (A9, F, 33).

In the long term, persuading people at risk of HIV to be examined as early as possible is beneficial for the people, their families, and their communities, but as can be seen from the above quotes, people were resistant to this. It was apparent

that the ART clinics need to pay more attention to HIV/AIDS surveillance and education. According to government regulations, PLWHAs need to have their CD4¹ tested twice per year in order to track the effect of their treatments. However, CD4 testing even once a year for PLWHAs could not be guaranteed, since the county CDC lacked the equipment necessary to perform the test.

Affordability: Can PLWHA afford to be sick? The Chinese national policy of “Four Free and One Care” has reduced AIDS patients’ financial burden, but it remains an obstacle, since PLWHA still need to pay something for OI treatment, despite the fact that medical assistance is subsidized by the local government. For example, in Henan province, only 129 prescribed drugs for OI treatment are free. For rural poor PLWHA, even though they may get free treatment, small payments may become a huge burden.

When I was hospitalized, I needed to pay the daily expenditures. Every day I needed more than 10 RMB (1.3 USD) for meals, and I was still hungry. When I was seriously sick, my wife and son took turns taking care of me. When I got a little better, I asked them not to come, to save the money for [my] meals. (H7, M, 41)

Impoverishment due to medical expenses has become a serious problem in rural China (Jin, Tang, Zhao, & Lu, 2004; Li & Tang, 2005; Liu & Kaufman, 2006; Saich, 2006). Lacking adequate income to purchase basic health care when needed was a common complaint among the informants. For rural PLWHA, “not seeking care” often is the choice that they make when they are sick but have no money to pay because of their economic difficulties. As H2 stated, “The biggest worry I face now is how to pay my medical fees. I try not to go for treatment for minor problems” (H2, F, 52).

In Henan province, there were different types of medical assistance for PLWHA with different levels of CD4. According to a health care worker from an ART Clinic in Henan Province, the practice works like this:

Our clinic’s standard is: if the CD4 is below 200, each patient can get free medication worth 1,200 RMB per

year; if it is higher than 200, each patient gets 800 RMB per year. If someone takes very little of the free medication, he will be reimbursed. (ART clinic doctor)

Such a policy may sound good, but in practice there are some problems, as H9, a patient from the ART Clinic, said in his interview.

I think that the existing policies are good, but two problems remain. First, the types of drugs in ART Clinics are limited—lacking in many drugs. When I and many other villagers got sick and the ART Clinics could not meet our needs, we had to go to private clinics, at our own expense. Second, the reimbursement policies from village hospitals were unclear, and it seems that the ART Clinic never told us clearly how much we had spent. (H9, F, 33)

As H9 has stated, when ART Clinic could not offer necessary medication, PLWHA may seek treatment from private clinics, if they can afford it. H10 made a similar complaint:

I started to take ART drugs in January 2004. Sometimes I felt that the drugs of the ART Clinics did not work well, so I had to buy medicine from private clinics, which is cheaper and has better effects, but they still cost me 30 to 50 RMB (4 to 7 USD) every time. I had a canker sore on my mouth, and the ART Clinic could not treat it; I had to see a doctor in a private clinic. Last year, I spent 3000 RMB (450 USD) on medical care, and most of it was spent in a private clinic. (H10, M, 42)

Both H9 and H10 stated that the 129 free drugs of the ART clinics are not good enough for OI treatment. Some local doctors confirmed this.

Among the 129 types of free drugs, more than 10 types needed to be changed—of course further clinical research is required. Since purchasing drugs invites public bidding, usually cheaper drugs are easier to get, but the treatment effect is not that good. Patients always need to pay for better drugs. Moreover, the government needs to provide second-line medicine,

because the current drugs are no longer effective for some patients who have taken them for a long term. (ART clinic doctor)

Another doctor also suggested that “Experts should update the list of prescribed drugs according to changing disease conditions more frequently, in order to improve the quality of treatment” (ART clinic doctor).

Right now, many PLWHA in Henan and Anhui have entered the peak outbreak period of opportunistic infection, which occurs after more than ten years of illness. This means that their demand for medical care and assistance is becoming greater. However, the conditions of insufficient drugs and fees for OI treatment remain heavy burdens for these poor rural PLWHA.

Acceptability: Can PLWHA be accepted as ordinary patients? On a more hopeful note, relationships between provider and patient were quite good at the ART clinics we visited. As a nurse put it, “[I] put myself in their position: you treat them well, and then they treat you well. Sometimes with patient explanations, they will all be reasonable” (ART clinic nurse).

However, sometimes the good provider-patient relationship may jeopardize the universal precautions that the health providers need to take.

There is no need for protection, we just need to be more careful. We are required to wear masks and gloves, but now it is so hot and inconvenient. Besides, wearing those is not good for the patients—they will say, ‘I see, you are scared.’ The potential risk does exist, because we need to give them injections. The other day, one nurse was pricked by the needle accidentally. Now he went back home to have a rest and wait for the test result. (ART clinic nurse)

We found that such accidents happened in almost every ART clinic, and most health-provider participants in this study had experienced being pricked by an infected needle. Universal precautions should thus be made an urgent priority.

There are also other issues in ART clinics that need to be addressed. In most ART clinics, workloads are heavier and the pay is less than elsewhere.

Sometimes I really want to quit. Not because of fear of HIV/AIDS—mainly because I am too tired. Sometimes in one morning nearly 20 persons come here for intravenous drips. Everyone had three bottles. I just could not handle it. After the work, I was too tired to move. (ART clinic nurse)

As an ART clinic nurse, this woman's monthly salary was 800 RMB (around 120 USD) plus a 400 RMB (around 60 USD) stipend. This is lower than incomes at ordinary clinics and hospitals of the same level. In addition, at the time of interview, neither she nor her colleagues had received payment for three months. Even patients protested the unfair situations of the providers, and some of them even asked us to report the situation to upper-level government in order to remedy their providers' low salaries and delayed payments. They put it very simply: "Who is going to treat us if they leave?"

As mentioned, patient-provider engagement and communication is quite good within the ART clinics: patients trust their providers, express their gratitude for their providers' stressful work, and are willing to discuss their illness and life obstacles with them. Most providers can lose their initial feelings of fear and can treat PLWHAs without prejudice. A director of one ART clinic concluded that the good relationship between providers and patients stemmed from doctors' professional ethics and sense of responsibility, and said that the ART clinics have been assigned a mission from the government to comfort patients and prevent them from causing troubles in the society. These providers play important roles, both in preventing the spread of HIV/AIDS in families and communities with infected individuals and in helping to improve the quality of life of those who are infected by providing consultations, treatment, and social support.

ART clinics thus manage to create a small comfortable atmosphere within the community for the PLWHA. However, the external medical institutions are less welcoming. We found that many informants reported their experience of being rejected by ordinary hospitals just because of HIV-related stigma and discrimination. Even doctors interviewed from county hospitals thought that the existing medical system

discriminates and excludes PLWHA in certain ways.

Now the existing medical system just barely satisfies PLWHA's needs. If they need to have a small surgery, such as an abortion or a tooth extraction, their medical needs are often denied, because it may cause the pollution of medical instruments. In many cases, PLWHA are put into a double-bind: if they tell they are PLWHA, the hospital may not provide the service; if they do not tell, they may cause the infection of health providers and the pollution of medical instruments. Sometimes a small operation needs to be coordinated by the CDC and the Bureau of Health. (county hospital doctor)

Most county hospitals try to exclude PLWHA in the name of considering other patients' well-being. Sometimes this exclusion by the county hospital turns the CDC into an OI treatment department for PLWHA. However, compared to county hospitals, especially those set up for communicable diseases, the CDCs lack the advanced technology, facilities and professionals to provide PLWHA with proper treatment.

However, certain hospitals especially welcome PLWHA because the fees-for-service system brings them more money. Such providers are more interested in making money than in addressing PLWHA's needs fully. For example, expensive drugs may be prescribed unnecessarily. In this situation, the PLWHA is often left with no other options, because the hospital may be the highest-level government-assigned hospital for treating HIV/AIDS within the county, and the only one in which they can enjoy certain preferential policies.

Discussion

This article has evaluated health service access in rural Henan and Anhui provinces in an integrative way, through the examination of availability, affordability, and acceptability of treatment for PLWHAs. We find that ART clinic medical care does benefit PLWHA, however, issues like poverty, stigma and discrimination, and the "fee for service" health care system prevent PLWHA from accessing the most effective

care. Moreover, PLWHAs encounter institutional obstacles as a result of the philosophy of marketization and privatization of the health care system.

Inadequate Funding of CDCs

At present, government allocations to county-level preventive health services cover only approximately one-third of their expenses; the rest of their funding derives from income from professional services. The CDCs do not get sufficient government allocations, and are thus unable to get new equipment or sufficient reagents and staff for disease surveillance. From 1949 to the mid 1980s, the government's emphasis in its health work was on the prevention and eradication of infectious diseases and similar basic public health services (Wang, 2004). The slogan then was "Prevention First," and the work of local CDCs was highly emphasized. However, in the wake of the government's move towards a market-driven economy, the role of the government in financing, organizing, and delivering public services has been weakened, leading to an underfunded and fragmented public health care system (Liu, 2004a). In central and western China, many CDCs at the county level have not upgraded their laboratory instruments in many years; some are barely able to pay salaries to their workers. In order to ensure their survival, many CDCs are forced to expand profitable services, especially when PLWHAs are turned down by other ordinary hospitals. CDCs, in the name of "health inspection," may charge a variety of fees in order to survive (Liu, 2004a). This survival strategy has deeply changed their working emphasis and has drastically lowered their ability to prevent and control large-scale epidemics such as HIV/AIDS. These conditions are a signal that China's preventive health safety net has been damaged.

Weakness of Referral System

According to the original design, a three-level network of county-township-village health units would exist as a structural foundation, as well as a formal bottom-up referral system for HIV/AIDS prevention, control, and treatment in rural China. However, the structure has become split and the foundation is not reliable anymore. One reason for this is that the existing

health care system attempts to restrict the mobility of PLWHA to the ART clinics only; another reason is that the functions of township public health centers are limited, due to a lack staff and facilities. In terms of the care provided, township hospitals may offer little more than the village clinics: for minor OI treatment, the clinics can take care of them, but serious OI treatment is a tough job for them. Usually, rural PLWHA just skip the township hospital and seek help at county hospitals when they encounter serious OI problems.

Lack of Training of Health Providers

Among the interviewed 13 health providers, 3 had not received any kind of HIV/AIDS related training, although one of these had been sent by the county hospital to an ART clinic as an 'expert' in HIV/AIDS care. Even those who had received trainings complained that most of the trainings are not that useful for their daily work, "because training organizers only want to spend the training money." Universal precautions for health providers remains a big problem, and many health providers are at risk of contracting illness because of the lack of proper protection.

Regional Inequality and Inconsistent Medical Assistance

With the decentralization of health care units, the financial allocation from central government remains low, so that individual contributions for treatment are overly high. Thus the inequality of economic growth brings out health inequalities between different provinces, between city and rural areas, and between the rich and the poor. As investment and spending decisions have been decentralized to provincial, county and township governments (Liu, 2004a), it is no wonder that rural PLWHA receive different medical assistance in different provinces, and even counties, townships, and villages have different policies for medical assistance. We also noticed that ART Clinics in two nearby counties in the same province had different policies for reimbursement and medical assistance during our field work.

Conclusion

Based on our examination of the interaction between rural PLWHAs' health service access experience and institutional obstacles in this paper, we argue that there is an urgent need to reconstruct a sustainable and effective public health system in China to cope with HIV/AIDS and other epidemics and diseases. The government has to pay serious attention to the work of disease prevention, and to put "prevention first" as the priority of the Chinese public health system. Such prevention work needs not only focus on the issue of HIV/AIDS, but should be extended to an emphasis on other diseases and health issues, including sexually transmitted diseases, such as gonorrhea and syphilis, women's reproductive health, and drug abuse etc. If the CDC system is guaranteed reliable government funding, it can focus effectively on its mission. However, only by strengthening the three-level referral system in rural China, getting rid of the institutional discrimination and stigma of PLWHA, and increasing the training of providers, will PLWHA be able to utilize health service more consistently and equally. The government should take responsibility for revising the unequal distribution of benefits caused by the household registration system and provide similar basic public services, including health, for all of its citizens, regardless of where within the country they live. On the one hand, there should be health equality between urban and rural areas. As well as this, health fairness between east coastal, central, and western areas through tax-sharing and public funding needs to be promoted. Furthermore, China should invest in public education regarding HIV/AIDS knowledge, safe sex practices, personal hygiene, and other public health practices, that might prevent future epidemics.

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Endnotes:

1. A CD4 count is the measured level of a certain type of protein, which is often present in certain types of white blood cells. CD4 stands for "cluster of differentiation four," and is an important component of the body's ability to produce an immune response to a would-be infection. A CD4 count can also refer to the specific lab work that is done to determine its level, as a routine part of

treatment for someone with the human immunodeficiency virus (HIV), which can lead to acquired immune deficiency syndrome (AIDS) (www.wisegeek.com).

Food Stamps and Dependency: Disentangling the Short-term and Long-term Economic Effects of Food Stamp Receipt and Low Income for Young Mothers

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The Food Stamp Program (FSP) remains one of the most widely used of all U.S. social "safety net" programs. While a substantial body of research has developed around the primary goals of the program—improving food access, nutrition, and health among low-income families—less attention has been paid to the broader goals of hardship and poverty reduction. Using 38 years of data from the Panel Study of Income Dynamics, we examine several immediate and longer-term economic outcomes of early adult FSP participation for a sample of 3,848 young mothers. While FSP participation is associated with some negative outcomes in the immediate future in areas including family income-to-needs and transfer income, such effects are substantially reduced or disappear over the long run. These results suggest that concerns about the adverse economic effects of assistance, based solely on short-term outcomes or outcomes measured at a single point in time, do not hold for the long run. We find no evidence that food stamp recipients in early motherhood are any more or less dependent on public assistance programs than other young mothers who have low income but do not use food stamps.

Key words: Food stamps, transfer income, welfare, low income, women

More than one in eight individuals in the U.S. currently receives benefits from the Food Stamp Program (FSP) [now the Supplemental Nutrition Assistance Program (SNAP)]. Since the emergence of the FSP as a pilot program in 1961, and as a nationwide program in 1974, it has pursued the goal of helping "low-income people and families buy the food they need for good health" [Food and Nutrition Service (FNS), United States Department of Agriculture (USDA), June 2010]. Although the program's targeted approach to meeting a basic human need has helped it to avoid the most virulent of attacks on the U.S. welfare system (Super, 2004), evidence of SNAP's success in meeting a broad range of objectives, particularly reductions in food insecurity and improvements in nutrition and health, is mixed (Gundersen, Jolliffe, & Tiehen, 2009).

The current economic downturn has brought with it substantial increases in both the number of recipients and the amount spent on FSP/SNAP. The USDA estimates that over 40.4 million people were enrolled in the program as of April 2010, an increase of almost 20 percent from only a year earlier. According to Congressional Budget Office (CBO) estimates, two-thirds of the 2008-2009 increase was generated by increased enrollment (CBO, 2009).

The expansion of benefits, even as enrollments have risen sharply, suggests that the desire to provide for low-income families and to employ them as agents of stimulus spending has, for now, trumped concerns about expense and program dependency. Moreover, as Douglas Besharov and Karen Baehler (1993) have noted, the expansion of federally-funded food stamp benefits relieves, to some degree, pressures on states to expand eligibility, access, and benefits to joint state- and federally-funded cash assistance programs. Still, given historically unprecedented high rates of participation, interest in tracking a variety of program participation outcomes—both consumption and health-related, as well as economic—will persist. Some, such as Robert Rector (2001), claim that the FSP seeks to maximize caseloads and dependence on the

program by allowing people to receive assistance without work requirements. Whether FSP participation does, in fact, “promote dependency” is an unsettled question; research evidence is mixed and is highly sensitive to method and to both the timeframe and outcome under consideration (Gundersen, Jolliffe, & Tiehen, 2009).

We argue that it is important to tease apart short-term from longer-term FSP-participation effects, as well as to differentiate between consumption and health-related outcomes (which FSP participation is manifestly intended to effect) and economic outcomes (which are often the focal point of dependency concerns). Using both standard regression and sister fixed-effects models and 38 years of data from the Panel Study of Income Dynamics (PSID), we examine several short and longer-term economic outcomes of FSP participation for a sample of 3,848 young mothers. We examine only women who have formed families before age 28, using the proportion of early motherhood spent receiving food stamp income to predict outcomes up to age 40 in the areas of family income-to-needs, time spent with low income, and amount of transfer income.

Such a study has implications for those who argue that policies intended to alleviate poverty instead intensify economic problems for the poor by making them less self-reliant (Herrnstein & Murray, 1994; Horn, 2002; Mead, 1986, 1998; Murray, 1984). Although this indictment is considerably less likely to be leveled against food stamp use than against the use of cash assistance, to the extent that the image raised by such a prominent critique of the cadre of U.S. poverty programs is one of sustained and prolonged dependency, we need models of program effects that capture not only those conditions that accompany or immediately follow an initial period of program participation, but also those that are experienced much later in an individual’s life course. Further, isolating particular programs as major contributors to individuals’ economic struggles requires careful attention to the ways in which program effects may be confounded by those individual and familial factors potentially associated with participation (Blank & Ruggles, 1996).

Background and Significance

A considerable body of research has examined associations between participation in the FSP and a range of health and nutrition outcomes, including food spending, nutrient availability, dietary quality, and food security, with notably mixed results (Breunig & Dasgupta, 2005; Burstein, Price, Rossi, & Fox, 2004; Currie, 2003; Gibson-Davis & Foster, 2006). More recent studies have extended the set of outcomes to include consumption stabilization (Blundell & Pistaferri, 2003; Gundersen & Ziliak, 2003), obesity (Baum, 2007; Ver Ploeg & Ralston, 2008), healthy food choices (Frazao, Andrews, Smallwood, & Prell, 2007), and other indicators of family and child well-being, such as children's math and reading test scores (Frongillo, Jyoti, & Jones, 2006).

Most of this research focuses on conditions and outcomes immediately associated with FSP participation. What happens to food stamp recipients after they leave the program or over the long run is largely unknown. Two studies have looked at factors associated with returns to participation after exits, tracking individuals up to 30 months after they exited the program (Blank & Ruggles, 1994; Gleason, Schochet, & Moffitt, 1998), but there is no research that has examined other or longer-term outcomes. Moreover, while substantial attention has been paid to the long-term consequences of receiving other forms of government assistance (Cancian & Meyer, 2004; Meyer & Cancian, 1998; Newman, Holupka, & Harkness, 2009; Vartanian & McNamera, 2004), there is no comparable literature on the economic consequences of early adult FSP participation, either alone or in conjunction with other government assistance programs. Several of these studies have found that government assistance has minimal, if any, detrimental long-term effects on economic outcomes (Newman et al., 2009; Vartanian & McNamara, 2004).

Although many of the existing studies on FSP-participation effects rely on comparisons between recipients and eligible non-recipients, there is widespread acknowledgement that this approach may be hampered by unmeasured differences between these groups, differences that, if associated with the outcome of interest, will bias results (Fraker, Martini, & Ohls,

1995; Gibson-Davis & Foster, 2006; Krueger, Rogers, Ridao-Cano, & Hummer, 2004). For example, in apparent conflict with the FSP's goal of improving nutrition and health among recipient families, the majority of existing studies suggest that food stamp income either increases or has no effect on food insecurity (Gundersen, Jolliffe, & Tiehen, 2009; Gundersen & Oliveira, 2001; Wilde & Nord, 2005). However, there is substantial evidence that the primary driver of this finding may be pre-existing differences between recipient and non-recipient households. Blank and Ruggles (1996) find that women who enroll in cash assistance programs, the FSP, or both, tend to have lower past, current, and future anticipated earnings than those who do not; they also tend to have more children, fewer years of education, and a higher incidence of disability than their eligible, non-recipient peers.

The line of reasoning suggested above asserts that it is not food stamp receipt per se that leads to particular participant outcomes but rather some, often unmeasured or unmeasurable, trait linked to both. Such traits are usually thought of as unfavorable (e.g., acute need, poor health) and as leading to unfavorable outcomes, but it is also possible that the opposite may be true (e.g., willingness to engage in help-seeking behavior could have long-term benefits). Several recent studies have found that correcting for selection bias using instrumental variables, propensity score matching, or switching probit models reveals relationships that are interpretable in ways favorable to the FSP: specifically, that receipt of food stamps reduces food insecurity (Mykerezzi & Mills, 2008; Yen, Andrews, Chen, & Eastwood, 2008) or, at a minimum and to a limited extent, its severity (Gibson-Davis & Foster, 2006); and may lower mortality for participants relative to a condition of non-receipt (Krueger et al., 2004).

A relationship between FSP participation and future outcomes that is driven by unmeasured family differences is not a causal one, so it becomes important to account for these differences in trying to isolate a relationship between participation and economic conditions. For this reason, we examine both standard regression models and sister fixed-effects models to account for unmeasured family background differences. As we explain in greater detail below, it is also important to note that

we are examining exposure to the FSP, measured as a proportion of time in early motherhood with FSP participation, rather than strict categories of receipt versus eligible, non-receipt.

Setting aside for the moment pre-existing differences between groups, there are a number of reasons that the economic outcomes of FSP participants might differ from those of nonparticipants. Fraker and Moffitt (1988), Hoynes and Schanzenbach (2007), and Keane and Moffitt (1998) find that FSP participation may produce some reduction in labor supply, although as with other FSP-participation outcomes, their results are mixed. Because paid employment contributes to the development or maintenance of skills and abilities that increase the value of an individual to prospective employers, labor supply reductions suggest that food stamp receipt may lead to lower future earnings for individual families. Detrimental effects accrue with time spent in the program, both because individuals grow more dependent on government aid the longer they use it, and because labor market skills deteriorate the longer a person is out of the labor market.

Alternatively, and depending on how assistance is used, use of food assistance could contribute to human capital gains and greater earning ability. An individual who uses a spell of food stamps to complete a training or education program may have greater future earnings. Moreover, evidence suggests that FSP participation acts as a consumption stabilizer, also potentially contributing to human capital gains (Blundell & Pistaferri, 2003; Gundersen & Ziliak, 2003). Consumption stability may lead to better health, and better health may contribute to higher, more consistent earnings. For example, using PSID data during the years of food stamp program rollout, and comparing data from low-education, female household heads living in counties that participate in the FSP, to data for those living in non-participating counties, Hoynes and Schanzenbach (2007) find no consistent evidence that FSP participation affects family income and some evidence that participation reduces the likelihood of illness-related work absences.

We examine whether FSP participation has negative economic effects for recipient mothers relative to low income, non-recipient mothers, both in the short-run and the longer-run.

Data and Variables

Sample

Study data come from the 1968 to 2005 PSID, a nationally representative, longitudinal data set that began in 1968 with approximately 5,000 families and 18,000 individuals, and expanded to include over 8,000 families and nearly 23,000 individuals by 2005. The PSID oversampled families in poverty and black families to obtain relatively large sample sizes for these groups. With weights, the sample is representative of the non-immigrant United States population.

Using the longitudinal advantages of the PSID, we select and follow women with children for up to a 38-year span. We examine women over initial four-year periods from two overlapping samples: (a) "younger young mothers," those who became PSID-designated "heads of households" or wives with child(ren), at less than 23 years of age (becoming, at most, age 25 by the end of the initial period), and (b) "older young mothers," those who became heads of households or wives with child(ren) at less than 28 years of age (becoming, at most, age 30 by the end of the initial period).

Each woman's characteristics (e.g., family income, number of children) are then averaged over each of these initial periods. The use of four-year periods is intended to capture the characteristics of the woman shortly after she has a child (generally her first, although some have children before they become heads of households or wives), while reducing the potentially biasing effects that can result from using only one year of data.

Outcomes are reported over five-year periods: ages 26-30, 31-35, and 36-40, as well as for the entire period, age 26-40. We use the younger sample for the age 26-30 outcome period, and then include the older sample (which incorporates the younger sample because they necessarily have a child by age 28) for the 31-35 and 36-40 age periods. Models for the outcome periods, age 31-35 and age 36-40, using only the "younger young mothers" sample yielded similar results to those obtained using all young mothers, so only this latter set of models is presented. Note that the regressions include age at the beginning of the initial period to control for the amount of

time between starting and ending periods. The use of discrete, five-year outcome intervals in separate models allows us to comment, not only on whether receipt of food stamps differentiates recipient from non-recipient women in the long run, but also whether and to what degree any such effects persist over the next 5 to 15 years.

Outcomes, including family income-to-needs, proportion of time with low income, and average transfer income, are measured at the household level—the level that is arguably of greatest interest for policy makers. Household level outcomes implicitly include the contribution of a spouse or other partner, if present, and such contributions are viewed by many as a critical factor in alleviating the poverty of low-income mothers and their children (Maynard, Boehnan, Corbett, Sandefur, & Mosley, 1998).

Although this study focuses on food stamps, it must also consider cash welfare assistance [Aid to Families with Dependent Children (AFDC) at or before 1996, and Temporary Assistance to Needy Families (TANF) after, referred to hereafter as AFDC] because there is considerable joint participation among low-income single mothers. Before passage of the 1996 welfare reform legislation, women who qualified for AFDC were automatically eligible for food stamps, and substantial overlap between the two programs continued after 1996. However, food stamp eligibility thresholds have been typically higher than welfare eligibility thresholds both before and after 1996. Consequently, while the overlap in program participation is substantial, it is not total, which enables us to derive estimates of FSP participation effects apart from AFDC participation effects.

Marriage is another factor that tends to distinguish FSP-only recipient women from joint FSP/AFDC recipient women, as married women are considerably less likely than their non-married counterparts to be eligible for AFDC. Although widely debated, the premise that marriage bolsters the economic prospects of low-income and welfare-reliant women has been prominent in recent discussions of poverty policy (Lawrence, 2007). For this reason, as well as because AFDC primarily targets single women, we include models that interact women's initial-period marital status with the primary independent variables

to determine whether independent variable effects are different for married and non-married young mothers.

Primary Independent Variables

The central question for this study is whether a mother's early use of food stamps, or both AFDC and food stamps jointly, predicts long-term economic outcomes. Key variables include:

- (a) proportion of time receiving only food stamps ("FSP-only recipient");
- (b) proportion of time receiving food stamps and AFDC jointly ("joint FSP/AFDC recipient");
- (c) proportion of time spent with income above 150 percent of the federal poverty line (FPL), without AFDC or food stamp receipt ("non-eligible, non-recipient"); and,
- (d) proportion of time with income at or below 150 percent of the FPL, without AFDC or food stamp receipt ("low-income, non-recipient" or "eligible, non-recipient").

Because these variables capture proportions of an initial four-year period of motherhood, values for individual women range from 0 to 1, and include 0.25, 0.50, and 0.75. As noted above, this approach differentiates those who have received food stamp income for only one of these four years from those who have received such income over the entire period. For the purpose of analysis, the excluded category is *proportion of time spent as a low-income, non-recipient*. We report estimates as the differences between the two most "extreme" conditions: receipt over all four years and low-income, non-receipt, also over all four years.

For the low-income, non-recipient group, designating the cut-off point for sample FSP-eligibility at 150 percent of the FPL, rather than the actual 130 percent eligibility threshold, has two distinct advantages. First, it allows for income fluctuation over the course of the year: some individuals living in families with annual incomes above 130 percent of FPL may have been eligible for food stamps for some fraction of the year. Second, earnings may be endogenous to FSP participation, and

it would therefore be inappropriate to use a tight bound on earnings to define the sample.

As noted in the preceding section, our analysis includes interactions between marital status (married versus non-married) and proportion of time in various recipient or non-recipient states as primary independent variables. Marriage is defined as being married for at least 50 percent of the initial four-year time period.

Covariates

Other variables used in analyses are averaged over the initial four-year period, and include: mother's race; mother's education; number of children; age of the youngest child; age of the head of household; family income-to-needs; state unemployment rate; maximum welfare payment for a family of four in the state; year started in the sample; region of residence; year entering the sample; and city size. As a proxy for a disability, we also control for whether the woman had any work limitations during the initial period (Newman et al., 2009; Vartanian & McNamara, 2004).

In addition to variables measured during the initial period, regression models include several variables calculated in the ending (i.e., outcome) periods, including: the proportion of time in particular marital states; number of children; age in the ending period; and whether the focal woman's work is limited by health conditions at any point during the outcome period.

Because adult economic outcomes may be related to economic conditions in the family of origin, our models also control for childhood household income. A full list of independent and dependent variables is given in Table 1.

Dependent Variables

We examine three economic outcomes, all measured during the ending period. These include: (a) family income-to-needs (or family income relative to the poverty line); (b) proportion of time with income at or below 150 percent of the FPL; and (c) AFDC, food stamp, and other welfare income (referred to hereafter as transfer income).

Method

Outcomes are modeled using both sister sibling fixed-effects (FE) models and standard regression models. Use of FE models controls for unobserved, permanent family factors, including parental factors (e.g., intelligence or emotional states), which are factored out of the estimates if and only if they are permanent features of the family (Duncan & Raudenbush, 2001; Leventhal & Brooks-Gunn, 2000). Our use of these models acknowledges the possibility that low-income women enrolling in the FSP differ from similarly eligible but non-participating women in ways that may obscure or be mistaken for program participation effects.

Hausman tests, which detect differences in coefficient estimates between fixed and random effect models, indicate that the random effects models (which produce almost identical coefficients to OLS models) produce essentially the same results as the FE models for two of the three models. Because standard regression models provide more powerful tests and are not limited to women with sisters, we present only standard regression results for models of these first two outcomes. However, for models of effects on transfer income, Hausman tests indicate statistically significant differences in coefficient estimates; sibling FE model coefficient estimates for food stamp-only receipt and for joint FSP/AFDC receipt differ substantially from coefficient estimates derived from standard models. Results for transfer income are therefore presented in two ways: first, using tobit models (Table 3), and then using sister fixed-effects models, as these are better able to control for unobservable family differences (Table 4).

The type of analysis used is also determined by the distribution of each dependent variable. Results for the log of family income-to-needs are modeled using OLS regression analysis with robust standard errors, clustered by family status for the women during their childhood years. To account for left censoring (i.e., a disproportionate number of zero values) of the remaining two dependent variables, the proportion of time with low income and total transfer income, we use tobit models with robust standard errors.

Results

Descriptive Results

Because the study examines differences between non-married and married mothers, we present descriptive statistics for each group, as well as for all observations, in Table 1. Overall, there are 3,748 observations, including 1,013 single mothers and 2,735 married mothers. Sample sizes are larger here than in the regression samples, because all single mothers and all married mothers, regardless of age, are included.

Each descriptive statistic reflects an average value across the first four years after the birth of a first child. During this initial period, the average percent of time young mothers spend using the FSP and AFDC jointly is 14 percent for all mothers, but nearly 42 percent for single mothers and only four percent for married mothers. Consistent with the higher eligibility threshold for the FSP, the proportion of time spent receiving food stamps alone is nine percent for all mothers, 15 percent for single mothers, and seven percent for married mothers. Young mothers spend an average of seventeen percent of the initial, four-year period as low-income non-recipients, and an average of 60 percent as non-eligible non-recipients (i.e., having incomes above 150 percent of the federal poverty line).

Turning now to conditions measured during the ending or outcome period, the most sizable differences between the married and the non-married group are for the existence of work limitations and for the four dependent variables. As we might expect, married mothers have higher household incomes, and single mothers have higher levels of transfer income and time spent with low income.

Regression Results

Log of family income-to-needs. Table 2 shows the regression results for the log of family income-to-needs over the entire outcome period (age 26 - 40), as well as five-year sub-periods (ages 26 - 30, 31 - 35, and 36 - 40). Joint FSP/AFDC participation has negative effects on future family income-to-needs across the outcome age periods. The future family income-to-needs ratio is around 0.30 points lower for young mothers with joint participation during the entire initial period, relative

Table 1. Weighted Means and Standard Deviations for Married and Non-Married Mother Groups

| | All Mothers | | Non-Married Mothers | | Married Mothers | |
|---|-------------|-------|---------------------|-------|-----------------|-------|
| <i>Initial Period Variables</i> | M | SD | M | SD | M | SD |
| Percent of time joint FSP / AFDC recipient | 14.41 | 30.00 | 41.81 | 40.80 | 4.26 | 15.37 |
| Percent of time FSP-only recipient | 9.34 | 20.26 | 15.10 | 24.81 | 7.39 | 17.83 |
| Percent of time low-income, non-recipient | 16.74 | 26.21 | 22.24 | 25.40 | 15.81 | 26.08 |
| Percent of time non-eligible, non-recipient | 59.51 | 41.79 | 21.15 | 31.11 | 72.54 | 36.37 |
| Non-married mother | 0.27 | 0.44 | 1.00 | 0.00 | 0.00 | 0.00 |
| Married mother | 0.73 | 0.44 | 0.00 | 0.00 | 1.00 | 0.00 |
| Family income-to-needs | 2.23 | 1.48 | 1.17 | 0.81 | 2.63 | 1.49 |
| Grew up in low-income household | 0.06 | 0.25 | 0.05 | 0.22 | 0.07 | 0.26 |
| Number of children | 1.61 | 0.89 | 1.69 | 0.98 | 1.59 | 0.85 |
| White | 0.53 | 0.50 | 0.19 | 0.39 | 0.66 | 0.47 |
| Black | 0.42 | 0.49 | 0.77 | 0.42 | 0.30 | 0.46 |
| Not Black or White | 0.04 | 0.20 | 0.04 | 0.20 | 0.04 | 0.20 |
| Age of the youngest child | 2.18 | 1.64 | 2.71 | 2.06 | 1.99 | 1.40 |
| Max state welfare payment (\$00) (\$2006) | 8.64 | 4.18 | 7.93 | 4.13 | 8.90 | 4.17 |
| State unemployment rate | 6.23 | 1.92 | 6.40 | 2.00 | 6.17 | 1.89 |
| City size greater than 500,000 | 0.04 | 0.19 | 0.07 | 0.26 | 0.03 | 0.16 |
| Living in the South | 0.47 | 0.50 | 0.50 | 0.50 | 0.46 | 0.50 |
| High school dropout | 0.22 | 0.42 | 0.26 | 0.44 | 0.21 | 0.41 |
| High school graduate | 0.35 | 0.48 | 0.34 | 0.47 | 0.35 | 0.48 |
| Some college | 0.32 | 0.47 | 0.35 | 0.48 | 0.31 | 0.46 |
| College graduate | 0.11 | 0.31 | 0.06 | 0.23 | 0.12 | 0.33 |
| Age at start of sample period | 22.63 | 2.97 | 22.02 | 2.79 | 22.86 | 3.00 |
| Whether any work limits | 0.13 | 0.34 | 0.30 | 0.46 | 0.07 | 0.25 |
| <i>Ending Period Variables</i> | | | | | | |
| Percent of time married | 63.30 | 42.38 | 24.14 | 36.28 | 77.80 | 34.58 |
| Percent of time never married | 14.74 | 33.45 | 49.72 | 46.03 | 1.78 | 11.31 |
| Percent of time widowed | 1.56 | 10.40 | 1.70 | 10.85 | 1.52 | 10.22 |
| Percent of time divorced or separated | 20.39 | 33.63 | 24.44 | 37.00 | 18.89 | 32.17 |
| Age at end of sample period | 37.04 | 4.19 | 35.46 | 4.82 | 37.62 | 3.77 |
| Number of children | 2.24 | 1.05 | 2.20 | 1.21 | 2.25 | 0.98 |
| Whether any work limits | 0.10 | 0.27 | 0.22 | 0.35 | 0.06 | 0.21 |
| <i>Dependent Variables</i> | | | | | | |
| Family income-to-needs | 2.45 | 1.89 | 1.55 | 1.32 | 2.78 | 1.96 |
| Percent of time with low-income | 34.60 | 39.06 | 59.67 | 40.05 | 25.34 | 34.34 |
| Transfer income (000) (\$2006) | 1.16 | 3.09 | 2.55 | 4.42 | 0.64 | 2.22 |
| N | 3,748 | | 1,013 | | 2,735 | |

to young mothers with low income, but no participation over the same initial period.

Table 2. OLS Regression Results for the Log of Family Income-to-Needs Ratio

| | Full Outcome Period: Ages 26 - 40 | Early Outcome Period: Ages 26 - 30 | Middle Outcome Period: Ages 31 - 35 | Late Outcome Period: Ages 36 - 40 |
|---|--|---|--|--|
| <i>Independent Variables</i> | B (SE) | B (SE) | B (SE) | B (SE) |
| Joint FSP / AFDC recipient | -.29 (.09)*** | -.31 (.09)*** | -.31 (.08)*** | -.36 (.10)*** |
| FSP-only recipient | -.36 (.12)** | -.44 (.12)*** | -.04 (.11) | -.09 (.15) |
| Non-eligible, non-recipient | -.01 (.13) | .05 (.14) | .38 (.09)*** | .24 (.11)* |
| Joint FSP / AFDC*Married | .23 (.12) | .30 (.12)** | -.09 (.11) | .09 (.14) |
| FSP-only*Married | .28 (.14)* | .38 (.14)** | -.09 (.13) | .01 (.18) |
| Non-eligible, non-recipient *Married | .16 (.13) | .12 (.14) | -.22 (.10)* | -.13 (.12) |
| Adjusted R ² | .56 | .56 | .64 | .57 |
| N | 2,289 | 2,240 | 3,219 | 2,695 |
| Number of families | 1,829 | 1344 | 2,551 | 2,175 |

Note: OLS regression is used for the log of family income-to-needs with a full set of control variables. *p < .05. **p < .01. ***p < .001.

For food stamp-only receipt, we find strong negative effects in the early outcome period (ages 26 - 30), even somewhat stronger than the effects for joint usage, but these coefficient estimates decrease in size and significance over time, until the coefficient estimates are close to zero in the last two outcome periods. We find some differences between married and non-married mothers, with the effects of food stamp-only receipt for married mothers close to zero or zero in all outcome periods.

Proportion of time with low income (below 150 percent of the poverty line). As shown in Table 3, we find no evidence that joint FSP / AFDC receipt during an initial four-year period of motherhood has a long-term impact on the proportion of adulthood spent with low income. However, we do find that, relative to non-married mothers, married mothers spend less time with low income over the full outcome and the early outcome periods, with a statistically significant interaction coefficient of -0.45 in the early period and -0.27 in the full period. These

differences for married and non-married mothers in the full period results appear to be driven by the initial period outcomes and not by later period outcomes.

Table 3. Tobit Regression Results for the Proportion of Time with Low Income and Transfer Income

| | Full Outcome Period: Ages 26 - 40 | Early Outcome Period: Ages 26 - 30 | Middle Outcome Period: Ages 31 - 35 | Late Outcome Period: Ages 36 - 40 |
|---|--|---|--|--|
| <i>Independent Variables</i> | B (SE) | B (SE) | B (SE) | B (SE) |
| <i>Percentage of time with low income</i> | | | | |
| Joint FSP / AFDC recipient | .08 (.07) | .10 (.11) | .19 (.13) | .28 (.17) |
| FSP-only recipient | .19 (.09)* | .28 (.15) | .05 (.18) | -.24 (.23) |
| Non-eligible, non-recipient | -.22 (.10)* | -.50 (.16)** | -.61 (.16)*** | -.71 (.21)*** |
| Joint FSP / AFDC*Married | -.23 (.10)* | -.45 (.17)** | .04 (.19) | .11 (.25) |
| FSP-only*Married | -.16 (.12) | -.27 (.19)** | .15 (.22) | .49 (.28) |
| Non-eligible, non-recipient *Married | -.08 (.10) | -.09 (.16) | .15 (.17) | .49 (.22)* |
| Adjusted R ² | .39 | .37 | .37 | .32 |
| <i>Transfer Income</i> | | | | |
| Joint FSP / AFDC recipient | .27 (.05)*** | .41 (.07)*** | .28 (.08)*** | .19 (.07)** |
| FSP-only recipient | .14 (.07)* | .31 (.09)*** | .22 (.10)* | .12 (.10) |
| Non-eligible, non-recipient | -.13 (.08) | -.15 (.11) | -.40 (.12)*** | -.10 (.10) |
| Joint FSP / AFDC*Married | .04 (.08) | .08 (.11) | .17 (.11) | -.03 (.11) |
| FSP-only*Married | .11 (.09) | .10 (.12) | .12 (.13) | .07 (.13) |
| Non-eligible, non-recipient *Married | .07 (.08) | .08 (.11) | .24 (.12)* | .11 (.11) |
| Adjusted R ² | .54 | .47 | .44 | .45 |
| N | 2,289 | 2,240 | 3,219 | 2,695 |
| Number of families | 1,829 | 1344 | 2,551 | 2,175 |

Note: Tobit regression is used for the percentage of time with low income and for transfer income with a full set of control variables.

*p < .05. **p < .01. ***p < .001.

We find similar results for food stamp usage alone. The coefficient estimate for FSP-only receipt becomes statistically significant only in the model used to predict proportion of future time with low income over the entire 15-year period. This finding appears to be driven by early outcome period effects, which then fade over time. The interaction of marital status

with food stamp program participation variables suggests that younger mothers who are married fare better than those who are not, but only in the early outcome period, where the effect of FSP participation is close to zero for married mothers.

Transfer income. As shown in Table 3, standard regression models suggest that joint FSP/AFDC participation during initial motherhood years substantially increases the amount of transfer income used during the early outcome period (age 26-30), with weaker but still statistically significant increases during the subsequent outcome periods. For the entire 15-year outcome period, standard regression models indicate positive, statistically significant effects of joint FSP/AFDC participation on future transfer income.

However, as described fully in the Methods section, we find that sister sibling fixed-effects regression models offer a better fit for the relationship between young mothers' participation in the Food Stamp Program, and their future transfer income. As shown in Table 4, for the later outcome period (age 36 - 40), we find substantially smaller and insignificant effects using the sister fixed-effects model, relative to the standard regression (i.e., tobit) model, suggesting that the tobit estimates may be overestimating the effects of joint participation. We also ran a tobit model using only young mothers and their sisters, with results similar to those achieved using the full-sample tobit model ($b = 0.26$, significant at the 0.01 level). These results suggest that sample differences (i.e., a sisters sample versus a full sample) do not account for the differences in coefficient estimates between the tobit and FE models, but rather that the FE model better estimates the effects of joint participation.

For young mothers who participate in the Food Stamp Program alone, the future transfer income story is much the same. Standard regression models suggest that FSP-only recipients have higher levels of future transfer income relative to their low-income, non-recipient peers (Table 3). Projected transfer income is higher for FSP-only recipients than for low-income non-recipients during the age 26 - 30 outcome period and, though to a lesser degree, for the age 31 - 35 outcome period. The effect disappears, however, for the age 36 - 40 outcome period.

Table 4: Fixed Effects Regressions for Transfer Income

| | Full Outcome Period: Ages 26 - 40 | Early Outcome Period: Ages 26 - 30 | Middle Outcome Period: Ages 31 - 35 | Late Outcome Period: Ages 36 - 40 |
|---|--|---|--|--|
| <i>Independent Variables</i> | B (SE) | B (SE) | B (SE) | B (SE) |
| Transfer Income | | | | |
| Joint FSP / AFDC recipient | .17 (.06)** | .29 (.08)*** | .16 (.06)** | .04 (.05) |
| FSP-only recipient | .05 (.09) | .13 (.12) | .00 (.08) | -.06 (.06) |
| Non-eligible, non-recipient | -.09 (.09) | -.09 (.11) | -.20 (.08)** | -.08 (.06) |
| Joint FSP / AFDC*Married | -.01 (.09) | .05 (.12) | -.04 (.09) | -.01 (.07) |
| FSP-only*Married | -.07 (.12) | -.15 (.16) | -.04 (.12) | .06 (.09) |
| Non-eligible, non-recipient *Married | .03 (.09) | .02 (.11) | .11 (.08) | .08 (.06) |
| W/in R ² | .34 | .37 | .31 | .18 |
| N | 775 | 742 | 1,119 | 876 |
| Number of families / Average size | 321 / 2.4 | 311 / 2.4 | 451 / 2.5 | 356 / 2.5 |

Note: Results are for sister fixed effects models with a full set of control variables.

*p < .05. **p < .01. ***p < .001.

In the FE models shown on Table 4, we find that the effects of FSP-only receipt on future transfer income are small and statistically insignificant, in this case for all age categories. As with the models for joint FSP / AFDC receipt, these differences again appear to be attributable to the statistical controls introduced by the FE models.

In the FE models shown in Table 4, we do not find differences in the relationship between FSP participation, either alone or jointly with AFDC, and future transfer income for married and non-married women.

Discussion and Conclusion

We have tested the question of whether the use of food stamps, either alone or in conjunction with other types of government assistance, results in economic or other hardships in later life, or whether simply being poor, or the combination of poverty and other factors, threatens economic outcomes for married and non-married mothers. The results indicate that if

we were to look solely at the entire 15-year outcome period, we might conclude that the effects of government assistance are adverse and far-reaching—that food stamps taken when one is a young mother negatively impact economic outcomes over the long run. Our data indicate that this conclusion may well be faulty and premature. By looking at five-year periods after the initial young parenting period, we find that it is generally only the period between the ages of 26 - 30 that is affected by time using food stamps. If other, longer periods after the initial period show any effects at all, these effects generally diminish as time passes.

Our models show that joint participation, however, does affect outcomes, such as lower future family income-to-needs, and for earlier outcome periods, receiving more transfer income, relative to those who have low income without public assistance in the initial period. We acknowledge that the reference group in these models (time with incomes below 150% of the poverty line) will tend to have higher income relative to those on AFDC, and therefore may not be an appropriate reference group. Our reference group was better suited for comparison with those who spend time using food stamps. However, we find no differences between those who jointly use AFDC and food stamps in future time spent with low income, relative to low-income, non-recipients, either in the short run or long run.

Generally, we found few differences between married and single mothers. While some short-term differences were found, these differences did not last over the long-term. These results support the notion that food stamp usage alone negatively affects some outcomes but that these effects are generally short-lived. For all outcomes, including income-to-needs, time with low income, and transfer income, we find that young mothers who use food stamp income alone have similar economic outcomes to low-income, non-recipient mothers. These results for food stamp recipients run counter to theories of dependency for public assistance recipients.

In general, we do not find that time receiving food stamps improves the economic situation of young mothers relative to those with low income and no transfer assistance. At the same time, because of the generally short-lived nature of initial food

stamp usage effects, we find that the long-term impact of time on food stamps is neither positive nor negative for the economic outcomes we have examined relative to time with low income without government assistance. Thus, if, as some studies have suggested, the use of food stamps leads to positive outcomes in other or non-economic areas, such as nutrition, consumption stabilization, or physical and emotional well-being, these alone may well justify continued support of the food stamp program (Perez-Escamilla et al., 2000).

It is important to emphasize that while there are few differences over the long run between the transfer and non-transfer income groups, this does not mean that either group, especially single mothers, fares particularly well over the long run. Income is barely over the poverty line for the early outcome period (age 26 - 30), and is at or near 150 percent of the poverty line at ages 31 - 35 and 36 - 40 (results not shown). In light of these descriptive findings, we would also caution against construing certain economic outcomes as negative in a prescriptive, rather than a statistical sense. What may be "good" economically may not be so for the less quantifiable outcomes of health and well-being, such as caring for children. As a goal shared by food and nutrition programs more generally, "ensuring the health of vulnerable Americans" may be seen as having implications beyond the nutritional (Fox, Hamilton, & Christenson, 2004, p. 1).

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Doing a Little More for the Poor? Social Assistance in Shanghai

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Shanghai was a leader in nation-wide social assistance reform. It has established an extensive and complex social assistance system. This paper offers a general overview of different major assistance programs in Shanghai and uses a recent survey of Minimum Living Standard Guarantee System (MLSGS) recipients in urban Shanghai to briefly examine the performance of social assistance. It finds that on the program construction and administration level, Shanghai's social assistance is advanced. However, due to high living costs and relatively low values of social assistance, social assistance plays a limited role in relieving the distress of recipients. The paper analyzes the main reasons for this and argues that efforts should be made to give the poor more assistance and help them to get rid of poverty.

Key words: *Social assistance, Shanghai, Poor, MLSGS, poverty*

Since the 14th Congress of the Chinese Communist Party (CCP) in 1992, China has formally clarified the objective of establishing a socialist market economic system, which initiated a transitional period of socio-economic development with the adoption of a market-based economy. Shanghai, as a commercial and industrial center with a large number of state owned enterprises (SOE) in China, first felt the pressure of transition and the challenge of urban poverty caused mainly by unemployment from SOEs. In order to deal with the problem of new urban poverty and to maintain social stability in the city, a new social assistance program—Minimum Living Standard

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Guarantee System (MLSGS) was introduced. MLSGS made its first appearance in Shanghai in 1993 and became a prelude to social assistance reform in China. Since then, Shanghai has consistently played a leading role in the reform and development of social assistance in China. Shanghai's MLSGS gradually increases its benefit level and enlarges its coverage. In order to meet the medical, education and housing needs of the poverty-stricken households, as well as to supplement their financial power, Shanghai has established special assistance programs step-by-step since the early 2000s, including medical aid, education aid, housing assistance, etc. Thus, eligible MLSGS recipients in Shanghai can also enjoy a variety of special assistance benefits.

Shanghai's experiences attracted great attention from the Ministry of Civil Affairs (MCA) and many other cities in some relatively developed coastal areas. With the effort of central government, MLSGS has become a national program and special assistance programs have been propelled gradually. So far, special assistance programs are regulated, administered and funded by local authorities without national guidelines, and large regional differences exist. As a leader of social assistance reform, Shanghai has established an extensive and complex assistance system which makes it stands out in China.

What are the major contemporary programs in its assistance system? How successful is the system in relieving the distress of the social assistance recipients? How can the social assistance system in the most affluent and thriving city in China be improved? This paper aims to find the answers to these questions.

Main Programs

Minimum Living Standard Guarantee System (MLSGS)

MLSGS is the main body of the social assistance system in Shanghai. It is authorized by national guidelines and administered by Shanghai Civil Affairs Bureau (SCAB). This means-tested income assistance program provides a basic living benefit for poor households. To qualify for this benefit, an applicant must be a holder of Shanghai permanent household registration (or *hukou*), and have average earnings below

the minimum living standard. Before 1999, MLSGS was exercised under the traditional relief structure that enterprises provided assistance to employees and government to the unemployed, such as the three-nos (residents without working ability, without an income, and without family support). As directed in the national guideline of 1999, the government has since taken the responsibility of administration and funding for all the needy, whether working or not. The means test is stringent, which means that applicants are required to draw upon all other available resources before turning to the government for assistance (Huang, 2003, p. 160).

The Shanghai government adopted the 'basket of goods' approach that basically measures subsistence needs in absolute terms; the mechanism of up-rating is to change the cost-of-living in line with the movement of the price index, real wage increases, and local financial capability. The urban assistance level has risen from 120 yuan (per head, per month) in 1993 to 425 yuan in 2010. Shanghai is among the cities with a high assistance level in China. Yet, this benefit level is quite low in relative terms. It is calculated that in 2008 the assistance level only accounted for 17.8% of the average disposable income, lower than those of the other three Municipalities in China (*zhi xia shi*), respectively 24.7% in Tianjin, 19.8% in Chongqing, and 18.9% in Beijing, let alone the international standard: half of the average or medium income.

Medical Aid (MA)

MA is a locally-regulated, SCAB-administered program providing medical assistance for poor households whose average income is lower than the 150% of the minimum living standard, within which there is a patient with uremia, mental disorder, cancers or other officially-defined serious illnesses. To be eligible for MA, claimants should prove that they are unable to afford the substantial medical expenses after taking into account all other available assistance and compensation from working units, family and medical insurance.

According to the recent regulation, the MA scheme will reimburse the eligible claimants for 50% of the total medical expenses if the expenses are no more than 30,000 yuan. For expenses more than 30,000 yuan, the reimbursement rate

increases to 60%. However, the maximum reimbursement that each claimant can apply for within a year is 50,000 yuan. The eligible claimants have to first pay medical expenses on their own before receiving the MA benefits with relative hospital receipts.

Education Aid (EA)

EA is a locally-regulated program co-administered by SCAB and the Shanghai Commission of Education, with the intention to prevent students of poverty-stricken families from dropping out of school. It has mainly two forms: one is exemption of tuition fees and other miscellaneous expenses, and the other is a stipend for eligible students from poor families. To be eligible for EA, claimants should submit applications every semester. If their applications are approved, they can get education stamps. The students submit education stamps to their schools to get exemptions, and they can also enjoy different levels of stipend according to the poverty level of their families. Currently, on the compulsory education level in Shanghai, stipends for students from MLSGS families are 110 yuan per month and 60-170 yuan per month for students for other families in difficulty. The source of funding comes partly from government finance and partly from the revenues of schools or social donations.

Housing Aid (HA)

HA, or low-rent housing scheme, is a locally regulated program and is administered by the Shanghai Housing, Land and Resources Administration Bureau. It targets families in 'dual-poverty'—meager income plus poor residential conditions—and provides recipients with cash or in-kind transfers to improve their residential conditions. It is mainly funded by the municipal and district government.

To qualify for HA, currently a household must meet the conditions that household monthly income and assets should be no more than 960 yuan and 120,000 yuan respectively. Further, a per-capita residential housing area should be below 7 square meters. In practice, housing aid is mainly available to special target households, such as the childless elderly, dependents of deceased soldiers, and the disabled. It is estimated that a small

proportion of the families with poor residential conditions in Shanghai can get HA (Huang, 2003, p. 173) .

Temporary relief

Temporary relief has long been the main part of social relief system in China. Without statutory rules and regulations, such a scheme is usually operated under the discretion of sponsors. The rate of payment hinges heavily on available funds. There are two typical schemes that might overlap with each other. The first one is the "warmth-delivering project." It is initiated by virtually all tiers of governments from the central to the grass-roots, and semi-official organizations, such as the Federation of Trade Unions. The 'warmth'—in cash or in-kind handouts—is usually delivered during the important Chinese festivals or days such as Spring Festival, New Year's Day, National Day, etc. Often it is the heads of governments or departments that direct the relief by means of home visits. It should be noted that this kind of provision is not seen as just material or cash transfers, but, more importantly, a reflection of the benevolent concern, or so-called 'warmth,' from the Government and Party to the poor families.

The second form is the social aid scheme, which is generally funded by social donations. Most district governments and social offices, as well as a variety of different social organizations and foundations, have established such programs. It aims to provide emergency relief for persons who have suffered from unexpected misfortunes and who are not eligible for state assistance (Huang, 2003, p. 164). This is still regarded as an important supplement to the public assistance system today in Shanghai.

Performance

There's no denying that Shanghai has established a rudimentary social assistance system consisting of several assistance programs, and has taken the lead in protecting the poor in China. However, we must ask how far this social assistance system is successful in relieving distress or poverty among the recipients? What are the recipients' attitudes towards social assistance? This section will briefly examine the performance of social assistance from the micro perspectives of recipients'

income and expense conditions and the recipients' attitudes towards social assistance by using data from a recent survey of MLSGS recipients in urban Shanghai.

At the end of 2008, SCAB commissioned a household survey of those who received a minimum-living-standard allowance (MLSA). A total of 400 households were surveyed, involving 1182 people. The monthly value of the MLSA was 485.3 yuan per household. Besides the allowance, 103 of the 400 households also received monthly housing aid benefits of 623.5 yuan per household and 62 received monthly education aid benefits of 142.8 yuan per household. Seventy-three households received medical aid and other temporary relief; the monthly benefit was 105 yuan per household. The respondent profiles were not fully representative of the population of all social assistance recipients, and so a weighting procedure was employed which reduced, but did not entirely eliminate, the problem of sample bias (SCAB, 2009). It is this survey that provides the basis for the analysis and assessment that follows.

Income and expense of living

It is hardly surprising that giving households a regular monthly cash benefit and other assistance will help to increase income and relieve distress. Yet, the degree of relieving impact depends on the value of the benefits and the living expenses of the households.

As shown in Table 1, before getting various assistance benefits, the poor households' per capita monthly income was 340.8 yuan, while with all the assistance benefits the per capita monthly income increased to 560.9 yuan, an increase of nearly 65%. Table 2 reveals that per capita monthly expenses were 578.3 yuan. Among all the expenditures, the expenditure on food is the largest proportion, and accounted for 42.6% of expenses. It is followed by education and medical expenditures, which accounted for 22.6% and 13.5% of expenses respectively. From the two tables, it can be seen that the expense outweighs the income and the gap is 17.4 yuan.

Table 1. Per capita Monthly Income of Urban MLSGS Recipients in Shanghai (2008)

| Income (Yuan) | |
|-----------------------------------|-------|
| Without assistance benefits | 340.8 |
| With assistance benefits | |
| Special assistance benefits | 396.7 |
| MLSA+ Special assistance benefits | 560.9 |

Note: Special assistance benefits include benefits of housing aid, education aid, medical aid and other temporary relief.

Table 2. Per capita Monthly Expense of Urban MLSGS Recipients in Shanghai

| Type of expense | Expense (Yuan) |
|-----------------------------|----------------|
| Food | 246.2 |
| Education | 130.4 |
| Medical treatment | 78.2 |
| Water, electricity and heat | 33.9 |
| Life daily necessities | 28.6 |
| Housing | 23.4 |
| Communication | 21.9 |
| Traffic | 15.7 |
| Total | 578.3 |

As to the overall income and outcome conditions of the 400 households, 330 households (82.5%) said they were unable to make ends meet every month. Sixty-eight households (17%) said they could barely make ends meet. Only 2 households (0.5%) admitted they have a little balance every month. Most of the households who can't make ends meet chose to obtain assistance and help from their families and relatives.

It is obvious that in Shanghai the social assistance benefit was an important part of poor households' income and helped to relieve their degree of poverty. On the other hand, due to the high cost of food, education and medical treatment, as well as relatively low values of social assistance benefits, the majority of social assistance recipients lived beyond their incomes. That is to say, social assistance played a limited role in relieving the distress of the poverty-stricken families.

Recipients' Attitudes

Since social assistance aims to help its recipients to improve their living conditions, the recipients' attitudes towards social assistance matter and to some degree can reflect the performance and effectiveness of social assistance. The survey indicated that 85% recipients responded it is convenient for them to receive social assistance benefits and 96% recipients can get their benefits in time, which means the administration of social assistance in Shanghai is basically effective. In fact, a distinctive feature of the administrative framework of the social assistance system in Shanghai is the initiation of a social assistance administrative agency (SAAA) (*shehui jiuzhu guanlisuo*) at the level of Street Office or town government. The aim of SAAA is to set up a community-based administrative agency independent of government departments. Besides MLSGS and MA, SAAA is also involved in the administration over EA, HA and temporary relief, together with related departments. This kind of design makes SAAA become the only agency through which urban residents can claim social assistance: government departments, working units, and social organizations can distribute the relief (Huang, 2003, p. 174). The administrative innovation of social assistance in Shanghai improves the effectiveness of benefits delivery and also sets a good example for other areas in China.

As to the recipients' degree of satisfaction, 152 households (38%) felt satisfied and 160 households (40%) felt all right, while 88 households (22%) felt unsatisfied with their benefits. The main reason for dissatisfaction was low values of assistance benefits. So, it is not surprising that of those 232 households who gave suggestions on social assistance, 180 households (78%) focused on increasing MLSA and 17 households (7%) asked for improvement of MA.

It is interesting that although 82.5% households couldn't make ends meet even with various assistance benefits, there were still 78% households who held a basically satisfactory attitude toward social assistance. This is partly because regular social assistance benefits actually enhance the households' income, which gives the recipients the feeling of economic security. This happens in part because the administration is

effective, which guarantees the effectiveness and convenience of benefits delivery, and partly because the influence of traditional culture of welfare in China makes the poor expect to get assistance from families and relatives instead of government.

Commentary

It cannot be denied that on the program's construction and administration level, Shanghai's social assistance is absolutely advanced in China. However, due to high living costs and relatively low values of social assistance, it can be assumed that the poor in Shanghai probably still live a difficult life. The findings reported in the recent survey are fully compatible with this assumption. The reasons for this situation can be mainly attributed to two aspects: social assistance and the design of such social assistance.

First is the idea of social assistance. The emphasis on the idea has recently experienced a renaissance in welfare research, largely in tandem with the growing appeal of institutionalist approaches in different disciplines (Clemens & Cook, 1999; Hall & Taylor, 1996; Immergut, 1998; Thelen & Steinmo, 1992). Ideas influence institutions, as policy-makers possess values and beliefs which shape their comprehension of and response to social problems. In Shanghai, the idea of a citizenship right to social assistance is not well developed. Although the State Council decreed the Regulation of Minimum Living Standard Guarantee System for Urban Residents, marking a milestone for the government formally to take the responsibility of assisting the poor (Leung & Wong, 1999), there is general desire in China to avoid an overly generous welfare provision for the people. This lays the ideological foundation for setting social assistance benefits at the subsistence level to merely avoid starvation, homelessness, and raggedness (Tang, Cook, Wang & Ren, 2000, p. 78).

There is no exception in Shanghai. The Shanghai government adopted the 'basket of goods' approach that basically measures subsistence needs in absolute terms to determine the social assistance level. Thus, the benefit rate of social assistance is set at a minimum subsistence level to avoid it being viewed as an attractive form of support, which reflects the idea that

social assistance provision works only to provide basic living needs for the impoverished residents, not as a way to resolve poverty. Under this idea, the benefit level of social assistance in Shanghai is quite low in relative terms. As mentioned above, it is calculated that in 2008 the assistance level only accounted for 17.8% of the average disposable income, lower than those of the other three Municipalities (*zhi xia shi*), which is not compatible with Shanghai's status as the most affluent city in China.

Second is the design of social assistance. These programs, such as MA, HA and EA, are based on so many stringent conditions that only a small proportion of poor households are eligible. Thus, the effect of special programs on providing relief to the poor is very limited. As shown in Table 1, if MLSA is not included, the per capita income only increased by 16%, to around 397 yuan. To take MA for an example, the policy specifies that MA is for poor households with the patients of uremia, mental disorder, cancers, or other officially defined serious illnesses. Thus, poor households with the patients of other illnesses, chronic or acute, are excluded. In fact, the survey finds that patients with a chronic illness comprise nearly 83% in all the patients of the 400 MLSGS households, and they cannot get any assistance from MA (SCAB, 2009).

At the same time, the requirement that the eligible claimants have to first pay the medical expense on their own means many poor households can't get immediate medical treatment due to lack of money. If they do obtain MA benefits, what they get is insufficient, because the social assistance benefit level is so low. According to the Shanghai Ordinance on Social Assistance, setting of benefit level should also take into consideration the local economic development level and financial capability as well as average living condition, minimum expenditure for subsistence and consumer price index. This kind of policy design means in practice the setting of the benefit level is not fully determined by the needs of the poor but is also determined by local financial capability. Since the government financial resources mainly focus on promoting production and city construction instead of social welfare, poor citizens in Shanghai usually can't reap the benefits of economic prosperity and growth.

In order to give the poor more assistance and help them to get rid of poverty, efforts should be made in three aspects.

First, the idea of social assistance should be changed. Basically, social assistance programs involve two levels. First is a living guarantee, which is to provide a minimum standard of living to people with no other resources, though its operational definition varies within, as well as between, countries. The second is an anti-poverty program which helps to prevent social marginalization and exclusion (Eardley, Bradshaw, Ditch, Gough, & Whiteford, 1996, p. 47). Currently Shanghai's social assistance mainly has the first level: that of guaranteeing to the poor a minimum subsistence standard of benefits; the idea of eliminating poverty is neglected. Hence, the concept of social assistance should be changed through emphasizing the idea of combating poverty. In this way, social assistance can gain more attention from the government and the poor can get a relatively decent benefit, which is good for human development and social inclusion. This change of idea would shift focus to actually getting rid of poverty through the aid of various social assistance programs.

The second area of change involves policy. Since improper policy design makes social assistance play a limited role in relieving the distress of the poor households, several policies should be adjusted and rectified. The setting of benefit levels should be done scientifically and carefully according to the basic living needs, which not only include subsistence and regular needs, but also irregular or exceptional needs. Further, strict eligibility requirements of special assistance programs should be liberalized gradually to cover more poor households. For example, MA has to cover poor households with the patients of other illnesses step-by-step in order to prevent the vicious circle of illness and poverty. And, in order to guarantee that patients receive medical treatment in time, the requirement that the eligible claimants have to first pay the medical expense on their own should also be changed to make MA more accessible. As for HA, conditions on household income and assets as well as per-capita residential housing areas should also be gradually liberalized in Shanghai.

The third area for change involves charitable experiments on aiding the poor, which should be encouraged. Although the local government bears the important responsibility of assisting the poor, the role of charitable organizations cannot be ignored. In fact, how to coordinate the relationship between

government and charitable organizations in helping the poor is a crucial issue. Compared with other areas in China, Shanghai has a relatively sound environment for developing charitable organizations, and some organizations have already carried out several experiments in aiding the poor, such as the Shanghai Charitable Medical Aid Program and the Charitable Training Program. In future, more assistance programs run by charitable organizations should be encouraged and developed. At the same time, the partnership between government and charitable organizations should also be promoted.

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Clinical Social Work and the Biomedical Industrial Complex

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This article examines how the biomedical industrial complex has ensnared social work within a foreign conceptual and practice model that distracts clinical social workers from the special assistance that they can provide for people with mental distress and misbehavior. We discuss: (1) social work's assimilation of psychiatric perspectives and practices during its pursuit of professional status; (2) the persistence of psychiatric hospitalization despite its coercive methods, high cost, and doubtful efficacy; (3) the increasing reliance on the Diagnostic and Statistical Manual of Mental Disorders, despite its widely acknowledged scientific frailty; and (4) the questionable contributions of psychoactive drugs to clinical mental health outcomes and their vast profits for the pharmaceutical industry, using antipsychotic drugs as a case example. We review a number of promising social work interventions overshadowed by the biomedical approach. We urge social work and other helping professions to exercise intellectual independence from the reigning paternalistic drug-centered biomedical ideology in mental health and to rededicate themselves to the supportive, educative, and problem-solving methods unique to their disciplines.

Key words: *Clinical social work, social welfare, mental health, psychiatry, pharmaceutical*

According to the National Association of Social Workers (NASW), clinical social workers mainly focus on “the mental, emotional, and behavioral well-being of individuals, couples, families, and groups,” are essential in settings such as health centers and hospitals, substance use treatment programs, schools, agencies for children or the aged, employee assistance programs, and private practice, and “represent the largest group of behavioral health practitioners in the nation” (2005, p. 7). Based on data from the U.S. Bureau of Labor Statistics (2010) and Whitaker and Arrington (2008), one can estimate that approximately 40% of the 642,000 social workers in the U.S., or 255,000 individuals, practice clinical social work.

Over the past three decades, the medicalization of distress and misbehavior has exploded. In professional and popular forums, problems previously attributed to environmental, social, and personal factors—such as poverty, disintegration of family and community, grueling work, and abusive or neglectful childhoods—have been increasingly attributed to brain dysfunctions stemming from as-of-yet-unconfirmed genetic and chemical defects (Conrad, 2007; Moynihan & Cassels, 2005). Some studies suggest that social work education and practice shifted from understanding how personal-historical-ecological-contextual factors may bring about behavioral problems, to viewing severe distress and disability as manifestations of biological diseases defined by the successive editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (Lacasse & Gomory, 2003). The shift is accompanied by clinical social workers’ use of descriptive psychiatric labels as explanations for their clients’ problems (Frazer, Westhuis, Daley, & Phillips, 2009) and, in academic social work writings, by an apparent acceptance and a dearth of critical analyses of the worth of psychotropic drugs (Cohen, 2010). For certain authors, some of these developments indicate that clinical social workers are appropriately “making research-based assessments of mental illnesses etiology” (Walsh, Green, Matthews, & Bonucelli-Puerto, 2005, p. 43). We argue otherwise in this paper, suggesting that the redefinition of the causes of disturbing behavior

along the lines of current psychiatric practice is part of a larger ideological and institutional project that is only loosely tied to science. We also argue that it has narrowed the options of clinical social workers and other helping professionals.

Professional validation and survival might appear as motives for clinical social work's turn to the view that serious distress, psychosocial disability, and misbehavior are manifestations of somatic problems requiring primarily medical solutions. In this era of relative retrenchment of federal and state spending away from human services and toward health care (Bielefeld & Chu, 2010), the activities of social workers would continue to benefit from official standing and public and third-party funding within the biomedical-industrial complex and existing welfare state.

When Relman (1980) introduced the phrase "biomedical industrial complex" to echo President Dwight Eisenhower's famous 1960 warning about the influence of the military-industrial complex, he wished to emphasize the influence of large corporations on the medical system. Later writers, focusing on its psychiatric portion or counterpart and emphasizing its ideological elements, such as medicalization, described a mental health-industrial complex (Duhl, Cummings, & Hynes, 1987), a psychiatric-industrial complex (Carpenter, 2001), or a psychopharmaceutical-industrial complex (Breggin, 1997; Murray, 2009). In accord with these authors, we use the term to refer to the reinforcing and interlocking connections between the pharmaceutical, biotechnological, and medical industries that—together with academic experts in the helping professions, governmental funding and regulatory bureaucracies, such as the National Institute of Mental Health (NIMH) and the Food and Drug Administration (FDA), and professional and family lobbies—promote and support a biomedical model of psychosocial distress and disability. Spending in the U.S. on mental health and substance abuse has been forecast to reach \$239 billion by 2014, of which \$72 billion is expected to be for psychotropic drugs (Levit et al., 2008).

Critics of the biomedical complex observe that over the past fifty years it has monopolized mental health practices to the detriment of its ostensible beneficiaries. Its primary purpose seems to be "biomedical dominance" (Carpenter, 2001,

p. 70), the successful inculcation of the view that a medicalized approach (conceptual, scientific, clinical, institutional) to psychosocial distress, disability, and disapproved behavior is valid and is the best approach for everyone. Critics document that the approach obscures the differential benefits accruing especially to the leading players, theorized in most discussions to be large private corporations (especially but not exclusively pharmaceutical) and their allies in politics, the professions, and academia. These benefits translate into money, and therefore influence to recast all the issues involved, "to the extent of altering public perceptions as to what is occurring and why" (Turnock, 2009, p. 136). Some policy analysts have noted how heads of corporations benefit lavishly but illicitly from the biomedical industrial complex (e.g., Cassels, 2009), and at least one clinician (Murray, 2009), has argued that the psychopharmaceutical-industrial complex leads many clients to adopt and internalize "disease-model messages ... in ways similar to cult indoctrination" (p. 283), that is, impervious to evidence and experience. These observations illustrate the complexity of the system; they are not meant to promote a conspiracy-theory-type of explanation. Our use of psychiatric-industrial complex and associated terms is meant to re-focus attention of social workers on the explicit and implicit functions and on the dynamic nature of a very large social system, and of their roles in it. It is also meant to highlight interconnections between the constituent ideologies, professions, client populations, treatments, and institutions of the system, as well as connections between it and other large systems, such as criminal justice, welfare, education, and the military.

This paper's purpose is to examine and critique the biomedical industrial complex's power to define the nature, causes, and responses to psychosocial distress, disability, and disapproved behavior as physical diseases. It also posits that this unopposed authority threatens the well-being of distressed persons and suppresses innovative solutions to the perennial challenge of disturbing behavior that might not comport with this belief. Social workers delivering clinical services, by and large, have sought to align with and assimilate within psychiatry's explanatory framework without carefully analyzing its assumptions and outcomes. We think this has led to a loss of

intellectual and practical independence among social workers. In the hope of spurring readers to scrutinize existing systems of care and their compatibility with the values of social work, we review clinical social work's ancillary role to psychiatry and discuss the contemporary functions of the psychiatric hospital, of the DSM, and of psychoactive medications as elements in the modern psychiatric-industrial complex. We conclude by offering suggestions for social workers and other professional helpers considering employment in or currently working in mental health systems. In this paper we synthesize and analyze research and evidence culled from the publicly available mainstream literature. We are puzzled that we have not found previous academic social work publications highlighting the enormous threat that, in our judgment, scientifically untenable claims of the psychiatric-industrial complex present to both the well-being of our clients and to the professional independence and effectiveness of clinical social workers.

When we use terms such as mental disorder and mental illness in this paper, we simply refer to the many different behaviors that have become the targets of the mental health care system. We imply no agreement with the idea that these problems are at root biological, that they represent distinct clinical entities as characterized by the DSMs since 1980, or even that they should be separated conceptually as psychopathology from other problems of living. We think that they include at least two broad types of problems that should be distinguished, although people often manifest both simultaneously. On the one hand, there is *distress*: usually situational, life-stage-related difficulties in coping with life's demands that manifest as impairments in personal or interpersonal functioning, and for which people seek or accept help. On the other hand, there is *misbehavior*: deviant, offensive or socially disruptive behaviors that mobilize social groups to restrain the uncooperative individual. Failure to distinguish between these two categories and the differential societal response to each, conflates the perhaps empirically irreconcilable dual mandates to help clients and protect society under the single rubric of "mental health practice." This categorical mistake of not distinguishing therapeutic engagement from coercive police or managerial authority has long been a cause of ethical dilemmas

faced by public psychiatric social workers. It also fits with the recent patterns of transformation of the psychiatric-industrial complex following the downsizing of the large state mental hospitals during the 1970s and beyond.

Social Work's Historical Alliance with Psychiatry

When a shift occurred from the universal explanatory paradigm of religion to that of science in the 17th and 18th centuries, American society also began to view dependence and charity more rationally and critically, and by the 19th century took "steps toward a science of social welfare and a profession of social work" (Leiby, 1978, p. 43). This paralleled the development of almshouses, reformatories and hospitals as more humane and efficient institutions to deal with dependent populations, including the insane. The first almshouse in America was built in Boston in 1662, the first hospital in Philadelphia in 1752, and the very first hospital exclusively for mad people in Williamsburg, Virginia in 1773 (Grob, 1973).

The development of insane asylums took a sharp turn in the mid-1800s, when Dorothea Dix, a social reformer appropriated as a pioneer both by social work and psychiatry, championed the creation of state-run institutions for the insane as alternatives to detaining them in penal institutions. Building upon her claim that insanity was "as curable as a cold or a fever" (cited in Scull, 1981, p. 156) if managed according to the principles of moral treatment (a combination of detention, labor, and re-education), she aggressively lobbied state legislatures for funds to build public insane asylums (Lightner, 1999), and 32 state mental hospitals were founded or enlarged as a result of her efforts (Leiby, 1978). Historians agree that Dix "was not above employing exaggerated rhetoric or embellishing facts" (Grob, 1994, p. 47) and that her statistics were inaccurate and unreliable (Rothman, 1990). Gollaher (1995, pp. 434-437) has shown how some then contemporary critics could be withering of the asylum movement and of Dix's uncritical promotion of it. The mostly well-intended actions of Dix and her allies, the emerging 19th century medical superintendents of insane asylums, and the uses they made of data are early examples of reforms and paradigm shifts in mental health justified on

the basis of largely (but not universally) uncritically accepted outcome claims made by social reformers and others to gain or extend professional turf (Abbott, 1988).

Eventually, any therapeutic value of moral treatment and its environment, the asylum, could no longer be sustained. When Dix began her campaign in the early 1840s, less than 3,000 people lived in public and private asylums. Fifty years later, there were 74,000 residents just in the public facilities (Whitaker, 2002). The latter population grew to consist of the mad, the syphilitics, the alcoholics and the senile elderly, inexorably turning the system away from curing to warehousing. This development paralleled the medicalization of these institutions (Whitaker, 2002, ch. 2).

It is well known that "social work is one of society's tools for securing conformity and controlling deviant individuals and groups" (Hutchinson, 1992, p. 126). Psychiatry, however, has been the prominent profession for these social management purposes. Much like psychiatry, social work, from its origin, focused on social pathology and used paternalistic interventions. Both groups skirmished with neurologists and the nascent applied psychologists in the early 20th century for professional control of "the Personal Problems Jurisdiction" described by Abbott (1988, pp. 280-314). Neither group had genuine scientific techniques of their own, but psychiatry won out because, on the basis of its historical identification as a medical specialty, it drew upon the age-old tradition and emerging breakthroughs of physiological medicine. More important, by using coercion and detention and defining them as treatment, psychiatry acquired an indispensable function in mutating societies increasingly based on the rule of law: the extra-legal incarceration of the insane and adult dependent populations—a management function that has remained intact to this day. In this endeavor, clinical social workers were relegated to being psychiatry's "handmaidens," probably because most practitioners were women and, as Abraham Flexner told them in 1915, lacked sufficient educationally transmissible techniques and individual responsibility in their work to qualify as professionals (Trattner, 1979).

The effort to become a full-fledged profession provided incentives for social work to value its association with

psychiatry and to utilize the latter "as an important working model and standard of comparison" (Lubove, 1983, p. 55). One can imagine that pioneer social workers did not wish to be psychiatrists and anticipated a rational, scientific social work profession whose practitioners worked for the moral, physical, and social betterment of deprived individuals, families, and groups. But it is difficult to imagine that they could look elsewhere than to psychiatry—with its mix of authoritarianism, history taking, advice giving, and medical language, for example—as they sought professional status. The alignment provided both a semblance of a scientific approach to enhance social work's hoped-for professional clout, and actual settings that could hire social workers. But it also led to social work's subordination to psychiatric authority and to its subsequent direct role in coercing clients, as no recognizable contractual psychiatry yet existed. Already by 1906, Dr. James J. Putnam of Boston's Psychopathic Hospital hired social workers to visit patients' homes and establish "friendly relation[s]" with them and their families "as a means of making [the physician's] directions to them effective" (Lubove, 1983, p. 63). (Putnam's use of social workers to extend psychiatric influence in the home of the client is a precursor to today's coercive assertive community treatment used with the severely mentally disturbed [see Gomory, 2005]).

Perhaps more than anyone, the pioneer social worker Mary Richmond cemented the intellectual alliance of social work with psychiatry by developing the notion of individual treatment (casework), the *sine qua non* of the profession. According to Lubove (1983), Richmond "singled out the combination of Juvenile Court and Psychopathic Institute (along with charity organization and medical social work) as decisive factors in the evolution of casework" (p. 45). This further identified social work intervention with paternalism, the medical model, and medical settings (Kirk, Siporin, & Kutchins, 1989, pp. 296-297). In her classic *Social Diagnosis*, a major response to Flexner's charges, Richmond (1917) changed the name of caseworkers' method from *investigation* to *diagnosis*, in order "to make advances toward a professional standard" (Richmond, 1917, p. 26). Struggling for professional acceptance, social workers strove to resemble medicine, by doing diagnosis and treatment rather than investigations.

A number of social work academics have argued that during the middle decades of the century, "[t]he hunches and hypotheses of Freud, Jung, Rank and Adler combined to stimulate ... [a] 'psychiatric deluge' in social work" (Reamer, 1992, p. 14). This argument is misleading if it implies that psychiatric influence was not always present in clinical social work, or that the latter was unique in being strongly influenced by psychoanalytic ideas. Although many clinical social workers at that time tried to direct their gaze to inner personality dynamics, as psychoanalytic theory requires, these practitioners also applied the gamut of psychiatric approaches, as they had in earlier decades (Alexander, 1972). Undoubtedly, some clients benefitted. But in the service of social control, casework also led to stigmatizing of some clients' lives and behavior (Dolnick, 1998). Margolin (1997) cites striking passages from several articles in social work journals in the 1960s where, especially if they were poor, clients were described by social workers as both emotionally and morally undeveloped.

Fifty years later, the mental health system has vastly expanded in breadth and depth. Today's psychiatric deluge in clinical social work is still about psychiatric thinking—although within a therapeutic landscape now dominated by psychoactive drugs.

Psychiatric Hospitals and Inpatient Treatment

Like any social reform, Dorothea Dix's campaign for building state mental hospitals had unanticipated consequences. Instead of ameliorating the difficulties of the mad, state asylums evolved into large warehouses for society's unwanted. Their population rose from 332,000 in the early 1930s to 559,000 twenty years later (Mechanic, 1990). Although much care of the people diagnosed with severe mental disorders did shift to the community starting in the late 1960s, in one of the largest shifts in American mental health policy, it continued to advance physical treatments for dimly understood and presumed diseases of the nervous system. Assumptions that governed the old state hospital treatments continue to undergird new community mental health services. Indeed, one key justification for implementing the previously mentioned assertive community treatment was that it would serve as a

"hospital without walls" (Bond, Drake, Mueser, & Latimer, 2001, p. 146).

Today, the psychiatric units of medical-surgical hospitals have become the major mental health crisis centers of the nation. In the latest available data as of this writing, Manderscheid and Berry (2006, p. 205) report that 50% of the 2.2 million psychiatric inpatient admissions, readmissions, and returns from leave in 2002 took place in non-federal general hospitals while only about 11% occurred in state and county mental hospitals. So, while policy makers, professionals, and the public saw the need for the institutional reform of the state hospital system and community mental health treatment, the interplay among the various elements of the biomedical-industrial complex, along with the continued need to manage this population, has led to a system of care that is today more medical in both approach and setting.

Just as the former state hospitals relied on the unique state-sanctioned power of psychiatrists to force people into locked wards, psychiatric crisis management today also rests substantially on coercion. In this connection, it is important to note that American national data on involuntary psychiatric examinations and detentions are extremely sparse. Using the Medline database, we could not locate a single such study published in the last 20 years, and our queries to national experts were similarly unsuccessful. This absence possibly contributes to misperceptions concerning the actual extent of involuntary psychiatric interventions. Using 2006 involuntary detention data for adults from California (California Health & Human Services Agency, 2009) and 2006 involuntary psychiatric examination data for adults in Florida (Christy, 2007), we found a very similar rate for both activities (44.6 and 49.3 per 10,000 persons in Florida and in California, respectively). Extrapolating from the lower figures, we estimate that 1.37 million people are subjected to involuntary psychiatric detention in the U.S. in a given year. This would mean that 62% of the nation's annual 2.2 million psychiatric inpatient admissions, readmissions, and returns from leave are officially involuntary (in addition to an unknown proportion of officially voluntary hospitalizations).

Inpatient treatment, based on 24-hour-a-day medical

care and a hospital infrastructure, is a costly undertaking. It absorbed \$41.4 billion of the 100.3 billion, or 41%, spent on mental health treatment in 2003, the latest year for which data are available (Manderscheid & Berry, 2006; Levit et al., 2008). However, less than 1% of the general population will ever be hospitalized (Bourdon, Rae, Narrow, Manderscheid, & Regier, 1994). Among the misallocation of current resources to these facilities that may require reconsideration is the utilization of professional social workers. In 1986, with approximately 218,000 inpatient residents, 21,000 social workers provided services at these facilities. By 2000, however, with only 139,000 inpatient residents, the number of social workers employed had almost doubled to 37,000 (Manderscheid & Berry 2006, p. 213). Perhaps there are good reasons for this apparently disproportional employment of social workers in coercive inpatient settings—good pay and benefits, more serious problems of the current hospitalized population requiring higher worker-to-client ratios—but we have found no discussion in the social work literature of either the questionable ethics of the use of coercion or of the potential misallocation of clinical social workers.

Given the routine application of force for hospitalization and treatment compliance, and the disproportionate share of mental health funds and professional services funneled toward such a small segment of the population, one might expect to find compelling data showing that psychiatric hospital treatment improves the lives of patients. This is not the case (Kiesler & Simpkins, 1993; Pfeiffer, 1990; Pottick, Hansell, Gaboda, & Gutterman, 1993). An extensive review by Kiesler and Sibulkin (1987) of randomized controlled studies conducted from 1967-1979 comparing mental hospitalization to some alternative intervention found no differences or the alternative outperforming hospitalization on outcomes of readmission, psychiatric symptoms, employment, social functioning, and patient satisfaction. To our knowledge, no similar comprehensive systematic review has been published since Kiesler and Sibulkin's. However, more recent research comparing inpatient psychiatric hospitalization to day hospital/crisis respite care (Sledge et al., 1996), a Soteria-like alternative residential program (Fenton, Mosher, Herrell, & Blyler, 1998), a

consumer-managed residential program (Greenfield, Stoneking, Humphreys, Sundby, & Bond, 2008), and a variety of community-based services (Lloyd-Evans, Slade, Jagielska, & Johnson, 2009), also failed to demonstrate superior outcomes for inpatient hospitalization as compared to less-restrictive and usually consumer-preferred alternatives.

In sum, though it serves only a tiny fraction of troubled persons in our country and alternatives have been shown to produce better outcomes for patients, inpatient hospital treatment takes almost half of the over 100 billion dollars of annual mental health spending in the modern mental health system. More importantly, and less discussed, psychiatric hospitalization continues to be made possible by explicit coercion, a problematic ethical and political issue that is difficult to examine or discuss comprehensively, due to the paucity of available data. These considerations undermine the argument that it constitutes a value neutral, science/evidence-based form of medical treatment.

The DSM and the Political Economy of Social Work

The Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association (APA) is the "bible" for mental health professionals. Insurance companies and managed-care organizations require its codes and diagnoses for reimbursement or payment of mental health services. Is this because the DSM constitutes a valid diagnostic tool to identify mental disorders? Clearly not. The 1980 DSM-III was created by the neo-Kraepelinian branch of American psychiatry, strictly adhering to the view that psychiatry is a branch of medicine that deals with people who are physically sick, that distinct boundaries exist between mental disorder and normality, and that diagnostic systems needed codification to improve reliability and validity (Klerman, 1978). However, when the APA in 2002 explained the need for a fifth revision of the manual, it acknowledged the lack of any evidence supporting claims of biological etiology of mental disorders in the interval: ... the goal of validating these syndromes and discovering common etiologies has remained elusive. ... [N]ot one laboratory marker has been found to be specific in identifying

any of the DSM-defined syndromes (Kupfer, First, & Regier, 2002, pp. xviii-xix).

The Chair of the DSM-IV Task Force, Allen Frances (2009), repeated the assessment verbatim when commenting on the upcoming DSM-V slated for publication in 2013:

The incredible recent advances in neuroscience, molecular biology, and brain imaging . . . are still not relevant to the clinical practicalities of everyday psychiatric diagnosis. The clearest evidence supporting this disappointing fact is that not even one biological test is ready for inclusion in the criteria sets for DSM-V. (p. 1)

Building on the lack of gold standard validity for DSM categories, a compelling conceptual and empirical literature critical of the DSM has accumulated in all the helping disciplines. The DSM's criteria for distinguishing mental disorder from normality are critiqued for being undefined and tautological (Jacobs & Cohen, 2004, 2010), and the manual is faulted for having impoverished the study of distress and misbehavior (Andreasen, 2007), for emphasizing the diagnosis rather than the client's story (Tucker, 1998), for the marginal improvements in reliability produced by the DSM-III and successors (Kirk & Kutchins, 1994), for its categories' lack of fit with observed distress in individuals (Mirowsky & Ross, 2003), for its persistent gender and class biases (Caplan & Cosgrove, 2004), for the frankly political processes by which categories are included or excluded from it (Caplan, 1995), and for the financial ties between the pharmaceutical industry and DSM Task Force members (Cosgrove, Krinsky, Vijayaraghavan, & Schneider, 2006).

Despite the consensus concerning the fragile scientific basis of the DSM and its mostly cultural and political accomplishments, a content analysis of 69 syllabi of psychopathology courses in schools of social work found that only six (8.5%) assigned any literature which critiqued the reliability and validity of the DSM (Lacasse & Gomory, 2003). This is ironic, since the two strongest critics of the DSM are social work academics Stuart Kirk and Herbert Kutchins, who have argued in many articles and books that the much-touted improvements in

reliability promised by the DSM rest on “flawed, incompletely reported, and inconsistent” evidence, and that the DSM’s success can only be understood by analyzing “the politics and management of science” (1992, pp. 15-16). No scholarly work has invalidated this critique; it has only grown substantially.

The DSM nonetheless remains the only well-accepted tool for billing mental health services, which makes sense given its functions in the psychiatric-industrial complex. It is published by the profession officially owning the problem of mental illness, which it defines. It enables the conduct of clinical trials which are predicated on the existence of distinct mental disorders—for which the FDA grants pharmaceutical firms an exclusive patent to market branded psychoactive drugs, most of which reap revenues in excess of \$1 billion per year shortly after marketing. A DSM diagnosis also serves as a necessary condition for a wide range of services and resources, especially as federal funding for social services decreases and that for health services increases (Smith, 2010). For these reasons, the manual serves both as economic incentive and constraint on mental health professionals (Kirk & Kutchins, 1988). In a recent survey of clinical social workers, 86% stated they gave a DSM diagnosis “often to always,” 94% citing insurance reimbursement as the main reason to do so (Frazer et al., 2009), with half of respondents stating that they would not use the DSM if they were not required to do so. Despite its profound limitations and its completely uncertain benefits for the day-to-day work of helping distressed clients (Caplan & Cosgrove, 2004), the DSM remains an indispensable component of the technology and education of the helping professions for one reason: it reflects a medical view of distress and misbehavior.

Psychiatric Medications and the Pharmaceutical Industry

The biomedical model holds that distress and misbehavior are bodily diseases and must be treated as such. Supporters of the model promote it as objective scientific knowledge. Believing that the model is valid has important political and economic ramifications, including broadened rationales for forced treatment (since disease implies non-responsibility) and

allocating public resources for palliating distress according to medical or psychiatric criteria (Olsen, 2000). Importantly, the model has helped to consolidate the pharmaceutical industry as the leading player in the mental health system. In turn, the industry promotes the model as naturally suited to the concerns of the professions and the public. This has been a boon to expand markets for branded drugs, and drugs' popularity in turn promotes the legitimacy of the model and relieves its adherents from producing the hard evidence needed to validate it scientifically. Despite extremely dubious contributions of drugs in improving indicators of mental distress in comparison to the pre-drug era (Healy, 2008; Whitaker, 2010), it remains controversial to question the status of a drug prescription as the paradigmatic healing intervention in mental health.

Consider the case of the antipsychotic drugs. These have been the primary psychiatric treatment for psychosis since the 1950s. When their extraordinarily burdensome adverse effects and limited longer-term therapeutic benefits became too consequential to ignore—and useful to emphasize in promoting the next wave of drugs—a group of second-generation, or atypical, drugs was introduced starting in 1989 and promoted to clinicians and patients as a decisive advance in the treatment of schizophrenia. However, their clinical trials were filled with deliberate confounds, which made assessing the drugs' utility difficult (Cohen, 2002). Duplicate data were published in multiple articles, confusing the picture of how many clients had been studied and inflating the drugs' perceived efficacy (Huston & Moher, 1996). When manufacturers detected problems—such as the tendency of olanzapine to cause extreme weight gain—they withheld the information *and* claimed the contrary (Dyer, 2007). They made concerted efforts to influence physicians to prescribe the drugs for off-label purposes (Brody, 2007) by individual detailing and continuing education activities, while researchers enmeshed in financial conflicts of interest created “evidence-based guidelines” recommending the drugs (Healy, 2006). The industry also provided generous funding to groups such as the National Alliance for Mental Illness (NAMI) (NAMI received 75% of its total donations from 2006 through 2008, or \$23 million, from this source), which in turn has advocated tirelessly for liberal public funding of the drugs (Harris,

2009). From less than \$1 billion in 1995, sales of antipsychotics in the United States rose to an astounding \$11.5 billion in 2006 (Wilson, 2009), with Medicaid apparently paying for 69% (Waters, 2007), mostly for off-label prescriptions for which the FDA had not considered any clinical trials and for which the drugs had not been approved.

In 2005, the large NIMH-funded Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) trial found that the generic 1950s drug perphenazine (about 9¢ a dose) was as efficacious as the newer antipsychotics (about \$9 a dose) and that all antipsychotics tested were discontinued on average by 74% of clients before the 18-month study ended (Lieberman et al., 2005). Furthermore, the newer medications offered no superior quality-of-life (Jones et al., 2006). Commenting on his profession's lapse in the evaluation of the newer antipsychotics, Lieberman (2006) acknowledged:

The claims of superiority for the [atypicals] were greatly exaggerated. This may have been encouraged by an overly expectant community of clinicians and patients eager to believe in the power of new medications. At the same time, the aggressive marketing of these drugs may have contributed to this enhanced perception of their effectiveness in the absence of empirical information. (p. 1070)

Discussing the findings' ramifications for public policy and spending, Rosenheck, Leslie, and Doshi (2008) contextualized the annual spending on the newer antipsychotics:

... the additional cost of using these [rather than older drugs] ... is substantially greater than the \$8.5 billion total income of all 47,000 U.S. psychiatrists ..., could fund 150,000 case managers [for] 1.5 million additional consumers—or could support three times the total number of social workers currently employed in the United States. (p. 516)

In 2008 and 2009, several states and the Federal government launched suits against drugmaker Eli Lilly for illegal marketing of Zyprexa (olanzapine) and other drugs for off-label indications, resulting in the largest corporate fine in U.S. history,

\$1.4 billion. Observers were quick to note that Zyprexa's sales that year alone were over \$4 billion. By mid-2009, major fines had been imposed on the makers of most atypical antipsychotics on the market (i.e., Feeley & Fisk, 2010; Kmietowicz, 2009; Tanne, 2010).

In recent years, books about psychoactive medications have appeared in the social work literature (e.g., Austrian, 2005; Bentley & Walsh, 2006; Dziegielewski & Leon, 2001). By and large, these writings strongly affirm the therapeutic value of currently promoted medications and suggest how social workers can facilitate their use. None of these writings, however, have analyzed the scientific or political basis for psychiatry's unrestrained promotion of pharmacological treatment, for example, by scrutinizing randomized controlled trials or examining how the pharmaceutical industry influences physicians. In all these texts, claims for the advantages of the second-generation antipsychotics are repeated without any critical analysis. Similar presentations are made for all newer classes of psychotropics, which seems extraordinary, given that the so-called pharmacological revolution in mental health is now nearly 60 years old. Along the way, psychiatric social workers did not object to the enormous transfer of public funds to the pharmaceutical companies; we have found no evidence that the issues described were considered by the profession at large.

The majority of teenage foster children receive psychiatric medications, with a sizeable minority receiving at least three drugs per day (Zito et al., 2008). Children on Medicaid are four times more likely to be prescribed antipsychotics than children with private health insurance (Wilson, 2009). In child welfare, tragic stories have emerged in which young children were given cocktails of psychotropics died or committed suicide (e.g., Rebecca Riley, 4 years old, Massachusetts; Gabriel Myers, 7 years old, Florida). In each of these two instances, social workers were involved: they took children or their families to doctors' appointments, diligently monitored the medication intake, and even recorded drug-induced harm to the children (Wen, 2010). Yet they had no power to effect any changes in the systems in which they participated. These social workers appeared to function as enforcers of a thoroughly medicalized approach to family poverty, disorganization and distress, to

the detriment of the unfortunate children involved (see Florida Department of Children and Families, 2009).

On a macro level, the NASW engages in political advocacy, but has been silent on the promotion of drugs to consumers at the expense of psychosocial treatment or prevention programs (Lacasse, 2005). Moreover, in 2007, NASW took money from Jannsen in exchange for the cooperation of NASW members in a "research project" on a recently released injectable anti-psychotic, which, it was argued, was actually a thinly veiled marketing project (Clark, 2007; Cohen et al., 2007; Wong, 2007). That a social work organization ostensibly committed to social justice might fulfill the role of enabler of companies which are increasingly shown to be America's worst corporate citizens seems truly bizarre.

From the restriction of the practice of psychotherapy to psychiatrists as medical doctors from about 1910-1950 (Abbott, 1988, p. 302) to the recent use of drug treatments, little appears to have changed for social workers. Not permitted to perform psychotherapy in those early days, they cannot prescribe medications today, yet their default stance is to encourage or require that clients accept what psychiatrists prescribe. Social workers might assume that, although lying outside their expertise, such interventions are benevolent and beneficial. Psychiatrists are conceded the intellectual/ideological higher ground, based on their presumed grasp of yet-to-be-validated theories (psychoanalysis previously, brain circuit imbalance theories of mental disorders presently). Social workers benefit (in prestige and salary) in both instances by supporting something medical, but this requires them to construct the problem as a disease inside the client, regardless of their ethical mandate and professional socialization about systemic and person-in-environment approaches. Social workers are valued by psychiatrists for their commitment to this model, and it is not surprising that professionally they remain the handmaidens of psychiatry. Yet when social workers tacitly agree with the biomedical model of human problems, their clients not only enjoy the benefits but also suffer the consequences of this naïve commitment.

Arguably, psychiatry has been subsumed as a satellite branch of the pharmaceutical industry, with most intellectual and practical innovations centering on the introduction of new drugs, the popularization of new indications for

existing drugs, and the expansion of DSM disorder categories to fit drug prescription trends. Emboldened by generous financial support of its activities from the drug industry, psychiatry presents its biomedical hypotheses in textbooks, articles, press releases and government websites as established facts, concealing enormous definitional and logical contradictions and weak empirical evidence for biological theories of mental disorders (Boyle, 2002; Moncrieff, 2008; Pam, 1990, 1995; Read, Mosher, & Bentall, 2004; Valenstein, 1998).

Material deprivation, poor parenting, interpersonal violence, and disorganized and decaying communities are strongly correlated with emotional and behavioral disturbances (Hollingshead & Redlich, 1958; Hudson, 2005; Read, van Os, Morrison, & Ross, 2005), but the biomedical model concedes only minor importance to these factors. Rather than striving to improve human relationships or living conditions to prevent and alleviate distress and psychosocial disability (Umberson & Montez, 2010), the biomedical complex siphons off resources to develop and distribute more psychoactive drugs.

Displacement of Primary Clinical Social Work Functions

While clinical social workers are engaged in studying, assessing, and assigning DSM diagnoses or taking in biased accounts of psychotropic medication effectiveness and convincing clients to take their medications, they are distracted from applying and developing their own profession's quintessential approaches to understanding, palliating, and preventing personal distress and maladjustment. Social work's *person-in-environment* perspective provides an alternate framework for these problems by focusing on: people's interpersonal, emotional, educational, and material needs; harmful effects of deprivation, abuse, and trauma; and the benefits of supportive social relationships, self-awareness and self-regulation, constructive thinking and problem-solving, and other coping mechanisms. The social work perspective primarily lends itself to an advocacy role in securing clients necessary resources and protecting them from physical or psychological harm. This perspective also is embodied in numerous, well-tested psychosocial interventions that help clients to gain insight into their problem situations, teach skills and alternative behaviors to deal with

those problems, obtain familial and other social support to encourage healthy life-styles, and, perhaps most crucial of all, preventive or early intervention programs that preempt mental problems before they develop or worsen. These approaches stand in stark contrast with reductionist, biomedical theories that locate the cause of mental disturbances and focus treatment almost entirely within clients' neurochemistry.

Considering treatments for clients diagnosed with severe mental disorders as an example, social workers have applied a variety of psychoeducational techniques, such as modeling, verbal instructions, positive reinforcement, and environmental restructuring to effectively increase clients' normative behavior and to replace psychotic responses (Wong, 1996; Wong, Wilder, Schock, & Clay, 2004). Using cognitive-behavioral therapy (CBT) that emphasized stress reduction and coping strategies, social work professor William Bradshaw and his associates (Bradshaw, 2003; Bradshaw & Roseborough, 2004) produced large effect-size improvements in psychosocial functioning and similar magnitude reductions in severity of symptoms in patients with long histories of being diagnosed with schizophrenia. Bradshaw's findings are partially corroborated by results of meta-analyses showing moderately positive outcomes of CBT for persons diagnosed with schizophrenia in other clinical studies (Pilling et al., 2002; Wykes, Steel, Everitt, & Tarrier, 2008). Cognitive enhancement therapy, a social-cognitive intervention, has shown impressive results in clients recently diagnosed with DSM-IV defined schizophrenia (Eack et al., 2009). Social work researchers have also reanalyzed outcome data and noted the successful treatment of persons with acute psychosis in small, home-like, community-based programs operated by nonprofessional staff with minimal use of antipsychotic medications (Bola & Mosher, 2003; Bola, Mosher, & Cohen, 2005).

These effective community-based programs offer a less restrictive and less costly alternative to confinement in mental hospitals or psychiatric units of medical-surgical hospitals. This evidence is bolstered further by evidence from an early psychosis psychotherapy intervention program in Lapland, Finland, which has been effective in modifying the course of psychosis (Seikkula et al., 2000, 2006) and which likely even

lowers the prevalence of DSM-IV defined schizophrenia (Whitaker, 2010), an outcome seemingly beyond reach of our current mental health system in the U.S. However, it will be very difficult for social workers to improve psychosocial services or deliver them to a broader span of clients as existing mental health services, funding, and research are all centered on a view of psychosis, severe distress and maladjustment as developmental brain disease and the accompanying psychopharmacological treatments (Wong, 2006).

Another important approach to addressing psychosocial distress, disability, and disapproved behavior applicable by social workers is prevention or early intervention. Similar to public health programs that prevent the outbreak of diseases by promoting proper sanitation, healthy diet, vaccinations, avoidance of toxins, and other methods, preventive mental health programs aim to reduce participants' exposure to risk factors and to teach participants skills to counter potentially harmful behaviors. By intervening before problems have become serious or have caused irreparable damage, preventive interventions can be more humane, less expensive, have negligible adverse effects, and hold greater potential for reducing the overall prevalence of psychosocial distress in the general population than any type of treatment-after-the-fact (Albee & Gullotta, 1997; Ammerman & Hersen, 1997; Blair, 1992).

A few social work researchers are taking the lead in formulating prevention and early intervention programs to preempt the development of psychosocial problems that are precursors to severe mental disturbances and finding evidence of efficacy. Fraser and his colleagues (Fraser, Day, Galinsky, Hodges, & Smokowski, 2004) used a randomized design to demonstrate the effectiveness of in-home, parent training and child social skills training to increase children's prosocial behavior, improve self-regulation of emotions, increase contact with peers, raise concentration and perseverance on classroom tasks, and to reduce aggression towards other children. Hawkins and associates (2009) conducted a large-scale controlled evaluation across 24 towns in 7 states of similar skills-building programs for youth and adolescents aimed at preventing alcohol, tobacco, and other drug use (correlated with severe mental disorders) and delinquent behavior. These investigators found

statistically significant lower rates of drug use and delinquent behavior in youth participating in the prevention programs. In a series of studies, Lecroy designed a psychoeducational prevention program for adolescent girls to promote appropriate gender role, positive body image, independent decision-making, assertiveness, improved peer relationships, and seeking help when it is needed (Lecroy, 2004a, 2004b). In one phase of his research, Lecroy (2004b) used a randomized design to evaluate his program and found statistically significant differences in favor of the intervention group in five out of eight outcome measures.

While promising, these programs require substantial additional research and refinement. For example, a more recent meta-analysis of CBT applied to clients with a schizophrenia diagnosis (Lynch, Laws, & McKenna, 2010) found results contradicting Pilling et al. (2002) and Wykes et al. (2008). In addition, the favorable findings of the Hawkins et al. (2009) have only been partially duplicated by other investigators (Feinberg, Jones, Greenberg, Osgood, & Bontempo, 2010; Haggerty, Skinner, MacKenzie, & Catalano, 2007), and the statistically significant differences obtained by Lecroy did not have large effect sizes (Lecroy, 2004b). Nevertheless, these psychosocial prevention and treatment programs—which controlled studies have shown to directly benefit clients and their communities—deserve considerably more attention and commitment from social workers, rather than the heavily advertised and possibly toxic pharmaceuticals that are already omnipresent in our society.

Conclusion

We have argued that social work, early on in its professional existence, identified with psychiatry, these two professions becoming “tied to the most fundamental of society’s functions, the control of those who are identified as deviant. The poor, the insane, the criminal, the dependent... The possibility of injustice in such a function is clear enough” (Reid, 1992, p. 40). We have also highlighted that, as a result of its allegiance to institutional psychiatry, social work has become over the past generation inextricably entangled in the

biomedical/psychiatric industrial complex. Its medicalized and coercive worldview has become the professional air clinical social workers breathe, making it difficult to even notice some of the adverse consequences raised by this uncritical cooperation. Despite the scientific failure of the medical approach to reduce human distress and misbehavior to any causative biological state, it claims an ever-greater share of public funding to treat human distress and misbehavior as biological diseases.

A challenge to our perspective is that the biomedical complex provides attractive jobs for many social workers and its ideology dominates nearly all mental health agencies. Nevertheless, despite inducements and pressures to conform to the biomedical doctrine, social workers must confront the issues discussed here if they are to preserve their integrity as members of an independent profession. It seems crucial that social work education implement, to borrow a phrase from Reeser and Leighninger (1990), a "specialization in social justice." Using the moral, political, and economic beliefs with which they resonate, students should be helped to articulate their own vision of a just society, learn how to analyze the political, economic, and social structures of society and understand how these can oppress people, and empower themselves to reduce or counter the influence of institutions that mislead and oppress. Moreover, students should be helped to envision and build the sorts of economic and political structures that place clients' interests at the top of social workers' priority lists. They should also develop the sort of open-mindedness that will maintain a constantly vigilant reexamination of their own roles within the mental health system and the empirical claims promulgated under it. It would be naïve to think that human distress and misbehavior could be vanquished by any socio-economic or therapeutic project, but it would be more naïve and misguided to act as an obedient ancillary profession marching to the drumbeat of a rapacious biomedical industrial complex.

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Book Reviews

A Note from the Editors

There has been growing interest in comparative social welfare research over at least the last decade. In this volume, we publish 3 reviews that focus on this area of inquiry: a review essay of *The Oxford Handbook of the Welfare State* by James Midgley, Jennifer Zelnick's review of *Poor Women in Rich Countries: The Feminization of Poverty over the Life Course*, and Dorinda Noble's review of *Child Protection Systems: International Trends and Orientations*. Several other reviews are relevant to this topic since they focus on the decline of the welfare state (*Ill Fares the Land*) as well as new approaches to community organizing (*Contesting Community: The Limits and Potential of Local Organizing*), new community-focused approaches to achieving justice (*Social Work and Restorative Justice: Skills for Dialogue, Peacemaking, and Reconciliation*), and service provision in an altered political context (*Politics and Partnerships: The Role of Voluntary Associations in America's Past and Present*). The reviews conclude with a compelling look at the experience of those who live in two worlds (*Mexican Voices of the Border Region*).

Marguerite Rosenthal and Jennifer Zelnick
Book Review Editors

The Study of Well-being, Social Policy and the Welfare State: A Review Essay

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Francis G. Castles, Stephan Leibfried, Jane Lewis, Herbert Obinger & Christopher Pierson, Eds. (2010). *The Oxford Handbook of the Welfare State*. New York: Oxford University Press. \$150.00 (hardcover).

To organize the phenomena they study and to better comprehend and interpret the world, social scientists frequently employ quasi-paradigmatic frameworks reflected in the use of terms such as "globalization," "development," "human rights" and "the welfare state." These and other constructs have been widely adopted not only in academia but in media, political and popular circles as well, and they have often been a focal point for vigorous debates. This is certainly true of the welfare state, which is used both as a noble ideal and a term of derision. In the academic world, the term generally has a favorable connotation and is associated with a sizable body of explanatory and normative theory that addresses the way statutory policies and programs have contributed to social well-being over the years. It has also generated a significant amount of comparative inquiry that has been facilitated by the construction of numerous typological representations of the welfare systems of different countries.

Despite an impressive record of achievement, the welfare state perspective has limitations that are not always acknowledged by those who view the study of social well-being through its particularistic lens. Although academic inquiry into the welfare state is often equated with the broader study of the complex processes that enhance or diminish social well-being, scholars using this approach have paid little attention to non-statutory interventions such as community social support

networks, faith-based provisions, familial obligations and the services of nonprofit activities, all of which contribute to well-being. Another issue is the implicit adoption of a preferred normative perspective in welfare state studies that reflects the field's commitment to social liberalism and social democratic statism and bolsters its steadfast resistance to traditionalist and market liberal critiques. Despite its ostensible objectivity and commitment to social science rigor, the welfare state perspective reflects an historic, ideological preference for state intervention, and particularly for income transfers and social service provisions.

Another issue is the Eurocentric character of welfare state scholarship which limits its wider relevance. Although this is understandable since it has been heavily influenced by the experience of government interventionism in Europe, its comparative utility is questionable. The term's imprecise usage also presents problems. The field's literature often implies that the welfare state is a type of country where the government allocates sizable resources to social programs, but the term is also used as a loose synonym for social policy or to refer to a nexus of governmental social services. In this usage, governments are often said to "have" welfare states rather than social policies. The lack of a standard definition is also revealed in a plethora of welfare state typologies which have sought to classify welfare states but with different and often confusing results. Generally, the countries of western and northern Europe are categorized as welfare states but there is disagreement about which other countries should be designated in this way. These challenges undermine the usefulness of the welfare state approach to those seeking to understand the complex ways in which social well-being is affected by different institutionalized practices as well as government policies.

These issues are not adequately addressed in the significant book that is undoubtedly the definitive work on welfare state studies. Despite its comprehensiveness, bulky dimensions and high cost, it does not offer a clear definition of its core construct or address the limitations of its approach. Instead, it perpetuates a shared implicit understanding of its meta-theoretical assumptions and serves as a sort of in-house repository of the factual information, theories and normative beliefs with which

those working in the field will already be familiar. Those who approach the study of well-being from different intellectual, as well as normative, perspectives are less likely to find it useful except, of course, in that it offers an authoritative exposition of the state-of-the-art of welfare state scholarship.

Nevertheless, there is much in this collection of value. It is far-ranging and comprehensive and provides helpful summaries of many of the topics and issues that characterize welfare state scholarship today. The book's 48 chapters are divided into eight sections covering topics such as the history of the [European] welfare state, different approaches to the study of government provision, the key actors, policies and programs that characterize the welfare state, outcomes, and comparative typologies. The final section contains two chapters that discuss the future prospects of the welfare state. Some of the sections are well organized, but others seem somewhat arbitrary or accommodate chapters that could arguably have been more helpfully located elsewhere. Most of the chapters are relatively brief and will be appreciated by students and others who wish to have a succinct overview of key subject areas.

It is, of course, impossible to review all of the book's chapters here but some deserve special attention. Many are noteworthy for their concise exposition of complex topics and issues. The chapters in Part V of the book on core government social policies are especially helpful, offering impressive comparative summaries of fields as diverse as pensions, long-term care, unemployment insurance, family benefits, social assistance and labor market activation (or welfare-to-work as the term is more widely known in English-speaking countries). In addition to these essentially descriptive chapters, some are issue-focused and address important topics such as the impact of government intervention on employment and economic development, the effects of globalization on the welfare state, public attitudes towards the welfare state and the role of political parties in shaping government social policies.

Some chapters make a significant contribution by demonstrating the complexity of the field and showing that it is very difficult to formulate viable generalizations about government welfare provision. One example is Obinger and Wagschal's analysis of social spending in the OECD countries, which

reveals the challenges of deciding which countries have the highest levels of spending and can thus legitimately be classified as the most "advanced" or "developed" welfare states. They point out that different rankings emerge when different criteria are used. While the Nordic countries are high social spenders in terms of direct public spending, Britain and the United States emerge as high spenders when fiscal and private spending criteria are employed. They also point out that while Britain and the United States (and a few other countries as well) have lower levels of taxation than the Nordic welfare states, the former have more progressive taxation. Their review also challenges other widely held assumptions about the welfare state, showing, for example, that despite the widespread use of the rhetoric of crisis in welfare state studies and claims about the harmful effects of globalization on government welfare, social spending has increased in most OECD countries since the 1980s. The chapter contains several other interesting examples that reveal the limitations of conventional approaches to the analysis of social spending.

Another chapter that questions widely held assumptions in welfare state studies is Arts and Gelissen's thoughtful discussion of typologies which are widely used in welfare states research. Focusing primarily on Esping Andersen's *Three Worlds* typology, they offer what they call a "critical appreciation" of this typology by reviewing a significant body of literature that has challenged both its empirical validity and many of the assumptions on which it is based. They also discuss efforts to expand the model by, for example, including the so-called Southern or Mediterranean welfare states, the Antipodean countries, Eastern Europe and the nations of East Asia which are said to comprise a distinctive but dubious "Confucian" or "productivist" welfare type. This discussion also introduces the other seven chapters in this part of the book (Part VII). The first group of chapters deal with the Western countries which are designated as "established" welfare states, while the latter deal with the nations of Latin America, East Asia, and Eastern Europe and Russia and are described as "emerging" welfare states.

In many ways, the typological preoccupation reflects some of the problems with welfare state studies that were touched

on earlier. Apart from the Eurocentricity and normative biases of the *Three Worlds* model, major methodological, semantic and empirical issues remain unresolved. These apply equally to the well known typologies of Wilensky and Lebeaux, Titmuss, Mishra and others that are not discussed at any length. Although Arts and Gelissen conclude that the "jury is still out" on the validity and utility of the *Three Worlds* model, it is clear, as this part of the book reveals, that it still drives typological activities in the field and that these activities consume a great deal of time and effort. Although few would question the role of typologies in seeking to classify countries, the continued fixation with deciding which countries belong in which category ignores the role of non-statutory welfare activities that contribute hugely to people's well-being. This fixation also impedes a proper understanding of the multifaceted and complex factors that affect people's well-being and diverts attention from some of the most critical issues facing the world today. The persistence of political violence, the entrenched reality of poverty, exploitation and oppression and the negative effects of powerful economic and global forces on the lives of ordinary people are just some of the problems that call for the attention of scholars concerned with the study of human well-being.

Equally problematic are the assumptions used in this part of the book to classify countries. Although these are not discussed, they appear benevolently to extend the welfare state mantle to some countries but not others. This not only reflects the book's normative biases but limits the validity of welfare state typologies. While Latin America, Eastern Europe and East Asia are classed as "emerging" welfare states, the nations of Africa are excluded even though many North African countries have quite extensive social insurance systems and some in the south, such as Botswana and Namibia, have recently introduced universal old-age pensions. As has been well-documented, the government of South Africa has significantly expanded its welfare services and its now quite extensive social assistance program has had a major impact on the incidence of poverty. The African countries also have a great deal to teach the West about social and community development and non-formal welfare activities. Similarly, the Gulf states, which spend

significant amounts of public money on welfare programs, are also excluded from the book, as are other Middle Eastern countries which have quite extensive statutory provision. India is also ignored but, despite the persistence of poverty and deprivation, the country has extensive and quite innovative statutory social welfare programs. Although these and other countries may not fit the typological classification used in this book, their statutory welfare programs are as varied and interesting as those of the countries that are included. They surely deserve scholarly attention.

These realities should provoke welfare state scholars to approach the study of government social policies and programs through a different lens that does not seek to impose an artificial quasi-paradigmatic construct on reality but views it from an alternative *emic* perspective that is based on a grounded understanding of reality. Instead of attempting to make phenomena conform to externally imposed artificial constructs, an approach of this kind seeks to understand reality as it is experienced by people themselves. Less reliance on the welfare state construct would not only enrich the study of statutory welfare but welfare phenomena in general, and foster the emergence of an academic field of inquiry that promotes a fuller and more convincing understanding of social well-being. This criticism should not, however, detract from the book's overall value and significant contributions to the social policy literature. Its discussion of the many issues and challenges facing statutory welfare programs around the world today, its comprehensiveness, concise presentation of complex issues and scholarly analyses make it a valuable resource which should be widely consulted.

Gertrude Schaffner Goldberg, Ed. (2010). *Poor Women in Rich Countries: The Feminization of Poverty over the Life Course*. New York: Oxford University Press, \$39.95 (paperback).

In *Poor Women in Rich Countries: The Feminization of Poverty over the Life Course*, Professor Goldberg and colleagues revisit the topic of the feminization of poverty in advanced industrialized countries first undertaken in earlier co-edited books,

The Feminization of Poverty: Only in America? (1990), and *Diminishing Welfare: A Cross-National Study of Social Provision* (2002), an analysis in the context of welfare state restructuring and retrenchment.

Like these earlier volumes, this study uses cross-national comparisons to investigate whether the feminization of poverty, an over-representation of women among the poor, is an international phenomenon as well as to assess the impact of global economic trends on the welfare state in different political and cultural contexts. In addition to providing an analysis of how changes in the economy and social policy have had an impact on women's poverty over the past decade, the new volume incorporates a life course perspective by extending the inquiry to focus on poverty among lone elderly women and the policies intended to address it.

Eight rich countries—Sweden, France, Germany, the United Kingdom, Canada, Italy, Japan, and the United States—are discussed in separate chapters written by native scholars. Country-specific chapters are organized around 4 factors that shape the condition for women's poverty: labor market conditions (e.g. labor force participation, unemployment, occupational segregation, gender wage gap); equalization policies (policies and services such as childcare that facilitate more equal labor market participation); social welfare (income support that compensates for lower wages, unpaid care demands); and demographics (including minority race, ethnicity and/or immigrant status). Goldberg contributes an introductory chapter that contextualizes the current studies' themes and methodology and two concluding chapters that summarize and synthesize the material, with special focus on the topic of lone elderly women across the study countries.

This ambitious book is based on excellent scholarship. Each chapter is thorough and written by authors with expertise in analyzing social welfare data and the political and social trends that shape them. For example, Ute Klammer's discussion of how German unification brought together East German women with a stronger position in the workforce and the support of public childcare centers with West German women whose position was shaped by a conservative "male breadwinner" welfare state model is interesting both in terms

of German trends and for comparing welfare "regimes." It is also interesting for a U.S. reader to ponder Claude Martin's description of the French welfare system, enacted in 1976 to allow single mothers an option to spend more time at home than in the workplace, given the shift towards pushing single mothers into the workforce in other rich countries. The "ethnicization of poverty" discussed by Sainsbury and Morissens in their chapter on Sweden is also a salient factor in several of the other chapter studies, pointing to limits of even the most successful welfare state models in reducing poverty for lone women in the context of the global labor market.

Goldberg's two final chapters synthesize data on single mothers and lone elders, building on the life course perspective and utilizing a common relative poverty standard of less than 50% of median disposable income (rather than each country's definition of poverty). Using this standard, an average of 1/3 of lone mothers and 1/5 of lone older women live in poverty in rich countries. The case studies in the book confirm that poverty is feminized among the lone elderly, though unlike the case of lone mothers, "regime" types (liberal, conservative, or social democratic welfare states) did not predict the level of elderly poor women. Briefly summarizing the policy comparisons is daunting, and attempting it made me wonder if a more concise presentation of conclusions was possible. However, the reader who wants to seriously consider the integrated role of labor market, income support, and child/elder care policies in the context of social attitudes and institutional practices towards women, racial/ethnic minorities, and immigrants will be rewarded.

The book succeeds in providing data and largely bridging the gaps among data differences and different poverty measures among countries, and it contains rich, detailed discussions of the countries' political and social contexts. The approach of having each case study deal with a consistent set of questions is an effective methodology for a case study comparison. This is an excellent book for scholars in the field of social welfare policy and for graduate level courses on social welfare policy.

The research for this volume was completed just before the economic crisis that began in 2008, though some of the

chapters do comment on the immediate effects of financial collapse and recession. What the authors are unable to comment on is the longer-term impacts of these phenomena. The book provides an excellent baseline for another study on those themes. Now more than ever, researchers and scholars need to work as advocates in social policy; Dr. Goldberg's career of solid work in this area is an excellent example for young scholars.

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Neil Gilbert, Nigel Parton, & Marit Skivenes, Eds. (2011). *Child Protection Systems: International Trends and Orientations*. New York: Oxford University Press, \$55.00 (hardcover).

Child Protection Systems is a well-written, thought-provoking work that updates *Combatting Child Abuse: International Perspectives and Trends* (1997, N. Gilbert, Ed.). *Child Protection Systems* tracks changes over the last 10-15 years to the child protection systems of the U.S., Canada, England, Sweden, Finland, Denmark, Norway, Germany, Belgium, and the Netherlands. All these nations have expanded their child protection systems, both in scope and in cost. Despite each system's unique character, all have been influenced by globalization, capital and labor mobility, and economic interdependence among nations. Furthermore, all are touched by growing neo-liberal attitudes, which increasingly reject the collective "welfare state" idea in favor of the stance that individuals must be self-reliant, approaching their lives as a "do-it-yourself" project. Almost all ten countries have dealt with gripping cases that provoked media and public outcry, and generated new or refined child protection laws. The editors assert that data related to out-of-home placements from the various nations are hard to compare because of differences in the way they are collected and assessed, as well as because of differences in how they variously define common terms. That said, the trend in out-of-home placements generally appears to be moving up. With the exception of the U.S., all these nations have adopted and are influenced by the U.N. Convention of the Rights of the Child.

Gilbert's 1997 edited book identified two primary orientations of child protection: child protection (exemplified in the U.S., Canada, and England), and family service (notably demonstrated in Denmark and the Netherlands). The child protection attitude views child abuse as deviant acts from which children must be protected; responses tend to be legalistic and adversarial. The family service orientation identifies abuse as a problem of family dysfunction which is best addressed by help and support in partnership with the family. In this volume, the editors added a third pattern to child protection systems: the child-focused orientation, which sees the child as an individual with a relationship to the state. Hence, the approach may be opposed to the parents. This orientation is concerned with the child's total well-being. Child-focused elements are emerging in policies of all the countries studied, such as in Finland, which is creating a "child-friendly" society. Also shaping all these nations' child policies is the idea that a nation is strategically wise to "invest" in its children so that they will be healthy, educated, and prepared to assume the nation's social and economic challenges.

In each nation's system, social workers are important. Norway, for instance, mandates specific education for child protection workers, many of whom are social workers. Because of media attention on high-profile abuse cases, a child-death case may expose the child protection employee to professional and social problems. Child protection systems in all ten nations are becoming more bureaucratized and more dependent on standardized tools. All these issues may discourage child protection workers and cause them to leave the field.

With the exception of Denmark, foster care is the most preferred alternative placement. Because Denmark and other Nordic countries tend to use out-of-home placements for troubled teenagers, the use of creative residential placements (such as those providing transition services for teens approaching adulthood) is more accepted than in the U.S. (In fact, the chapter on the U.S. system did not address residential care.) While the U.S. and England encourage adoption as an alternative, adoption is not used often in the other countries, and it is not allowed in Finland.

This book is an excellent tool for graduate students and professionals to compare and contrast child protection systems,

how those systems reflect a society's history and cultural thinking, and how systems address the world-wide problem of child abuse and neglect.

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Tony Judt (2010). *Ill Fares the Land*. New York: The Penguin Press, \$25.95 (hardcover), \$15 (paperback).

Written as a critique of contemporary Western politics and economies as well as a call to revisit the social welfare commitments of the post World War II period in Europe and the United States, Tony Judt wrote the essays in this book as he was paralyzed and dying of amyotrophic lateral sclerosis (ALS); he died in August, 2010 at the age of 61. Widely acknowledged as the leading historian of 20th century European history, Judt was also a social and political critic whose essays were frequently published in *The New York Review of Books* and other journals both in the U.S. and Britain, where he was born, studied and taught before assuming an endowed position at NYU.

The title of the book is taken from a 1770 poem by Oliver Goldsmith: "Ill fares the land, to hastening ills a prey,/Where wealth accumulates, and men decay." Judt details the several ways in which contemporary Western societies have experienced a decline in economic and social well-being as a consequence of having abandoned the vigorous economic and political commitments to the welfare state at mid-20th century. The erosion of good jobs, beginning in the 1970s, combined with changes in tax policies that favor the wealthy, has had dire consequences for sustaining welfare state programs that, among other things, reduced inequality and strengthened the social contract among the citizenry. Growing inequality is singled out as the most serious contemporary problem (p. 184). These developments are most acute in the U.S. and Britain and escalated under and following the Reagan and Thatcher regimes, but the populace in continental Europe, he suggested (clairvoyantly, considering the current economic difficulties there), was not well served by the advent of the European Union.

Judt begins each essay with a quote, many taken from

economists, principally Keynes, who supported a capitalist economy with a strong public sector and public spending when the private market faltered. Indeed, the book is a strong endorsement for social democracy, European-style. Judt acknowledges that socialism, too often conflated with the failed communist regimes of the last century, has acquired a bad name, especially in the U.S. And in a fascinating bit of intellectual history in a section entitled "The Revenge of the Austrians," Judt traces the influence on American laissez-faire economists, principally those at the University of Chicago, by émigrés who conflated any governmental interference with the economy as a precursor to authoritarianism, whether fascist or communist. At the same time, he offers a pungent criticism of the new left of the 1960s that, he states, was too concerned with individualism (a distortion of "liberty") and identity politics, resulting in a consequent denigration of the state and its capacity to represent society as a whole and improve the lot of most.

In one of the longer chapters, "The Unbearable Lightness of Politics," Judt harshly criticizes the trend toward privatization and the erosion of taxes sufficient to support welfare programs, public goods such as the railroads, healthcare and so forth. In fact, he states that we are returning to the pre-democratic state with privilege dominant and the expense of the taxpayer who, lacking the benefits of the welfare state, becomes politically disengaged and mistrustful of government (see the Tea Party). And he has this to say about political leadership: "During the long century of constitutional liberalism, from Gladstone to LBJ, Western democracies were led by a distinctly superior class of statesmen. ...Politically speaking, ours is an age of the pygmies" (pp. 164-165) [n.b., a friend comments that the statement insults Pygmies].

Inspired by a question addressed to him by a twelve-year-old, Judt wrote these essays for "young people" as a history of where we've come from and a guide for what is possible. *Ill Fares the Land*, however, would make an excellent resource for both undergraduate and graduate students. Brief, free of jargon but passionate about all the important questions of our time, this is an important book.

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James DeFilippis, Robert Fisher, & Eric Shragge (2010). *Contesting Community: The Limits and Potential of Local Organizing*. New Brunswick, NJ: Rutgers University Press. \$25.95 (paperback).

After decades of what seems like inexhaustible growth of neoliberal politics and policies, James DeFilippis, Robert Fisher, and Eric Shragge offer a provocative reflection on the state of community practice and present an insightful analysis of the role of community organizing in promoting social justice and social change efforts. *Contesting Community* looks back at the landscape of community organizing for social change and effectively describes key linkages between local work and broader social movements. The authors fittingly state "this book could not be more timely" (p. 12), an assessment which could not be more true. With the global economy still faltering a year after publication, their analysis of local organizing efforts within a historical, geographical, political, and ideological context remains salient.

There are several analytical perspectives offered throughout the book as it "contextualizes local work" (p. 2). The authors place current community theory and practice into more than a century of historical context, describing the growth of the neoliberal agenda over recent decades. This context helps guide the reader through a geographical perspective by demonstrating linkages between local organizing work and national social movement building. Analyses within political and ideological contexts provide community scholars and practitioners a framework for examining the utility of conflict-driven vs. consensus-driven models of organizing and development work.

The book contains six chapters. The first two provide a framework for understanding the concept of community, both theoretically and in practice. The traditional view of community organizing and its body of scholarly work is referred to in the book as a "canon" of mostly progressive and left-leaning ideas. The authors point out, however, that community work can also take the form of conservative efforts and refer to this body of work as an "anti-canon."

The third and fourth chapters offer an in-depth examination of contemporary community practice within a post-1980

neoliberal context. The authors present a critical analysis of community theory and practice in an era in which the role of the market is increasing and the role of government is decreasing through decentralization and devolution. They capture the complexity of the relationship between centralized state power and local community efforts and resources, and posit that the social policy and community practice implications of this environment generally support the status quo (i.e., conservative direction) rather than challenge it. They do, however, offer some examples of social justice organizations that have successfully utilized current concepts of communitarianism without losing focus on their progressive vision. Also presented are examples of organizations that have successfully promoted a conservative agenda, demonstrating that local community efforts and larger social movement tactics can be used by both Left and Right interests.

The last two chapters propose how a progressive movement may grow out of present conditions. In chapter five, examples of organizations that counter the neoliberal trends of the past three decades are presented. The last chapter draws six broad lessons to be learned from the journey of community practice and theory described throughout the book. The germane lessons are offered as propositions to guide future community practice and scholarship.

The book is engaging and provocative, raising potential areas for discourse among scholars and practitioners. For example, what is the role of radicalism in the current context—will a more conflict-driven approach move the debate? What could the role of collaboration and partnerships play in a conflict-driven approach? How will technology facilitate or serve as a barrier in challenging current neoliberal policies? How much worse will the economic crisis and resulting disparities get before communities push back against a neoliberal agenda?

As a reader who came of age during the 1980s and 1990s, I found this book to be an enlightening orientation to a significant era in the history of social welfare. The examples interwoven throughout the book illustrate the concepts well. Noticeably absent, however, was any mention of the disability rights movement, despite its significant gains during the 1970s

and 1980s. On the whole, *Contesting Community* is an excellent historical analysis of the evolution of community practice. This book is valuable reading for scholars, graduate students and practitioners in sociology, social work, public administration, public health or political science.

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Elizabeth Beck, Nancy P. Kropf & Pamela Blume Leonard (Eds.) (2011). *Social Work & Restorative Justice: Skills for Dialogue, Peacemaking, and Reconciliation*. New York: Oxford University Press, \$45.00 (hardcover).

The three co-editors of this important and groundbreaking text are affiliated with the School of Social Work at Georgia State University. Elizabeth Beck and Nancy P. Kropf are professors at the University, and Pamela Blume Leonard is the Executive Director of the Council for Restorative Justice which is based in the School of Social Work. It is their understanding and advocacy of restorative justice that comprises the first four chapters of the text. The editors have one overarching goal: to bring restorative justice principles and values, theories, research, and practices closer to the education and practice of social workers. Strengthening the linkage between the social work profession and the restorative justice movement, they argue, will result in mutual gains for both disciplines and innovative solutions to social problems.

The restorative justice movement grew out of community practice models in the 1970s that were seeking to offer alternatives to the dominant criminal justice institutional practices, particularly in the area of juvenile justice. Communities and governments abroad, most notably in New Zealand, and a few community justice centers in the United States, began experimenting with models of victim-offender mediation. The emerging paradigm shift was towards viewing crime as a breakdown in interpersonal relations and community life that required a transformative process that would allow individuals and communities opportunities for healing and restoration. The models of "justice" in the restorative justice movement strive to move away from the purely retribution approach of

our criminal justice system, with its focus on what should be done to the offender, towards interventions that focus first and foremost on the needs of the victim, while also attending to the obligations and needs of the offender.

The editors and case study contributors are successful in clarifying the intellectual debates, criticisms, and limitations surrounding the restorative justice movement and the diverse practice models that are used in restorative justice programs. While many restorative justice programs remain rooted in the criminal justice context, over the past two decades restorative justice programs have moved out into diverse social and institutional settings in the United States.

The contributors provide eight case studies, each focusing on a particular social or institutional context and illustrating the different practice models that have evolved in the restorative justice field. The case studies also delineate the commonalities between social work and restorative justice values, principles, skills, and practice theories (notably, strengths perspective, resiliency and empowerment theories). The case studies provide clear examples of different restorative justice processes. The case study on a school-based student conflict and the case addressing the needs of family survivors following a homicide illustrate the use of a Healing Circle process. A community conflict case, involving youth and community residents, demonstrates a Community Conferencing approach. The child abuse-protective service case shows the efficacy of using a Community Engagement/Team Decision-making approach. A case involving intimate partner violence and child protection illustrates a Child and Family Team Meeting approach. And a case study concerning elder maltreatment and protective services demonstrates the intervention of an Elder Justice Program that uses a Family Care Conferencing process. There is also a case study that illustrates the use of a Group Dialogue approach in one of Pennsylvania's maximum security prisons that was based on inmates' viewing a live performance of the play, "A Body in Motion," about victims of violent crime. And there is a chapter on restorative justice in an international context which discusses the significance (and shortcomings) of Truth Commissions and the specific case of post-war Liberia and the community challenges of addressing crimes of rape

and sexual violence.

The editors, as well as some of the contributors, are open in their recognition of the social change limitations of the restorative justice movement at the present time. Fundamental cultural change might be an aspiration for some in this movement, based on a revolution of social values and relations starting within local communities, but the challenge for restorative justice proponents and, of course, for social workers is whether they will also play a role in social movements that challenge structures of inequality and oppression. With this understanding, the editors of this text have provided practitioners and scholars alike with a text that should be as accessible and valuable to the uninitiated as it is to those who have years of restorative justice practice experience.

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Elisabeth Clemens and Doug Guthrie , Eds. (2010). *Politics and Partnerships: The Role of Voluntary Associations in America's Political Past and Present*. Chicago: University of Chicago Press, \$55.00 (hardcover), \$19 (paperback).

The relationship between the nonprofit and governmental sectors is often a difficult one, with many competing views about the proper role of each sector. In the current political climate, this connection is becoming more and more contentious. These differences are reflected in the scholarly conversation in research about lobbying, advocacy, privatization and devolution. Much of this literature tends to oversimplify the nature of the relationship and concentrate on the problems involved in purchase of services-contracting to the exclusion of other important considerations. Nonprofits are important actors in the political systems, and this is sometimes ignored. Fortunately, Elisabeth Clemens and Doug Guthrie and their colleagues have produced a book that asks provocative and creative questions about this important set of issues, raising theoretical issues and reviewing different aspects of the government-nonprofit relationship.

Politics and Partnerships consists of eleven chapters organized in three parts with an introductory chapter that lays the groundwork for the rest of the book by providing an overview of the interaction between nonprofits and government. The first part of the book deals with government-nonprofit relationships in historical context. Jonathan Neem discusses the interaction between nonprofit organizations and the emerging United States prior to the Civil War. He stresses the importance of the nonprofit sector in developing our national identity. Mark Hendrickson looks at the role of nonprofit labor research organizations in shaping the development of industrial society and takes the discussion into new areas. Chapter four, by Elisabeth Clemens, is probably the strongest contribution in the book. It is a very well-developed, insightful and comprehensive review of the American experience in government-nonprofit relations around the time of the great depression and provides a fascinating introduction to a major juncture in the creation of social welfare.

The following three chapters look at nonprofits in a world of markets. Alice O'Conner examines the role of nonprofits in creating the conservative movement of the past few decades, showing how philanthropy contributed the growth of the movement and providing concepts that are useful for analyzing what is happening today. James Evans discusses the development of nonprofit think tanks in the area of science and innovation, arguing that rather than becoming corporate appendages, nonprofit research centers became "universities without students." He provides compelling statistical data to support his assertions. In the next chapter, Doug Guthrie scrutinizes corporate philanthropy, using a large data set and statistical models to illuminate corporate giving agendas. The findings from this process are intriguing.

The third part of the book, four chapters of case studies with larger implications, examine boundary spanning activity of nonprofits. Chapters by Nicole Marwell and Michael McQuarrie report on nonprofits engaged in local politics, demonstrating that nonprofits are potent political actors that are engaged in public-private partnerships. These excellent case studies provide strong discussions of contemporary theory.

Marwell's discussion of electoral politics is especially vivid and helpful. On the other hand, Omri Elisha's chapter about evangelical mega-churches was somewhat limited, given the role of religion in both nonprofits and politics today. Though well written and interesting, this analysis of the faith-based dimension of government-nonprofit relations could be more fully explored. The final chapter was a little gem. Alyshia Galvez demonstrates how nonprofit organizations change and adapt with the winds of political and cultural change. She presents a New York organization serving immigrants before and after 9-11 and explains the changes that were made essential by the new environment.

Politics and Partnerships has a great deal to offer those with an interest in nonprofit organizations, social change, social welfare policy and community organization. The chapters are well written and well developed, theoretically rich and insightful. The book holds together remarkably well for an edited volume. A lot of effort and careful editing obviously went into making these essays work together and the result is impressive.

An important strength of this book is the range of nonprofit organizations discussed. Some of the government-nonprofit literature appears to deal almost exclusively with large government agencies contracting with large health and social service nonprofits, ignoring the diversity and richness of the nonprofit sector and the importance of citizens in their governance. This book illustrates a number of settings that are often forgotten in mainstream literature. The scholarship is very strong and the passion that the authors feel for their topics is evident.

This is an excellent book and it is an important contribution to the literature. It offers a superb introduction to the interaction between government and the nonprofit sector. It is full of provocative ideas and interesting research. Anyone who deals with advocacy, public policy, nonprofit organizations and similar fields will want it in their library and will refer to it frequently.

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Laura Velasco Ortiz & Oscar F. Contreras, Eds. (2011). *Mexican Voices of the Border Region*. Temple University Press, \$79.50 (hardcover), \$29.95 (paperback).

Arthur Schmidt's Temple University Press series "Voices of Latin American Life" began with Elena Poniatowska's celebrated *Nothing, Nobody: Voices of the Mexico City Earthquake*, published in English in 1995. Since then the series has offered English-speaking readers first-hand accounts from Brazil, Mexico, and Colombia. *Mexican Voices of the Border Region* brings together ten short testimonies of Mexicans and Mexican Americans in Tijuana and southern California, with brief introductions and a conclusion by the editors that situates the testimonies theoretically and discuss the nature and meaning of the border.

Border studies, as the editors explain, encompass a tension between conceptualizing the border as a region, and emphasizing the national differences and, in this case, walls, that divide it. Their goal is to use the testimonies to approach the "lived experience" of the border from different perspectives. They present the testimonies along a continuum from those who live solely in Tijuana, through those who move back and forth across the national border, to those who reside on the U.S. side. The border in both of its incarnations—as a region and as a division—structures the daily existence and life choices of all of those interviewed in fundamental ways.

The U.S.-Mexico border has emerged as an area of study in recent decades, and numerous monographs have examined different aspects of the borderlands. *Mexican Voices of the Border Region* is unique, however, in its multi-faceted approach. The life stories, or testimonies, begin with the category "the border never crossed"—Mexicans who live in the border region and whose lives are shaped by the border even though they personally have never crossed it. "The border as backdrop" includes narratives of individuals who have crossed the border on occasion, but whose livelihoods are based upon the border economy on the Mexican side. "The everyday border" includes individuals whose work lives include frequent crossings, including a human smuggler or pollero who guides would-be immigrants across. Finally, "the border traversed" looks at

Mexicans who have established their lives on the U.S. side of the border.

A number of themes emerge from these tales. Except for the last two—people of Mexican origin who have successfully found their place in U.S. society, one as a college student and one as a Border Patrol agent—the life stories reveal extraordinary hardship and violence. Most of those interviewed in Tijuana fled there from rural areas, where poverty, minimal education, and lack of opportunity combined with domestic violence and abandonment led them to leave home seeking a better life in the city and, eventually, on the border. Corruption of official institutions is endemic. Marriage and family relations are fragile and often destructive. Contrary to the popular belief in the United States that most Mexicans are eager to cross the border to access the affluence on the other side, most of the Mexicans interviewed in this book are merely struggling, often desperately, to find a niche where they can survive. The border economy provides that niche in multiple ways, from export agriculture to the maquiladoras (export-oriented industries or processing plants) to prostitution, to drug and human trafficking. Those that do cross generally find more continuity than change: poor working and living conditions, discrimination, and the added burden, for many, of illegal status.

The stories are heart-wrenching, and each one implicitly illustrates the three factors that the editors argue characterize the U.S.-Mexico border: adjacency, asymmetry, and interaction. Yet it is striking the extent to which those interviewed interpret and tell their own stories in individual, rather than structural, terms. This disjuncture is illustrated poignantly by the Mexican-American border patrol agent whose testimony closes the book. He notes that his ethnic and linguistic link to those he is pursuing is a disadvantage as well as an advantage in his job. "It sometimes happens that you feel very bad for the people," he comments. "It's really hard when you come across a family, when you see people coming in wanting to work, to improve their lives, and they come with their children. Honorable people struggling to have a better life ... But I have to do my job. The laws apply to them as well as to me" (174). Neither he, nor the others interviewed in the book, raise the political question of how the laws, and the structures of

asymmetry, came to characterize the border and so profoundly shape their lives.

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