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Despite many accolades, E. Franklin Frazier, the first African American to be elected to the American Sociological Society, is also an object of scorn. Specifically, some accuse Frazier of a view that blames the ills of the Black community on female-headed households, illegitimacy, and family disorganization. Some also accuse Frazier of characterizing the Black family as broken and pathological and the opinion that families must be formal and nuclear in order to be viable. This paper argues that these representations of Frazier are mistaken and offers a more accurate and holistic portrayal of Frazier's sociological judgements and theorizing regarding the African-American family.

E. Franklin Frazier, who in 1948 became the first African-American sociologist to be elected president of the American Sociological Society (now Association), was thirty-three years old and a seasoned social scientist by the time he came to the University of Chicago in 1927 to complete work on a doctorate in sociology. Frazier graduated cum laude from Howard University in 1916 before sociology was established as a curriculum. However, after working three years as a secondary teacher, Frazier earned a masters degree in sociology from Clark University. From 1920 to 1921, Frazier was a research fellow at the New York School of Social Work, where he conducted a study of the longshoremen of New York. Subsequently, from 1921 to 1922, Frazier studied in Denmark as a fellow of the American Scandinavian Foundation. Upon his return, Frazier accepted a position in Atlanta where he taught at Morehouse College and helped develop and direct the Atlanta School of Social Work.
Here Frazier began writing about the Black family, and by the
time he received his doctorate in sociology from the University of
Chicago in 1931, Frazier had at least forty scholarly publications
to his credit (Davis, 1962, pp. 431–433; Edwards, 1968, pp. xii,

Frazier’s prominence and importance as a sociologist are un-
questioned, and it is rare that there is a sociological assessment of
the African-American family without some reference to Frazier’s
work, especially his *Negro Family in the United States* (see Odum,
theless, criticisms and misconceptions regarding Frazier’s ideas
on the African-American family abound. This paper examines
these misconceptions and makes an effort to offer a more holistic
and accurate presentation of Frazier’s sociological views and
theorizing regarding the African-American family.

Frazier as a Symbol of Scorn:
Argument and Counterargument

Some scholars have examined Frazier’s ideas on the African-
American family for their historical importance and sociological
insight, but for others, Frazier has become a symbol of an ap-
proach to the study of the African-American family that blames
the ills of the Black community on female-headed households, il-
legitimacy, and family disorganization. Some believe that Frazier
felt that the African-American family must always conform to the
norm of the nuclear family in order to be viable. Still others blame
Frazier for setting in motion the view that the African-American
family is typically broken and pathological. Even scholars who
recognize that Frazier’s work has been misrepresented may be
inclined to ignore Frazier for fear of being associated with the
negative images that have been painted of him. There is no ques-
tion that Frazier made errors in judgment and exhibited certain
biases in his sociological endeavors, but too often criticisms of
Frazier are based on popular misconceptions rather than on close
readings of his empirical works.

Dorothy Roberts (1997), for example, in her study of race and
reproductive rights, *Killing the Black Body*, seized upon Frazier’s
*The Negro Family in the United States* as a symbol of scorn. Refer-
ring to this book, she stated, "Frazier reiterated the thesis that
dominant Black women, by perpetuating the slave legacy of un-
wed motherhood, were the cause of family instability" (Roberts,
United States does Frazier characterize Black women as dominant,
posit unwed Black women as the cause of family instability, or
explain unwed motherhood as purely a legacy of slavery. Fra-
zier did note, however, that despite conditions that resulted in
variations in maternal caring, the African-American mother, on
the whole, remained a stable and loving force in the care of her
children throughout the slave period. He observed:

Generally speaking, the mother remained throughout slavery the
dominant and important figure in the slave family. Although tradi-
tion has represented her as a devoted foster-parent to her master's
children and insufficient to her own, it appears that, where this
existed, the relations between the slave woman and the white child
were similar to the relations which normally exist between mother
and child. On the other hand, pregnancy and childbirth often meant
only suffering for the slave mother who, because of her limited
contacts with her young, never developed that attachment which
grows out of physiological and emotional response to its needs.
Nevertheless there is abundant evidence that slave mothers devel-
oped a deep and permanent love for their children, which often
causd them to defy their masters and undergo suffering to prevent
separation from their young. (Frazier, 1939, pp. 60–61)

Frazier (1939) also noticed that the experience of slavery
schooled many African-American women in self-sufficiency and
that "when emancipation came, many [African-American]
women had to depend upon their own efforts for the support
of themselves and their children" (pp. 125–126). Frazier sim-
ply acknowledged the resiliency and resourcefulness of African-
American women who had to survive and care for their children
in the absence of fathers and husbands. These fathers and hus-
bands were usually deceased or separated from their families as
a consequence of the system of oppression. Maternal or female-
headed households and women who were self-reliant were sim-
ply examples of the many adaptations that African-American
families made to prevailing social conditions. Frazier never sugges-
ged that these particular adaptations were pervasive or typical.
Again, Frazier did not blame African-American women as a cause of family instability.

It appears that Roberts has parroted many of the misconceptions about *The Negro Family in the United States* without having examined it for herself. She provided no specific examples to sustain her assertions. Interestingly, Roberts' chapter, "Reproduction in Bondage," would have found significant support from three of the chapters in *The Negro Family in the United States*: "Human, All Too Human," "Motherhood in Bondage," and "Hagar and Her Children" (Roberts, 1997, pp. 22–55; Frazier, 1939, 17–69). These chapters examined how the harsh conditions of enslavement affected sexual relations and the development of loving and caring relationships, variations in maternal caring, and African women who were forced to bear the children of the slave master. Roberts ignored these chapters completely and seemed not to know of their content.

Sociologist Robert Staples, who spent much of his career writing about the Black family, has more than likely read Frazier. He correctly observed that sociologist Daniel Patrick Moynihan helped to popularize the view in public policy debates that the Black family is characterized by matriarchy (Staples, 1971, pp. 154, 157). Moynihan further surmised that the development of the Black community is retarded by a pervasive matriarchy, which, he said, is dysfunctional in a patriarchal society (U.S. Department of Labor, 1965/1981, pp. 29–32). Moynihan claimed that Frazier's work on the Black family supported these views. I will not attempt to assess this or other conclusions by Moynihan regarding the African-American family—which are complex and varied in their accuracy—but Frazier's vilification is to some degree a function of his association with Moynihan's ideas. Staples (1971) also observed that "The Moynihan theory of the black matriarchy derives from his findings that 25 percent of all black families have a female head" (p. 157). This observation is only partly true because Moynihan argued that a matriarchy also was characteristic of double-headed households among Black families (U.S. Department of Labor, 1965/1981, pp. 29–32). Moynihan obviously did not limit his definition of matriarchy to family composition. Disappointingly, Staples (1993, p. 131), in subsequent writings, gave the impression that Frazier, like Moynihan, typified the
African-American family as matriarchal, a serious misrepresentation. Also, like some others, Staples (Staples and Johnson, 1993) cited *The Negro Family in the United States* to support his assertion that "the concept of the Black matriarchy emerged from the writings of E. Franklin Frazier . . ." (p. 131), but gave no page numbers or examples as support.

Taking a similar view, Joyce Ladner (1972, pp. 15–17) asserted that Frazier's work on the Black family began the focus on matriarchy, disorganization, the tendency to compare the Black family to White norms, and the inclination to emphasize Black family weaknesses rather than strengths. She stated: "E. Franklin Frazier asserted in *The Negro Family in the United States* that the family is matriarchal and inherently disorganized as a result of having inherited the legacy of slavery, and as a result of the mass migration to the cities which causes further disruption" (Ladner, 1972, p. 15). I have found no specific statements in this work by Frazier that characterized the African-American family as matriarchal or inherently disorganized. Frazier (1939; see "Part IV, In the City of Destruction") did identify social conditions that tended to demoralize poor families that migrated from the rural South to southern and northern cities. He (Frazier, 1939; see "Part V, In the City of Rebirth") also identified conditions that provided stability and strength to urban African-American families. Interestingly, when Ladner provided a lengthy quote in her book, *Tomorrow's Tomorrow*, to illustrate the strengths of Black families under slavery, she selected an example from Frazier's *The Negro Family in the United States* (Ladner, 1972, p. 31). Furthermore, Ladner (1972, pp. 16–17), in contradistinction to Frazier, gave praise to Andrew Billingsley's *Black Families in White America* as the first effort to assess the strengths of Black families and not simply their weaknesses. This is well-deserved praise, but Billingsley (1992, p. 23), a venerable elder in the study of the Black family, credited E. Franklin Frazier, among others, with recognizing the intense adaptive powers of Black people under the harsh conditions of White oppression. Also, he (Billingsley 1992, p. 101) contended that those who would argue that Frazier supported the notion that there was an absence of family life among Blacks during slavery have misread or have not read Frazier's works.
In the book, *All Our Kin*, anthropologist Carol Stack (1975) advanced the legitimacy of her own study of poor African-American families by asserting that studies by Frazier and others had overlooked the interdependence and cooperation of kinfolk in Black communities. This is true to some degree, but Stack (1975) further commented that “The underlying assumptions of these studies seem to imply that female-headed households and illegitimacy are symptomatic of broken homes and family disorganization” (p. 44). Stack’s study, of course, was focused quite differently than Frazier’s, and the failure to explain this difference or to explain Frazier’s views on illegitimacy as an indicator of family disorganization tended to add to existing misconceptions about Frazier. For example, Frazier observed widely varied illegitimacy rates among African Americans in the rural and urban South in the 1920s. His analysis regarding these variations clearly acknowledged their limitations as indicators of disorganization. He stated: “These differences in illegitimacy rates, even where they are approximately accurate, are not a measure of the social significance of the phenomenon in the various communities, for statistics on illegitimacy are only an enumeration of the violations of the formal requirements of the law” (Frazier, 1939, p. 110).

Others have followed suit in their negative characterization of Frazier’s work on the Black family. Sadye Logan (1996), in her edited book, *The Black Family: Strengths, Self-Help, and Positive Change*, stated, with no additional elaboration, that *The Negro Family in the United States* “confirmed the thinking of his [Frazier’s] contemporaries that the personal lives of poor Blacks were dysfunctional and characterized by pathology” (p. 12). Without a more detailed and in-depth examination of Frazier’s empirical findings regarding poor Black families, others can freely misuse Frazier’s work to validate their own misconceived generalization of the Black family as pathological. Frazier, however, did not make such a generalization.

In *The Black Extended Family*, Elmer and Joanne Martin (1978) asserted, “We do think . . . that it was through Frazier’s work that the pathology-disorganization perspective was firmly established in the social sciences” (p. 105). Unfortunately, this statement again assigns blame to Frazier for how others interpreted his work. Martin and Martin (1978, p. 105) also felt that Frazier
spoke of lower-class families in a condemning way and favored upper-class Blacks and mulattos. On the contrary, Frazier (1939, pp. 297–267) was also critical of mulatto and upper-class families, but he recognized the advantages they had in terms of their longer history of freedom, higher levels of education and home ownership, and self-consciousness regarding a family heritage. These advantages were byproducts of their familial connections to White propertied classes. Frazier also explored the complex issues of color prejudice and identity among these groups, as they became less isolated, subject to a more generalized White supremacy system, and encountered a more oppressed, landless, and demoralized Black peasantry. Speaking of the mulatto class, Frazier (1939) observed: “The development of family life on an institutional basis was closely tied up with the accumulation of property in these families” (p. 205).

Some scholars have tended to ignore Frazier, even though his work may have spoken directly to their theoretical concerns and empirical findings. Belinda Tucker and Claudia Mitchell-Kernan (1995a), for example, examined the current declines in marriage among African Americans and the substantial increases in African-American families headed by single mothers. Reviewing Frazier, they (Tucker and Mitchell-Kernan, 1995b) acknowledged that Frazier had been misunderstood, but they did not go very far to discuss the obvious parallels between Frazier’s findings and the findings presented in their book, *The Decline in Marriage Among African Americans: Causes, Consequences, and Policy Implications* (see also, Tucker and Mitchell-Kernan 1995c). They did not engage Frazier’s ecological analysis of the family and omitted serious examination of Frazier’s investigation of the relations between family structure and function. Instead, they asserted: “we do not hold the view that either the nuclear family or marriage is the only vehicle permitting the development of healthy communities and individuals. Yet we do view the dramatic decline in African-American marriage with some alarm” (Tucker and Mitchell-Kernan, 1995a, p. xix). Here Tucker and Mitchell-Kernan struggled to distance themselves from one of the criticisms directed at Frazier (the misconception that Frazier saw formal marriage as the only viable family form), while indicating that there is an important relationship between family structure
and function, a problem that Frazier explored with considerable sociological insight.

Interestingly, Susan George and Bette J. Dickerson (1995) addressed in their work the important role of the grandmother in single-mother families. They noted: “Grandmothers have been found to assume a variety of roles, ranging from becoming the primary parent to their grandchildren to sharing the burden of child care so that a young mother can finish her education to becoming the household ‘manager,’ overseeing and directing the activities of their daughters and grandchildren” (George and Dickerson, 1995, p. 152). George and Dickerson (1995) also observed that current social forces are “depleting the strength and resources of this form of intergenerational support” (p. 160). Their focus on African-American grandmothers is an enormously important line of research, but, unfortunately, George and Dickerson omitted a discussion of Frazier (1939, pp. 146-159), who was the first to examine, with sociological depth and detail, the stabilizing role of the grandmother in single-mother families. Telling the story of a grandmother who led her family to freedom during slavery, Frazier (1939) related: “The energy, courage, and devotion of this woman, who was nearly seventy, are characteristic of the role which the grandmother has played in the Negro family” (p. 146). Frazier also explained that the grandmother continued as a stabilizing force in the Black family during the modern, post-slavery period. He concluded: “The Negro grandmother has not ceased to watch over the destiny of the Negro families as they have moved in ever increasing numbers to the cities during the present century” (Frazier, 1939, p. 158).

More detailed conceptualizations of the African-American family have continued to circumscribe Frazier’s ideas in distorted and truncated forms. Two examples are conceptualizations by Walter Allen (1995) and Jualynne Dodson (1997). Allen (1995), in his article, “African American Family Life in Societal Context,” correctly noted that Frazier “rejects explanations attributing high rates of marital instability, desertion, and illegitimacy among urban Black families to innate, biological deficiencies” (p. 576). He also acknowledged that Frazier saw racism and economic disadvantage as disruptive to Black families. These facts are important
to differentiate Frazier's ideas from the racist thinking that blames African Americans for their own oppression.

However, Allen (1995) advanced several criticisms of Frazier that were profoundly flawed. First he argued that Frazier failed "to specify the societal-level processes thought to determine Black family patterns." Second, Allen contended that Frazier displayed a "consistent denial of legitimacy to aspects of Black family life representing departures from normative White family patterns." Third, Allen asserted that Frazier argued that Black family organization "results from a self-perpetuating tradition of fragmented, pathological interaction within lower-class Black urban communities" (p. 576), attributing a culture of poverty theory to Frazier. Further, Allen (1995, p. 578) tried to force a critique of Frazier into a debate between the relative importance of culture and class in the determination of Black family formations when such a debate was foreign to Frazier's paradigm. These descriptions of Frazier's ideas were unfair and ignored Frazier's ecological approach to the study of the Black family and his analysis of the relations between social organization and culture (see also, Frazier, 1957). In fact, Allen (1995) made an effort to advance an ecological model of the Black family, but this model paled in comparison to the theoretical relevancy and detail of the ecology-of-race-relations model in Frazier's comparative study, Race and Culture in the Modern World, and, of course, in his The Negro Family in the United States, which advanced a natural history of the Black family, a sociological conceptualization of the stages of growth of the Black family through time (see Davis, 1962, p. 434).

Dodson (1997, p. 67), on the other hand, divided conceptualization of the African-American family into two schools of thought: (1) the ethnocentric school and (2) the cultural relativism school. The former was assimilationist and assumed that the values, attitudes and behaviors of middle-class, Anglo-Saxon Protestants represented the norm of US life, and all want or should adhere to this norm. Although Dodson did not define or explain what she meant by values, attitudes, and behaviors of middle-class, Anglo-Saxon Protestants, she noted that the cultural relativism school said that families were different, not deviant and that it focused on strengths, not weakness. Further, the cultural
relativism school generally traced the origins of cultural distinctions among Blacks to an African cultural heritage (Dodson, 1997, p. 68). Dodson (1997, pp. 68–70) placed Frazier in the ethnocentric school.

On the contrary, Frazier (1968a), like the cultural relativism school, saw the Black family as a functional unit (cf. Dodson, 1997, p. 73). For example, he explained:

Viewed from the standpoint of its institutional character, the family may be regarded as disorganized when it does not conform to socially accepted norms of family life. But if we also view the family as an organized social group or cooperating unit with which the various members are identified and this identification is recognized by the community, then family disorganization may be defined differently. . . . In many sections of the rural South, especially in the plantation area, there are Negro families which do not conform to the institutional pattern of the American family. But it would be a mistake to label them as disorganized since they are stable groups and carry on the functions of the family. Therefore, in discussing family disorganization we shall be referring to the disintegration of the family group or its failure to function as a cooperating unit. (Frazier, 1968a, p. 227)

Thus, Frazier observed that the legitimacy of family forms was defined by the state or by the community and that family organization and disorganization were defined by conformity to accepted norms or by the functional character of the group. Frazier recognized the former and emphasized the latter in his analyses and policy considerations. Therefore, in this case, Frazier took on characteristics of the cultural relativism school. Nonetheless, it is generally well known that Frazier did not believe that African culture had a principle role in the way the African-American family developed in the US. Frazier is usually contrasted with White anthropologist Melville Herskovits (1941/1958), who is often celebrated for his support of the idea that African cultural survivals or Africanisms persisted in the New World. However, we should understand that Herskovits recognized that disruptions to traditional forms of social organization could seriously disrupt culture, as did Frazier. Their differences often revolved around interpretation. For example, Frazier viewed common-law marriages among rural Blacks in the South as an adaptive
response to the American experience that was related to the degree of acculturation to mainstream norms. Herskovits related this behavior to African marriage practices where sanction and consent by families were required and not the approval of the state (Frazier, 1939, pp. 133–136; Herskovits, 1941/1958, p. 171). Ironically, however, Herskovits (1941/1958) observed: “It goes without saying that the plantation system rendered the survival of African family types impossible, as it did their underlying moral and supernatural sanctions, except in dilute form” (p. 139).

Dodson (1997) also asserted that Frazier wanted “to demonstrate empirically Robert E. Park’s race relations cycle” (p. 67), which theorized that Blacks would ultimately assimilate into a White culture. Dodson was in error here. Much of Frazier’s work was focused on the assimilation problem, but Frazier (1957, pp. 327–338) did not accept assimilation, which meant, for him, the loss of identity, as a forgone conclusion for African Americans. His study of the African-American family was an empirical examination of the assimilation problem, which revealed the conditions under which assimilation was most likely to take place (Frazier, 1939, see “Chapter XXII, Retrospect and Prospect”; Odum, 1951, p. 238). Let’s examine the context of the assimilation problem.

White sociologist Robert Park, Frazier’s mentor at the University of Chicago, was a leading theorist on race relations and was considered by some to be an expert on Black Americans. Park had been a secretary to Booker T. Washington and president of the Chicago Urban League. He (Park, 1919, p. 116) theorized that contact between Africans and Europeans proceeded through a cycle that resulted in conflict, accommodation, and assimilation. For Park, Africans had produced no significant culture of their own and had brought little of this culture with them to the New World. Therefore, he believed that African Americans had no cultural traditions that would impede assimilation into a European-based American or White culture.

Park (1919) explained that the appearance of cultural distinctiveness that he observed among African Americans was a consequence of their “racial temperament.” This temperament, according to Park (1919), was characterized by a “genial, sunny and social disposition, in an interest and attachment to external, physical things rather than to subjective states and objects of
introspection, in a disposition for expression rather than enter-
prise and action” (p. 129). Park referred to African people as the
“lady of the races” since they presumably lacked the intellectual
and pioneering characteristics of White men. Park theorized that
through this racial temperament, African Americans selected as-
pects of White culture to which they had the greatest biological
affinity. His fundamental concern was: “How far do racial char-
acteristics and innate biological interests determine the extent to
which one racial group can and will take over and assimilate the
characteristics of an alien civilization?” (Park, 1919, p. 113).

Frazier, of course, rejected Park’s notion of racial temperament
in favor of a more environmentally- and socially-based concep-
tual frame. For Frazier, a distinctive African-American culture
was a function of the persistence of a distinctive form of social
organization. Furthermore, Frazier noted that assimilation also
involved identification, a step beyond acculturation, the simple
process of acquiring the cultural traits of another group. Thus,
assimilation meant that one group would no longer see itself as
distinct from another. For Frazier (1957, pp. 327–338), the end
result of contact between Whites and Blacks was not automatic-
ally Black assimilation, the destruction of a distinctive social
organization and identity. The inevitability of assimilation was an
empirical question whose answer was to be found in the study
of family life and the various forms of social organization that
affected its development (Odum, 1951, p. 238). If social forces
existed that would move African Americans toward assimilation,
Frazier (1968b, p. 16) theorized that it was the family that would
impede or facilitate this process.

The Dynamics of Social Organization
and Culture as a Method of Analysis

Frazier divided his The Negro Family in the United States into
culture and organization under which the African/African-American family
had to adjust (see Semmes, 1992, pp. 43–51). They were: “In the
House of the Master,” “In the House of the Mother,” “In the House
of the Father,” “In the City of Destruction,” and “In the City of
Rebirth.” These topics represented the broad societal levels of
social organization that affected the Black family through historical time, which included slavery, emancipation; post-slavery, rural life; migration, and urbanization. Frazier examined these variations in social organization in terms of their natural history and their implications for institutional viability. He revealed how socio-historical phenomena provided disorganizing influences to the African family and then identified conditions that tended to restructure or reorganize the family. Thus, Frazier’s objective was not to characterize the African-American family as either organized or disorganized but to discover the conditions under which one or the other took place (see Frazier, 1939, p. x).

Frazier’s first chapter, “Forgotten Memories” under Part One, “In the House of the Master,” gave some insight into how he developed his analysis. Frazier theorized that an African cultural heritage could not be sustained because slavery disrupted African systems of social organization. He observed that slave traders had little regard for family bonds and ethnic distinctions. Frazier felt that seasoning, the process of conditioning captive Africans for slavery, and the scattering of Africans among the smaller plantations in the North American South, tended to erode African culture. Also, for Frazier (1939, pp. 21–22), if there were surviving elements of African culture, they were inclined to have little influence on family structure and function under the newly emerging conditions of life in the New World.

Despite some lack of accuracy regarding the persistence of African cultural survivals (cf. Stuckey 1987; Holloway 1990), Frazier’s focus on social organization was theoretically powerful and empirically useful. For example, Frazier (1939, pp. 3–85) was able to identify five areas through which the conditions (variations in social organization) of enslavement shaped the Black family. First was the organization of the plantation that produced a distinctive division of labor. Second was the variety of natural relationships that grew up as men and women sought to fulfill their sexual desires. This included the sexual domination and exploitation of the African women by the White male. Third was the imposition of a European-American social heritage (in the presumed absence of an African heritage) through European Christianity; and fourth, there were the implications of the natural bonds that grew up between mother and child. The fifth was the system of domination
itself that promoted White supremacy and the intrusion into Black family life by White oppressors.

Frazier observed that slavery disorganized African family life in the New World, but the emergence of new forms of social organization, even under harsh oppression, could provide some stabilizing features to the family. He (Frazier, 1939) found, for example, that the "mother remained the most dependable and important figure in the family" (p. 41), and despite the harshness (Frazier, 1939, pp. 43–47, 50–52, 60–61) of child bearing, enslaved African women exhibited strong maternal caring toward their children. Also, unfettered sexual hedonism, for example, could and did in some instances spawn caring and sympathetic relationships (Frazier, 1939, pp. 23–29). Additionally, despite the fact that slavery was an economic institution, the plantation system took on a social character, through which some elements of family life could be achieved.

Emancipation provided new disorganizing experiences because it removed the economic basis for survival. Social relations were torn asunder as former slaves were displaced from plantations, denied land of their own, and moved about on a mass scale to test their new freedom, find new means of survival, and reconstruct their families (Frazier, 1939, pp. 93–95). In the midst of this new form of social disorganization, Frazier observed the emergence of female-headed family forms, headed by single and widowed grandmothers, which kept multiple generations of family members together, took in orphaned children, and provided the basis of a stable and viable family (Frazier, 1939, pp. 146–159).

Further, Frazier (1939, pp. 146–159, 163–181) observed that because of emancipation, the Black male, for the first time, could assert authority in the family and provide an economic role. In the context of American society, the male (father-husband) role facilitated the economic viability and protection of the family, which gave strength to the affective and socializing components of the family. However, because Frazier (1939, pp. 146–159) had already identified stabilizing features of female-headed families, it was clear that he saw no inherent instability in this family form. What is important is that Frazier wanted to identify the social and historical conditions that disorganized and stabilized Black
families, and he described the character of the social organization that contributed to and resulted from these conditions.

Frazier's concern with assimilation as a social problem and with factors that enhanced the stability and viability of the Black family directed him to an examination of miscegenation and its relationship to values, racial identification, and social stratification. For example, Frazier observed that an early Black elite had its origins among Blacks who were free prior to the Civil War. These African Americans were disproportionately of mixed racial heritage, having primarily been the products of unions between slave owners and enslaved African women. Among this group, social privilege, usually based on the ownership of property, and a group consciousness based on physical features and the acquisition of a culture different from the masses of Blacks were associated with familial connections to wealthy White families. Also, African-descent populations, absorbed by miscegenation into Native American and White communities, exhibited variations in their levels of racial identification. Some saw themselves as Black; others saw themselves as neither Black nor White, even within the same family. Some Blacks passed for White. How the broader society defined these groups, which included the imposition of harsh segregation laws under a system of White supremacy, also came into play. What is important with respect to family stability is that miscegenation often led to color (phenotypical) stratification that resulted in economic and social advantage. This economic and social advantage became associated with the elevation of male authority in the family, which, in turn, contributed to male interest in the family and greater family viability (see Frazier, 1939, Chapters X, XII, XX, and XXI).

Urbanization (Frazier, 1939, pp. 271–390), like the process of enslavement and the experience of emancipation, posed new problems for the survival of many Black families. As part of his emphasis on variation in social organization, Frazier (1968b, pp. 19–20) identified two major family forms, the natural family and the institutional family. The natural family consisted of the single-mother household, which was held together by parental affection and sympathetic ties. The institutional family was usually two-parent, generally but not always based on formal marriage, and characterized by greater stability and continuity. Frazier
concluded that natural family forms held together by peasant folkways and mores were least able to withstand the disorganizing influences of urbanization, which involved massive groups of migrating rural people who were becoming urban dwellers. The resulting disorganizing influences included separation from familial and communal supports and controls, disruptions to identity due to the quest for status in a new environment, increasing social differences due to rapid social mobility generated by growing occupational differentiation, the separation of sexual gratification from human feelings and commitment, the imposition of poverty and racial segregation, the encounter with more individualistic and hedonistic values, and the like (see, for example, Frazier, 1939, pp. 284–285, 336–339).

Again, Frazier (1939, pp. 393–475) identified the seeds of reorganization within the disorganizing influences of social life. In Part Five, “In the City of Rebirth,” the final section of his study, Frazier observed that urbanization produced a new Black middle class and an urban proletariat, which presented new opportunities for African-American males to gain authority (not dominance) in the family and to contribute economically to the family. He (Frazier, 1939) explained that the Black male industrial worker “assumes responsibility for the support of his family and acquires a new authority in family relations” (p. 475). These observations were consistent with Frazier’s sociological concern with the conditions under which males (husbands and fathers) gained an interest in the family. With regard to an emerging middle class, Frazier (1939) concluded: “Because of the fact that a large proportion of the middle class are salaried persons and there are few or no children in the families, relations between husband and wife, especially where both are employed, tend to be equalitarian, and a spirit of comradeship exists” (p. 439). Also, for Frazier, a critical component of family stability, along with the maintenance of a social heritage, was the degree to which racial barriers would fall, and Blacks could achieve economic integration into American society.

In conclusion, the reactive and disparaging portrayal of Frazier’s work on the family is unfounded. Fortunately, there are those who see Frazier’s work differently and who seek to build on that work in a more sociologically productive manner. Robert
Hill (1993), for example, who is known for his focus on the strengths of Black families, observed, “Frazier’s ecological studies of Chicago and Harlem revealed that black families were diverse rather than monolithic. . . . His analyses consistently attributed the primary sources of family stability to external forces (such as racism, urbanization, technological changes, and recessions) and not to internal characteristics of black families” (pp. 7–8). Hill (1971) stressed that Frazier’s work did not indicate that “disorganized patterns are characteristic of the majority of low-income blacks . . . .” (p. 1). He also was concerned that scholars do not test and update Frazier’s findings but use Frazier’s ideas selectively to support their theories of pathology and matriarchy (Hill, 1971, p. 57).

An examination of why so many have misinterpreted or misrepresented Frazier’s work on the Black family is beyond the scope of this paper. However, I suspect that the negative reaction to Frazier is more a reaction to how some have used Frazier to blame African-American families for the effects of poverty and racism suffered by Black communities. In addition, it is probably the case that a Eurocentric bias continues to play a role in graduate education in the social sciences, such that a close and comprehensive reading of Frazier, one of America’s greatest sociologists, is routinely omitted.

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Biracial Sensitive Practice: Expanding Social Services to an Invisible Population

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Although literature acknowledges the existence of a biracial population, there has been minimal discussion of the differences indicative of biracial clients and how these differences impact provision of services. Too frequently, race criterion has been utilized to categorize biracial clients resulting in an all but invisible population. A biracial individual may then assume a multiplicity of identities including African-, Asian-, Latino- and Native-American, when negotiating with macro institutions including social services. As an alternative to racial paradigms, identity across the lifespan is suggested as a more comprehensive model for biracial clients. In the aftermath said clients will be rendered visible by identity models that prevail less on the basis of race and more on the basis of experience extended across the lifespan.

Introduction

Social work practitioners are faced with the task of providing services to clients characterized as biracial. Biracial clients comprise a group which they may have had little or no practice experience with as a separate entity. Although the literature acknowledges the existence of a biracial population, there has been minimal discussion of the significant differences and similarities indicative of biracial clients and how these differences and similarities might impact the provision of services. Instead, discussions regarding services tend to incorporate biracial clients into groups on the basis of skin color and/or racial criteria rendering them invisible. In the aftermath practitioners ask: “What are the
comprehensive criteria for service delivery to biracial clients? In what ways are biracial clients diverse, and in what ways are they similar? Finally, what are the implications for biracial clients perceived as members of something other than their native group based upon racial attributes?"

In the backdrop of these queries, biracial clients pose increasing challenges to social work practitioners. The size of this historically invisible group is increasing rapidly, and indicators such as dating and marital patterns suggest the need for more comprehensive delivery of services. In answer to the aforementioned queries, this article profiles the biracial population in the United States. It very briefly discusses the dynamics faced by said group in the context of race and identity theory. As an alternative to racial paradigms, identity across the lifespan is put forth as a more comprehensive model for biracial clients who must negotiate for social services with social work practitioners.

Biracial Census: A California Profile

The United States 2000 census has made available an identity category separate from traditional race to accommodate biracial Americans (Census, 2000). Hitherto, the federal Census Bureau had not collected data profiling the U.S. biracial clientele. Consequent to criticisms from an increasingly vocal and active biracial population federal agencies have begun to modify standards for collecting race and ethnic data. However, such information remains unavailable for public consumption. Fortunately states such as California have acted with deliberate speed to accommodate racial changes in the state population.

In California a biracial person is defined as one descended from more than one racial category (Tafoya, 2000 p. 4). Because maternal/paternal race data are organized by monoracial criteria, it is impossible to report the biracial status of parents. Thus, the number of biracial births reported in the same data may be biased downward. Conversely, since racial status of children in the California data are derived rather than self-identified, it may actually overestimate the number of biracial births.

California today has one of the nation’s most diverse populations vis-à-vis immigration. While legal barriers to intermarriage
were abandoned relatively early compared to other states, this has otherwise enabled little more than a moderate increase in biracial births within a 15-year period. However, taken as a percentage of state data in toto, biracial births rose from just under 12% in 1982 to just over 14% in 1997. In real numbers this increase accounts for about 50,000 births in 1982 and about 70,000 in 1997 (Tafoya, 2000, p. 4).

Despite modest rates of increase, the number of biracial births in California is significant and substantial. In fact said births exceeded that of Asian- and African-Americans for the state of California in 1997 (Tafoya, 2000, p. 6). The increasing size of this biracial population provides a context for understanding the concerns raised by biracial Americans as pertains to identity. Furthermore, the task of accurately assessing this population complicates traditional tabulation procedures for monitoring civil rights. For example, it has yet been determined nationally how and if statistically smaller biracial populations will be aggregated into traditional race categories. Considering aggregate group data it will then be incumbent upon census agencies to construct more comprehensive procedures for categorization.

Due to levels of immigration California boasts the distinction of having one of the nation’s most racially diverse populations. That diversity however has not necessarily accounted for its biracial birth rate. The California data compared the births of native-born citizens with that of immigrants. Biracial births to native-born Californians increased from 14% to 21% between 1982 and 1997. This increase represents a 50% population differential. In contrast, fewer than 8% of California’s biracial births were attributed to immigrant mothers during the same time period (Tafoya, 2000, p. 5). Hence, the biracial birthrate is not necessarily attributable to immigration.

In 1997 births to couples in which one partner was white non-Hispanic and the other was Hispanic, Asian, or black accounted for an estimated 75% of all biracial births. The major portion of such births—53%—were to Hispanic/white couples. Births to Hispanic/black, Hispanic/Asian, and Asian/black couples accounted for 15% of biracial births. The remaining births were to couples composed of Native, Alaskan, Hawaiian, Pacific Islander Americans, etc. (Tafoya, 2000, p. 6–7). As a bellwether state, it
is plausible to suggest that what exists in California provides a glimpse of the biracial population that will eventually characterize the nation as a whole.

Racial Identity vis-à-vis Racism

Racism, according to Banton (cf Kitano, 1985), refers to the efforts of a dominant race group to exclude a dominated race group from sharing in the material and symbolic rewards of status and power. It differs from the various other forms of exclusion in that qualification is contingent upon observable and assumed physiological traits (Wilson, 1992). Said traits imply the inherent superiority of dominant race groups that are then rationalized as a natural order of the biological universe (Minor & McGauley, 1988).

The most zealous proponents of racism proclaim their superiority on the basis of race as a matter of scientific fact (Welsing, 1970). They postulate that they alone have been endowed with capacities necessary to bring about civilization. So-called "advancing civilization" was a thinly veiled form of racism devoted to rationalizing the right of one race to embark upon a worldwide mission aimed at conquering others (Pinderhughes, 1982; Daly, Jennings, Beckett & Leashore, 1995). By way of conquest and colonization, dominant race groups left no terrain of the world untouched by their professed superiority. After centuries of domination, the mission to "civilize" has necessitated a universal, almost mystic belief in the power of race to define identity (Hyde, 1995).

Consequent to identity vis-à-vis race, racism has prevailed as one of the most subtle, but no less devastating, and tenacious social problems in the modern era (Hernton, 1965; Kovel, 1984). Volumes of literature have contributed little to its demise. Germane to the American version is a biracial population rendered invisible by virtue of race categorization. The biracial identity by definition is predicated upon the notion that there are no pure races and/or biologically sound racial concepts apart from racism (Stember, 1976). About the importance of this assumption there should be no doubt. Notwithstanding current levels of diversity, to characterize identity in a narrow racial context does disservice to the scientific method. It enables the absurd rhetoric of hierarchy
within a single species and in fact provides a conduit for the continued social, economic, and political oppression of biracial persons nationwide.

Among biracial Americans manifestations of a racial identity are a direct result of domination. Domination by racist concepts allowed for the exportation of racial values, which biracial Americans internalized. As pertains to skin color, the uppermost in status became those who most approximate dominant race groups and the darkest a lesser extreme. In an attempt to conform, biracial Americans adhered to the racial prescripts of identity. Their efforts facilitated a value system that is in many ways not only physiologically alien to them but psychologically brutal to same (Keefe, 1984; Soule, 1992). The result is a configuration of identity whereby cultural and familial experience are all but totally irrelevant to the assessment of biracial clients. That being so, it is imperative to acknowledge the intimate associations between identity and power.

In the absence of power, the perpetuation of self-definition becomes ineffectual. Associated with power, racism perpetuates the racial model of identity. As a logical consequence dominant race groups maintain superior numbers, cohesion, and resources to sustain the current identity system (Schermerhorn, 1978). Biracial Americans are frequently their descendants i.e.: mulatto, Eurasian, etc. (Russell, Wilson & Hall, 1992). They may lack numerical superiority but in fact are cohesive and share a common experience of identity ambiguity extended from the race paradigm—an ambiguity that has galvanized their numbers.

Subsequent to biracial ambiguity, identity vis-à-vis race in the United States is generally regarded as rooted in culture (Hall, 1997). By lack of any biologically significant criteria, social scientists have determined race to be a matter of subjective interpretation. Thus, any biological traits that extend from identity based upon race may vary from one culture to another. Skin color, hair texture and the like ultimately interact differentially to determine biracial identity; therefore, identity is in fact a pliable cultural phenomenon. A biracial Puerto Rican, for example, may be identified as moreno in Puerto Rico and African-American on the U.S. mainland (Felix v Marquez, 1981). In the aftermath, biracial Americans are racially diverse by any given system of identity.
Individuals may be simultaneously perceived in the United States as Euro-, Native-, African-, or Asian-American dependent upon circumstances. However, a biracial identity that suggests African descent may be the most socially damning of all statuses. But even then, to look white forces the biracial individual to identify as white to engage a better quality of life.

As pertains to biracial Americans, traces including African blood necessitates their status as "minorities" (Kitano, 1997). It is their most potent and salient feature because an African phenotype contrasts with the dominant group ideal (Hall, 1990). African identity may have an effect upon every phase of life including, self-concept (Owusu, 1994). It is a "master status" which differentiates the race category of biracial clients from the dominant group as an inferior element of society (Gacia & Swenson, 1992; Herrnstein & Murray, 1994). So potent is this "master status" that it has recently served as grounds for litigation between persons of light and dark skin color but belonging to the same African descended race group (Morrow vs IRS, 1990; Hiskey, 1990). A resort to legal tactics is an indication that for some, identity has been particularly painful given the psychologically conflicting implications of race. That is, biracial Americans have idealized much of the dominant culture but unlike members of the dominant race group are prohibited from structural assimilation into it (Kitano, 1997). Their willingness to assimilate regardless reflects a desire not to devalue themselves but to improve their quality of life and live the "American Dream." In so doing, they may develop a racist disdain for dark skin because the disdain is an aspect of Western culture (Anderson, 1991; Martinez, 1993). They are cognizant of the fact that African blood is regarded by the various institutions as an obstacle that might otherwise afford them the opportunities necessary to succeed. For those who labor, unaware of the inherent limitations, failure is the end result. Furthermore, since quality of life closely correlates with having a color identification with the racial mainstream, light skin has emerged as critical to the biracial's ability to prosper (Hughes & Hertel, 1990).

Self/Other Identification

When asked to identify themselves by traditional race categories, biracial Americans are more often resentful or confused.
All too frequently the racial criterion has been used to categorize some as African-American who may subsequently experience serious identity conflict (Tizard & Phoenix, 1995). As a result, it is incumbent upon the social work practitioner to consult with biracial clients regarding his or her identity. They must be sensitive to the possibility that biracial clients—upon reaching adolescence—may have experienced a dramatic change in social status attributable to the U.S. system of racial identification. Such a change can directly impact social and psychological well-being, self-esteem, and interactions with others.

When asked to describe their identity as children, most biracial clients will first respond with a reference to their home and family life. If one were to ask them about any broader self-identification, the term biracial would until recently rarely be their response. The significance of these queries has implications for both identity and quality of life. Work is perhaps the most important decision confronting Americans regardless of race (Hall, 1990). It is in fact the major variable in determining quality of life. As practitioners assist biracial clients in their decisions, contradictions become even more apparent. Equality of opportunity for all Americans has only recently become a societal goal (Foster, 1993). Biracial clients in their youth observe prevailing racism in the high rates of unemployment and poverty in African-American communities. They know that hard work for them may not result in the realization of career objectives. Aspiring youth must then decide whether or not they will invest their time and energies developing competencies around an identity, because of which, society may not allow them to fully evolve. The decision to pursue a particular line of work is thus contingent upon risk. For biracial youth the risk incurred by embracing a stigmatized identity involve their emotional well-being. If they invest themselves totally in the effort and the effort doesn’t pay off; if they see that equality in the job market has eluded them in the process; they will face a profound devastation and lose all respect for societal institutions (Shams & Jackson, 1994). American communities are rife with casualties of previous generations. They consist of talented folk like themselves who struggled only to become alcoholics, prostitutes, and other societal derelicts. The alternative to taking the risk—particularly if one is a light-skinned biracial—is to distance one’s self from the stigmatized community. Embracing mainstream
society via passing for “white” or the creation of a new identity under the circumstances are seemingly viable alternatives.

Being biracial in America requires/enables living a life of multiple identities (Mills, Daly & Longmore, 1995). At the very least, biracial Americans are the result of a predominantly black/white society that demands adherence to certain race based social norms (Phinney & Alipuria, 1996). Alternatively, today’s less overt and more covert racism facilitates a separate biracial identity evolving its own set of applicable criteria. Being biracial then requires two processes. On the one hand, it may precipitate a conscious distancing from the stigmatized group—usually African descended. On the other hand it may involve the creation of a new identity based in part upon an inability to be accepted without reservation by either composite race groups.

Living as a biracial person in a racist society demands identity diffusion in the traditional Eriksonian (1968) sense; at the same time, a biracial life may exemplify the functional identity of a “black” or “white” citizen (Sowards, 1993). Given their experiences, by the time they become of age biracial Americans may be conflicted by identity (Tizard & Phoenix, 1995). As per the stigma associated with dark skin the ambitious confront major decisions pertaining to where they are going and how to get there. In a racist milieu that affects them personally they must prioritize American values, standards, and ideals. The bright and talented cannot possibly ignore the inherent contradictions between those values, standards, ideals and their personal lives. The middleclass who may have been sheltered from such a reality, encounter stinging consequences by the time they reach adolescence.

Identity Across the Lifespan

In contrast to the traditional race models is the idea that identity is a fluid social construction that extends across the lifespan of human development (Brown & Montague, 1992). In this view, identity is no more static than any other social entity i.e. custom, class or experience. Advocated as a model the idea that identity is shaped by social circumstances is radical and politically charged. In fact—especially for the biracial—identity is multifaceted, subject to change and a malleable component of the
social universe. Such experience-based models expose the perception of race models as thinly veiled manifestations of racism. Furthermore, the self as multiple identities is well demonstrated in an analysis of biracial clients whose skin color is associated with more than one racial category (Brown & Montague, 1992). Enlightened conclusions offer skin color and the development of a biracial identity model to point out how racial models have become obsolete and/or function to reinforce various social and political objectives.

The need of biracial Americans for a separate identity contrasts with the degree to which race remains imperative (Hall, 1997). While numbers may be few, those who prefer to distance themselves from their African heritage must—for mental health reasons—have the option to do so. This contrast highlights the power of achieved identity as a cultural concept that is to be developed preceding adulthood. But for biracial Americans, racist imperatives are unyielding, rendering other than race based identities questionable. The race dynamic is possible because the biracial identity is removed from its historical and political context. As a result, biracial lives are assumed unrelated and unresponsive to social circumstances, history, or culture. This allows for the idealization of race in mythic proportion conveyed by Western culture and its belief systems (Hall, 1993). The construction of an essentially racial identity then inhibits fluidity and models that incorporate development across the lifespan. Models of identity that emerge are inculcated by pseudo-scholars who perpetuate hegemony resulting in the many layers of victimization that biracial Americans frequently endure.

The development of identity across the lifespan serves as a powerful alternative to the pathologizing influence of racial canons and to approaches emphasizing racial characteristics to the exclusion of others. It suggests a very different model from the traditional view. This set of concerns involves personal and social recognition that one's race/skin color is not wholly definitive. Generally, this includes understanding the nature of personal preferences and valuing them in spite of their existence within a stigmatizing social universe. Initially, the breadth of meaning for the new identity may be uncertain: it may also mean a new perception of the biracial self.
In the interest of mental and emotional health Americans who perceive themselves as biracial must counter define the social and political universe. In the face of two powerful barriers—racism and culture—this characterizes the viability of their existence. Scholars of cultural diversity stress the process of self-acknowledgment and the proclamation of existence as the first critical step in personal and, later, social acceptance of what is different (Long, 1991). For biracial Americans, this simple proclamation is a revolutionary act in its repudiation of a culturally imposed stigma. They are unique in that their defining difference on the basis of skin color may be racially non-definitive. Since they can literally choose their identity—via straddling racial categories—the affirmation of identity may be complicated for otherwise absurd racist reasons. Thus, to the degree that identity is actually a culturally constructed phenomenon, biracial Americans develop their identities under a unique set of circumstances (Biracial kids endure . . . , 1995). Consolidation of it is more impacted by ambiguity with few positive and many negative consequences. The characteristic ambiguity of “passing-for-white” is nearly always one of difficult consideration. But it is a necessity of slowly and painfully appreciating an identity wholeness that cannot be understood via race canon ideology.

Antithetical to the racial traditions is coming to an appreciation of the cultural myths pertaining to race. Some of these myths are the obvious negative stereotypes about the associations of dark skin with inferiority and the superiority of European ancestry (Hall, 1992). Others are less well articulated, maintaining that some among biracial Americans—particularly the light-skinned—having European ancestry are arrogant and/or self-centered (Jones, 1994; Gatson, 1994). To the degree that these views have been consciously incorporated, they are easy to challenge, but they must be challenged by demythologizing personal contact. Such occurrences as recognizing other aspects of identity will slowly modify the more deeply entrenched assumptions.

The disadvantages of racial criteria as an identity paradigm in social work stem from a methodology rooted in cultural tradition—not science. Fortunately, such disadvantages have begun to manifest in the practitioner’s push for a scientific explanation of social phenomena. Conversely, by adhering to cultural tradi-
tion, the practitioner is forced to view identity from a culturally constructed perspective. This necessitates identity by racial criteria rather than reflecting reality. Under such circumstances a traditional pre-existing view of the identity universe is reinforced. The more scientific, logically constructed nature of identity across the lifespan is then overlooked accordingly. To reverse this trend and enable more biracial sensitive practice, the social worker attempting to service biracial clients will find it helpful to:

- determine what the class, social and familial circumstances of the client are
- be sensitive to the possibility that people who are in crisis or who are experiencing powerful emotions may resent erroneous assumptions about their identity
- seek biracial support systems if such action seems appropriate
- review the literature pertaining to biracial clients

Conclusion

When determining a biracial client's identity, it is imperative to consider the social context in which that identity evolved. A biracial individual may in fact assume a multiplicity of identities including African-, Asian-, Latino- and Native-American, when negotiating with macro institutions such as social services. Biracial clients comprise a composite group with enough feelings of solidarity to aid coalition forming when confronting institutional structures, which in turn may find it convenient to regard them by race—making them all but invisible. In other situations this sense of solidarity need not be called into play—as in a racially diverse neighborhood where class or ancestral heritage serve as the predominant identity criteria.

Macro institutions and the society-at-large have heretofore invalidated the biracial identity. In many respects, biracial clients being racially labeled is the result of and a response to oppression and exploitation: One might speak of the labels "half-caste" or "half-breed" as indicative of such oppression. By a purification of terms, such labels are assumed derogatory in designation. But lifespan experience may transcend terminology in the search for a comprehensive biracial identity. Pertinent to situations where racial identification may be important, the social worker will find
it helpful to let clients identify themselves, to remember that interpretations of identity may vary by social context, and to remember that individuals may not see themselves as members of the group they have been institutionally identified with.

For the entirety of U.S. history, biracial Americans have been oppressed by virtue of their inability to be rendered visible (Kitano, 1997, p. 317). Particularly, those perceived as black have suffered from discrimination, violence, and disrespect. The cultural suppression of their biracial heritage, sanctioned by the state at various institutional levels, led to the acknowledgment of the population now referred to as biracial. That biracial population began to form a separate identity, as part of a diversity cultural theme in the social services profession. This process has led to an increasing group consciousness among biracial populations both organizationally and symbolically, as indicated by the addition of identity categories to the 2000 census.

Whatever cohesion existent among biracial populations extended from racial criteria is the product of traditional racism. When confronted with the special needs and challenges of such a large and growing populace, U.S. institutions began labeling without meaningful input from effected groups. Individuals then tended to identify themselves as biracial or not depending on their level of interactions with other systems facilitating conflict.

Evolution of a human development across the lifespan model minimizes identity conflict and complies with the genesis of a new awareness in theory and practice. It is increasingly evident pertinent to the study of identity, self-image, family dynamics, etc. It is a necessity in a nation fastly becoming not only racially but also ethnically and culturally diverse as well. The subsequent diversity in higher education has facilitated assertions on the part of "minorities" to define identity for themselves. Their findings have validated the importance of self-experience as having a direct correlation to psychological well-being. Furthermore, are implications for the mental health of biracial clients in that they require the option, at least, to identify themselves rather than be identified by superficial racial characteristics. In the aftermath biracial clients will be rendered visible resulting in validation of identity models that prevail less on the basis of what race they are—vis-à-vis skin color—and more on the
basis of who they are—vis-à-vis experience—extended across the lifespan.

References


Work Values of Students and Their Success in Studying at the Study Centre for Social Work in Zagreb, Croatia

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Work values are relatively common and permanent goals that we want to achieve through our professional roles. According to a number of research studies, work values are acquired relatively early in the process of socialization, and they are relatively strong and unchangeable. In this article we investigate the question, whether among the students of social work there is any relation between such gained work values and success in studying. The results show that the value of altruism, which most characteristically distinguishes social work as a profession, is significantly correlated with success in studying. On the other hand, the correlation between utilitarian values and successful study is inverted.

Introduction

The study of social work at the University of Zagreb has a long tradition, much longer than in most of the former socialist countries. The Yugoslav Communists realized much earlier than those in other socialist countries that social problems were part of reality and would not be solved by the mere fact of socialistic development, as it was often insisted on in other countries of the socialist block. The first study of social work in Zagreb was founded in 1953. It was a two-year college. Experts from other countries (especially from the USA) who assisted in elaborating

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The first courses of lectures for the social work study contributed greatly to establish the programme. And it was this solid relationship and co-operation with colleagues from abroad that also distinguished Croatia at that time from other countries of the socialist block.

In 1970 a four-year university study of interdisciplinary type was founded. It was called the Interfaculty study of social work so as to emphasize also with its name that several branches of learning were involved. In fact, the courses were organized in such a way that teachers came from various faculties of the University of Zagreb as required by each subject. So the social work students had the opportunity to study at different faculties and gain more comprehensive knowledge of other branches of learning. Unfortunately, at that time the University of Zagreb as a whole was still too conservative for this type of study, and after a few years this innovative approach ceased to be practised. The study was reorganized and became a four-year university study, but without any elements of interfaculty study. Today, the study is formally located within the University of Zagreb School of Law, but in view of its contents it is completely independent. This connection with the Faculty of Law proved to be favourable in many segments. In fact, the Faculty of Law as the oldest academic institution of the University of Zagreb is a solid framework for the development of a young discipline, as social work is.

The war in Croatia and Bosnia and Hercegovina imposed upon social work as a profession and upon social workers as carriers of social function duties they had not known before and problems they had not met with until then. However, earlier contacts established with professionals outside Croatia helped to set up new functional connections in a relatively short time. Numerous foreign humanitarian organizations brought their direct help, but also new knowledge, techniques and skills. And a fair number of our social workers learnt them very quickly. The social work study has changed in its contents as well. A series of new subjects of study was brought on as a result of this new knowledge and experience. What has changed significantly, according to our opinion, is the attitude towards the social work students, and the students themselves have also changed. The new subjects of social work, new techniques and skills have changed the traditional
attitude towards the students. There is less classical work "ex
cathedra" and fewer lectures for a hundred students or more,
and there are more study groups in which experience is gained.
The training of students in real circumstances of social work has
been improved. And the students themselves are different. The
economic depression Croatia has been experiencing, and which
is still deepening today, has brought about a social selection at
the University. Students from distant places and from less for-
tunate economic environment cannot afford to study any more,
which results in a slightly more positive selection of students.
Our new incoming students completed their secondary school
education with higher grades, which was not the case before the
war. Therefore we have put ourselves the question, whether a
relatively greater success in studying results from this selection
or are there other reasons that could be found in a more favourable
perception of this profession.

Work Values

"By work or professional values those common and rela-
tively permanent goals are meant that individuals try to achieve
through their work role" (Šverko, 1987). Therefore they are that
field of our activity aimed at satisfying our needs that show which
needs in relation to our work role we want to satisfy and in
what way. When studying work values, Donald E. Super devised
his own "developmental diagnostic model" to be used in career
guidance, in which work values are essential. He believed that
the guidance of an individual in the choice of a professional field
should be preceded by a thorough examination of his or her work
values (Super, 1983).

Some research studies have shown that the system of work
values is formed relatively early in life and that it becomes the
most important determinant in the choice of a profession (Ginz-
berg, 1951). To put his idea of a "diagnostic developmental model"
into practice, Donald E. Super together with his colleagues started
a large international project called Work Importance Study in
which researchers from numerous countries all over the world
were joined. Scientists from 12 countries worked together, but
the most active were those from Australia, Italy, Canada, Poland,
Portugal, the USA, Spain and Croatia. On the basis of jointly set principles in all these countries national versions of the Values questionnaire were made. They consisted of two parts: one common or international, which was identical in all national versions, and a supplementary, specific national part.

The international part included the following 18 work values:

1. Ability utilisation—the possibility that one’s abilities, skills and knowledge find full expression in an activity.
2. Achievement—noticeable results of work, a high level of efficiency, and one’s satisfaction at having accomplished a task successfully.
3. Advancement—the possibility of making progress and earning promotion, that is of improving one’s own position.
4. Aesthetics—the possibility of aesthetic designing and satisfaction at the beautiful of the surrounding.
5. Altruism—helping others so as to solve their problems and to contribute to common well being.
6. Authority—the power to affect the beliefs and behaviour of others.
7. Autonomy—being independent in action, solving problems on one’s own initiative, and making one’s own decisions.
8. Creativity—the possibility of thinking out and solving the atypical, of inventing and creating new objects, processes or ideas.
10. Life style—being free to live and behave according to one’s own norms and values.
11. Personal development—the possibility of personal growth and self-fulfilment.
12. Physical activity—the possibility of physical activity and development.
13. Prestige—the possibility of establishing oneself in the society and enjoying a good reputation, appreciation of personal qualities and achievements.
14. Risk—the challenge of risking, the feeling of excitement at uncertain and bold undertakings of any kind.
(15) Social interaction—contacts with people, enjoying the company of others.
(16) Social relations—friendly relations and understanding with people with whom one works.
(17) Variety—change and diversity in one’s life and work.
(18) Working conditions—good physical conditions of one’s work and life (Šverko, 1987).

The Croatian team under the direction of Professor Branimir Šverko, a psychologist at the University of Zagreb, compiled the following two scales that were added into the national questionnaire:

(1) Cultural identity—being attached to the people of one’s own ethnic and/or religious affiliation.
(2) Participation in decisions—the possibility of one’s equal participation in making jointly important decisions.

The work within the Work Importance Study began in 1979, and the final version of the questionnaire in Croatia was finished in 1982, that is almost ten years before the tragic war on the Balkan Peninsula. It is interesting that at that time the Croatian team considered the importance of the problem of cultural identity, the problem that would lead to the tragic consequences in the former Yugoslavia almost 10 years after the Study was completed. The second item, participation in decision making as a part of the national questionnaire, was added under the influence of the system of self-management, which was at its height at the time the project was being carried out.

The later research studies of Kulenović, Jerneić, Šverko and Vlasta Vizek—Vidović have shown that individual values combine into “value orientations” according to the following model:

(1) “Orientation toward self-actualisation.” The main determinants of this factor are ability utilisation, achievement, personal development and aesthetics—the typical intrinsic values, characteristic of the person’s tendency to assert him or herself by fulfilling his or her own possibilities. Therefore creativity and participation in decision making also affect significantly this factor.
(2) "Individualistic orientation." This factor is determined by the life style and autonomy and to a smaller extent also by variety and aesthetics. It is also referred to as the "orientation toward self-expression."

(3) "Social orientation." The main determinants of this factor are social interaction and social relations. These values are characterized by the tendency toward social recognition gained through adequate relations with other people. Other values of moderate importance for this factor are variety, working conditions, participation in decision-making, and altruism.

(4) "Utilitarian orientation." The congruent determinants of this factor are extrinsic values related to material prosperity and social standing: economic security, advancement, authority and prestige, as well as working conditions. Cultural identity weights significantly with this factor, which shows that marked national and ethnic attachment has also a considerable utilitarian connotation.

(5) "Adventurous orientation." This factor is determined primarily by risk and physical activity, but to a smaller extent also by altruism and authority (Kulenović et al., 1984).

So the overall result of this international research was a questionnaire comprising 20 scales of values. Each scale in the questionnaire was presented with 5 questions.

In our research study we decided to examine the work values of our social work students and correlate them with their success in studying. We wanted to find out which were those values that were related to successful studying to the highest degree. For the purpose of this research successful studying was defined as regular taking of examinations and achieving good grades on examinations. If Super's idea (Super, 1983; Nevill and Super, 1986) that work values are essential in choosing a profession is correct, then it is to be supposed that success in studying and preparing for such a specific profession as social work is should be determined by those values that are dominant for this profession.

Methods

To define success in studying, the most formal and common method was used: the cumulative grade point average achieved
on the examinations that our examinees had to pass in order to enrol in the courses of the following year of study. For students matriculated in 1995 the average of grades from three years of study was computed, and for those matriculated in 1996 from two years of study. Because dropouts are most critical at the end of the first and second year of study, we believe that our examinees may serve as a representative sample of our male and female students.

At the University of Zagreb students may ordinarily take each examination three times. For the fourth time the student must be examined in the presence of a special commission appointed by the dean of the Faculty. To make distinctions between the students who succeeded in their first attempt and those who passed an examination only after previous failures, we penalized each following attempt by subtracting 0.25 point from the original grade achieved on the examination. Consequently, the grade of a student who took an examination four times eventually was one point lower. However, such cases of three or four attempts were unusually rare among our examinees. (One exemption was the course of Statistics in the first year and Introduction to Law, also in the first year of study, in which cases of even four attempts were rather more frequent.) In fact, the differences between the “penalized” average grades and original ones were statistically negligible. This was to be expected if we take into account our decision that the investigation would cover only those students who regularly completed their registration for two or three subsequent academic years on time. In this way a certain positively selected group of our examinees was created. The relationship between the work values of our students and their success in studying was measured with Spearman’s correlation coefficient $p$.

**Instrument**

The instrument used was a Value questionnaire for the assessment of work values (V-questionnaire). The questionnaire included 100 statements, each one preceded by, “It is or will be important to me.” One of the statements that followed, for example, was, “that I will be able to make use of my knowledge and skills.” A Likert’s type scale comprised four grades from “It is very important to me” through “It is absolutely unimportant
Each value was presented with five statements so that the highest possible score for each presented value was 20, and the lowest was 5. The grade points earned on examinations were taken from the education records of each student and entered into special protocols in our database.

Sample

Our sample comprised 111 examinees, three of who were male and 108 female students, which successfully completed their registration for the third or fourth year of study. Of 323 students who enrolled in the Faculty [first-time matriculates from 1995 and 1996] in the academic years 1995–1996 and 1996–1997 293 were women and only 30 men. Only 111 of them completed regularly all course requirements on time and were registered for their third or fourth year of study when the grading records of their examinations were being analysed.

In the time of survey the majority of examinees was 19 years old. Almost one half of our examinees were from families in which at least one of parents had a degree of a Croatian university. The share of fathers with higher education was 43.2 percent and of mothers 32.4 percent, which indicated that in these families university education was one of the habitual ways of their social advancement. This fact seemed to be important in the context of work values formation. As mentioned before, work values are formed relatively early in the process of socialization. Such climate was a permanent socialization factor at least in 36.9 percent of the families of our examinees, whose fathers worked as experts on the basis of their university education.

Results and Interpretation

The official grading system at the University of Zagreb is composed of numerical grades ranging from 1 to 5. The grade 1 is failing, and 5 indicates the greatest possible satisfaction of the examiner at the knowledge a student has shown in an examination. The students who enrolled in their first year of university study in 1995–1996 and are in their final year of study at the time this report is being written achieved a cumulative grade point average of 3.043 with the standard deviation of 0.574. The
other group of students enrolled in their first year of study in the academic year 1996–1997 and are now in their third year of study. Their cumulative grade point average was 2.576 with the standard deviation of 0.761. The lower cumulative average of the younger generation resulted primarily from the grade points earned in the first year, the average of which was considerably lower, whereas the older students had the opportunity to “improve” their average with grade points earned in the following years of study.

The first year of social work study is highly “saturated” with general courses, such as Statistics, Introduction to Law, Economics, Political Economy, and the like. Young people who have the aptitude for practical work in the field of helping others do not seem to be disposed for these general and theoretical courses. The following averages of grades are illustrative: the lowest average of earned grade points, that is 1.845, resulted from their examinations in Statistics. This average grade is below the grade 2.00, which is the first passing grade, because the students attempted to pass the examination more than once, and we “penalized” each following attempt. The highest average grade point was 3.653 and it was achieved on the course of Social Pedagogy, which better agrees with the profession and fits the goals and aptitudes of our students. However, this is the range of average grade points that the students have earned on examinations up to now.

Table 1 shows the arithmetic means and standard deviations for each of work values.

The first two columns of Table 1 display the arithmetic mean and standard deviation for each of the work values of our sample of 111 students who passed the examinations and completed all the requirements of their academic programme on time. The next three columns display the rank, the arithmetic mean and standard deviation of a certain work value of other students who enrolled in the first year contemporaneously with our sample, but failed to complete the course requirements on time. The majority of them are behind with their studies for at least one year.

The work values that in terms of their contents represent values of self-realization or “needs for growth”, as some authors suggested (Vizek-Vidović, 1984), hold the top three positions. This outcome is similar to that of international studies (Super, 1995).
Moreover, we have found the same hierarchy of work values with a recent survey in Mostar in which we questioned students of two different and opposing ethnic communities (Knežević, 1998). Orientation towards self-realization appears to be immanent in the student population in its process of social affirmation. Even in very difficult conditions of refugee camps, painful war experiences, of risky living in a town exposed to war devastation these values continue to be at the top of the scale (Knežević, 1998). This outcome is a proof of the theory according to which work values are gained relatively early in the process of socialization in the primary social environments, and are relatively unchangeable and permanent (Super and Šverko, 1995).
The value that distinguishes the population of social work students more than other student populations at the University of Zagreb is the value of altruism. In a study on the student population carried out in 1995 the other students of the University of Zagreb put the value of altruism in the 14th place, while our students put it in the third place whether they advanced regularly or not (Knežević, 1999). This is probably self-evident because we suppose that the choice of such a study as social work is for a great part is defined by the intrinsic needs to help other people in trouble. The value in which our successful students differ from other students is Economics. Our students who advanced in their study regularly (our sample) put this value in the 8th place, whereas those who did not succeed to take their examinations regularly rank this value two positions higher, that is in the 6th place. So they came two positions closer to other students from the survey of 1995 (Knežević, 1999). In fact, it is the rank, and not the average values, that determine the structure of values (Šverko, 1987). Therefore we believe that this is the segment in which there is one of the more significant differences between the group that was investigated and their colleagues who were less successful in their study.

There are two other values in which the students who progress regularly in their study differ from those who do not. These are Advancement and Creativity. The regularly progressing students rank Advancement two positions lower than their less successful colleagues. On the other hand, the questioned group of students put the value Creativity two positions higher than the group that do not succeed to study regularly. The values Economics and Advancement are utilitarian values, while Creativity is a value of self-realization and we would say that it “supports” the intrinsic orientation in deciding for the profession. The goal of our research study has been to find out to what extent work values are related with progress in studying, which is with the basic “business” in which a student is “engaged” in this period of his or her personal and social formation.

The two highest values of correlation coefficients, as it is evident from Table 2, and at the same time the only two values that are statistically significant on the level of 1 percent, are the correlations of success in examinations and the values of risk and
variety. Both correlations are negative in their direction, which indicates that the students who achieved better results on examinations do not tend to take risks and do not lean toward variety. The explanation seems to be logical. In fact, achieving good results on examinations does exclude taking risks, or in other words, the only way to earn better grades on examinations is studying and not risking the outcome. (For example, expecting the teacher to be in high spirits, or that when writing an examination paper he or she will be able to copy a part of the answer from previously prepared material.) It seems that this outcome, at least when speaking of students who fulfil the programme requirements

<table>
<thead>
<tr>
<th>Work value</th>
<th>Correlation coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal development</td>
<td>-.007</td>
</tr>
<tr>
<td>Ability utilisation</td>
<td>.125</td>
</tr>
<tr>
<td>Achievement</td>
<td>-.043</td>
</tr>
<tr>
<td>Social relations</td>
<td>-.109</td>
</tr>
<tr>
<td>Altruism</td>
<td>.235*</td>
</tr>
<tr>
<td>Advancement</td>
<td>-.197*</td>
</tr>
<tr>
<td>Economics</td>
<td>-.218*</td>
</tr>
<tr>
<td>Working conditions</td>
<td>-.166</td>
</tr>
<tr>
<td>Participation in decisions</td>
<td>-.093</td>
</tr>
<tr>
<td>Creativity</td>
<td>-.009</td>
</tr>
<tr>
<td>Life style</td>
<td>-.087</td>
</tr>
<tr>
<td>Cultural identity</td>
<td>-.189*</td>
</tr>
<tr>
<td>Aesthetics</td>
<td>-.077</td>
</tr>
<tr>
<td>Autonomy</td>
<td>-.063</td>
</tr>
<tr>
<td>Physic activity</td>
<td>-.127</td>
</tr>
<tr>
<td>Prestige</td>
<td>-.141</td>
</tr>
<tr>
<td>Variety</td>
<td>-.273**</td>
</tr>
<tr>
<td>Social Interaction</td>
<td>-.030</td>
</tr>
<tr>
<td>Authority</td>
<td>-.152</td>
</tr>
<tr>
<td>Risk</td>
<td>-.277**</td>
</tr>
</tbody>
</table>

* Statistical significance at 5%
** Statistical significance at 1%
regularly, does not confirm the prejudices according to which
"a grade earned on an examination does not reflect truly the
student’s knowledge."

The values of risk and physical activity belong under adventu-
rous orientation. In our research study we have found a statisti-
cally significant correlation (on the level of 1 percent) between this
orientation and the overall success, but negative in its direction
(−0.255). Adventurousness, by its contents, of course does not
fall under a value that would favour systematic progressing and
achieving good results in learning, at least when the present
model of progressing at our University is in question.

In our sample, a positive and statistically significant correla-
tion has been observed between Altruism as a value and passing
the examinations. From the educational standpoint this outcome
pleases us. It speaks well for the intrinsic motivation for the
profession the students have chosen. So those students who were
progressing regularly in fulfilling the course requirements, made
progress, in accordance with this outcome, because their orien-
tation was directed primarily toward the essence of the chosen
profession, and that is its altruism, and not because of the utili-
tarian values in the sense of advancement in the channels of the
vertical social mobility and the like. When the overall result of the
Utilitarian orientation is considered and correlated with general
success, another statistically significant, but negative correlation
(−0.231, significant at the level of 5 percent) is obtained.

As the table shows, also the value Economics results above the
0.20 threshold value of correlation and is in negative correlation
with success in study as well. Most probably the negative corre-
lration of this variable with success in studying is determined not
only by the intrinsic motivation for the social work study, but also
by the reality the profession is facing with regard to other profes-
sions. In fact, who has decided for a people-helping career (and
particularly if such a decision has been intrinsically determined)
cannot expect a remarkable material situation. The truth is that at
this stage of social development the greatest part of social work
in Croatia is located in public institutions. And employment in
such institutions provides at least security of employment and
reduces the possibility of being dismissed, but remuneration is
much smaller than in any form of the private sector.
There are two other values that are also statistically significant, although the correlation coefficients result below 0.20. These values are Cultural Identity and Advancement. Although the level of correlation does not permit us to speak of a relevant correlation, we are pleased that our students do not associate their cultural identity with their profession. It should be noted that in the questionnaire cultural identity is expressed through affiliation to the ethnic corps of the Croatian nation. In the situation of the accentuated need for affiliation to one’s “own” ethnic corps, which still exists in the Republic of Croatia, we are pleased with the finding that evidently this value does not represent one of the most important values to our students. And those that, in the pursuit of a professional status, have been successfully progressing in their education in particular do not experience this value as significant.

Conclusions

Students who have been covered with our survey, in respect of the work values hierarchy, do not differ from other research studies on the student population in Croatia (Vizek-Vidović, 1964; Kulenović, 1984; Knežević, 1999). The highest-ranking values are those that are related to personal development, which in fact are characteristic of the student population. We have examined the correlation of the work values system with success in studying; that is with achieved grade points on examinations. The results show that the highest correlation of the system is with the value of altruism; that is with the value that is at the root of the social worker profession. This indicates that the most successful are those social work students who have chosen the profession following their intrinsic motivation. We believe that a follow-up research would enable us to develop an instrument that would have some predictive value in relation to successfulness of studying. And therefore it might help in the establishment of a system of studying for our students.

References

From Plant Closure to Reemployment in the New Economy: Risks to Workers Dislocated from the Declining Garment Manufacturing Industry

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The current study investigates financial and emotional consequences to workers as the U.S. economy continues to shift from a manufacturing to a service economy. One hundred eighty-eight garment workers were surveyed before their plant closed in 1998 and six months later to assess reemployment opportunities, financial difficulty and emotional well-being. All workers experienced some financial difficulty after the plant closed, with single parents reporting the greatest financial difficulty. Workers who became immediately reemployed lost an average of $2.41 in wages per hour. Sixteen percent of the sample lost their health insurance. Overall depression and anxiety scores declined over six months, but not evenly. Men and single women did not significantly decline in depression or anxiety. Financial difficulty was the most important predictor for both depression and anxiety. Immediate reemployment served to increase depression in the presence of financial difficulty.

The late 1990s were characterized as a time of economic prosperity in the U.S., with falling unemployment rates and rising corporate profits. But there was a large sector of the labor force plagued by stagnant and declining wages, involuntary and part time employment, and decreasing job security. Much of the professional literature on the alleviation of financial hardship for families focuses on job creation and training for the unemployed and those on welfare. Yet there is growing evidence that public policy is focusing increasingly on job search and on-the-job training, rather than education, both for dislocated workers and
those on welfare. New welfare reform legislation stresses quick job entry, job placement, search assistance and limited educational attainment (DHHS, 1998). The Workforce Investment Act (1998), which repeals the Job Training Partnership Act (JTPA), sees training as a last resort, emphasizing instead job search assistance and employment counseling. At the same time, there is growing attention paid to the "working poor," those individuals who are already working, but still remain close to, or below, the poverty level (Rocha, 1997a). This group will increasingly challenge social work practice and public policy as our labor market continues to shift toward a low wage service sector economy for unskilled workers and our policies continue to de-emphasize education and training for workers.

The service and retail industries accounted for 83.3% of all new jobs between 1989 and 1995. At the same time, the manufacturing industry, once considered the most stable employer in the U.S. for non-college educated workers, declined in the 1990s. In fact, between 1979 and 1995 the manufacturing industry lost over 2 million jobs (Mishel, Bernstein & Schmitt, 1997). This decline is due, in large part, to increased competition with foreign corporations, as well as an increase in American companies who have shifted all or part of their production off-shore to lower wage countries.

In addition to the stress associated with continued downsizing of the manufacturing industry, there is a real threat of chronic financial difficulties for workers. Part of this difficulty stems from the lower wages offered by service and retail jobs, as well as a growth in involuntary part time and temporary work (Mishel and Bernstein, 1994). These jobs are also less likely to provide employer-related health insurance, with the poorest workers least likely to receive health insurance at work. In the five year period between 1988 and 1993, for example, employer related insurance covering the poorest workers declined from 35.5% to 30.3%. This is compared to 57.2% of Americans overall covered by employer-related health insurance benefits in 1993 (Shapiro & Parrott, 1995).

This shift in industry presents important new challenges for unskilled and semi-skilled workers. While the unemployment rate has declined sharply since the 1980s, the poverty rate has not kept pace with employment rates. For example, while the
unemployment rate fell to a low of 4.3% in August of 1999, 22% of U.S. children under the age of six lived in poverty the same year (U.S. Department of Labor, 1999; National Center for Children in Poverty, 1999). That number rose substantially for young African American (40%) and Hispanic children (38%). Sixty-five percent of these children lived in families with at least one employed parent. The problems that workers are dealing with presently are not the stressors from unemployment, but from an increasingly unstable, low-paying labor market.

The present industry shift from a manufacturing to service economy allows an opportunity to study how the transition affects workers, both financially and emotionally. The present descriptive study looks at demographic sub-groups of displaced garment manufacturing workers, both at the time of the plant closing and six months later to assess reemployment and job training status, financial difficulty and emotional well-being. The study poses the following questions: In terms of gender, marital status, and race, who experienced greater financial adversity and emotional distress after the plant closed? Which of these sub-groups experienced financial and emotional recovery more fully, six months later? Does obtaining work immediately after the closing rather than attending job training programs make a difference in financial and emotional recovery for these workers?

Effects of Plant Closures

There was a great deal of interest in the 1980s on both the economic and mental health consequences of unemployment. Numerous studies done in the 1980s found deleterious effects on individual functioning resulting from plant closures and layoffs (Kessler, Turner & House, 1988; Hamilton, Broman, Hoffman & Renner, 1990; Liem & Liem, 1988; Kong, Perrucci & Perrucci, 1993). Unemployment resulting from plant closures increased levels of financial hardship and emotional and physical distress of the workers. Plant closings increased marital strain and children’s behavioral difficulty, largely through the financial strain that was experienced (Perrucci, 1994). In fact, it was through financial pressure that the most significant effects of unemployment on individual and family functioning were found.
The research of the 1980s made great strides in understanding how short term unemployment affected workers and their families. There were fewer studies of dislocated workers conducted in the 1990s and these were either cross-sectional studies of workers immediately after a plant closing (Vosler and Page-Adams; Tang & Crofford, 1999), community samples of job seekers that were not necessarily dislocated (Vinokur, Price & Caplan, 1996) or national data sets of displaced workers that rarely assess mental health (Benedict & Vanderhart, 1997; Smith & Rubin, 1997; Hipple, 1997). However, for those that did assess mental health consequences for workers in the 1990s, similar patterns of negative outcomes were found.

Literature on Reemployment and Well-being

While numerous studies have shown adverse effects on individual functioning from plant closures, previous research also indicates that workers can bounce back relatively quickly from plant closures in the right circumstances. Kessler, Turner and House's (1989) one year follow-up, for example, found that their reemployed sample had experienced emotional recovery similar to a control group of stably employed workers. But Liem and Liem (1988) found that their reemployed blue collar sample had significantly higher levels of emotional strain than their stably employed control group, even after several months of reemployment. They attributed this to a possible psychological adjustment period to their new job. However, in other comparisons of reemployment, Burke (1986) found differences in well-being by whether employees found jobs with similar wages, working hours, and other employment characteristics associated with job satisfaction. In a discussion of these issues, Turner, Kessler & House, (1991) speculate that work conditions may lead to a loss of well-being. “If a consistent pattern of deskilling continues over the remainder of this century, as some have suggested, then a new kind of job loss will become increasingly common, with workers being retrained to take on jobs that are less rewarding than their previous jobs” (Kessler, Turner, & House, 1989, p. 654).
Risk Factors for Increased Vulnerability after Job Loss

Financial Distress

Previous research indicates that the effects of unemployment on health operate primarily through financial strain (Kessler, Turner & House, 1987). For those unemployed workers without financial problems, the negative effect on emotional well-being was half that of those with financial difficulty. In Mark Rank's (1994, p. 177) study of welfare families, he found that families lacking personal resources, human capital and economic assets "have a more difficult time weathering crises". Briar (1988) concurred with this finding in her study of unemployed workers, noting that without an economic cushion of some kind, workers may plummet financially. Financial distress is clearly related to several indicators of emotional distress, including depression, anxiety, somatization, and self-reported physical problems (Vosler & Page-Adams, 1996; Turner, Kessler & House, 1991), as well as the quality of marital and family relationships (Conger & Elder, 1994; Perrucci & Targ, 1988; Voydanoff & Donnelly, 1988).

These facts related to financial distress take on greater importance when the reality of the new economy is taken into account. The literature clearly shows that many of the expanding industries for unskilled workers tend to be primarily low wage industries (Mishel & Bernstein, 1994). Without additional human capital investment, either in the form of increased education or on the job training, displaced workers may take a substantial cut in pay during reemployment. Indeed, Rocha (1997b) found that human capital investments and assets were the most important predictors of financial well-being for female-headed families. Thus, it is important to assess the wages of reemployment and the effects of both reemployment and training on emotional well-being.

Demographic Risks

Looking at all workers together may mask some of the important demographic differences for financial vulnerability. For example, the concept of "feminization of poverty" was coined to emphasize the increasing number of poor women now heading
households and the high rates of poverty among this group (Hill, 1985). In fact, female-headed families are the fastest growing population in poverty, making less than half the median annual income of all families, and 76.7% of men's earnings (U.S. Department of Labor 1993; Mishel, Bernstein & Schmitt, 1997). In a study comparing male and female laid off auto workers, Gordus and Yamakawa (1988) found that women had less seniority and therefore longer layoff periods than men, collected less supplemental unemployment benefits, and suffered much higher income losses than men after reemployment.

While gender is generally included as a control variable, only a few studies on plant closings have investigated group variations in mental health outcomes by gender, and these results have been largely inconclusive. Kessler and McLeod (1984), for example, did not find significant differences in mental health outcomes between men and women. But Perrucci, Perrucci and Targ (1997) found that women reported higher levels of economic distress, but did not show significant differences in depression from men.

The rapid deindustrialization of the last two decades has major implications for minority families as well. In a review of post-industrial displacement, Bowman (1988) notes "racial minorities in general and black males in particular, are grossly over represented in the blue collar occupational categories being displaced" (p. 78). Minorities also are at a higher risk for job loss during recessions and are less likely to regain employment when economic recovery occurs. Because of their later entry into many fields and therefore lower seniority, women and minorities both are at greater risk for unemployment, longer durations of layoffs, lower levels of supplemental benefits, and greater financial hardship (Gordus & Yamakawa, 1988).

As with women, racial and ethnic-based differentials of the impact from unemployment on mental health have received little attention in either research on plant closings and unemployment, or in economic pressure in general. Many studies do not consider the effects of ethnic and cultural factors in the context of economic hardship. Some investigators make no mention of race or ethnicity (Perrucci & Targ, 1988), whereas others have samples composed solely of Euro-Americans (e.g. Conger & Elder, 1994; Friedemann & Webb, 1995).
Gaps in Current Knowledge Regarding Reemployment Opportunities for Dislocated Workers.

The present study addresses several of the gaps in the literature cited above. Current research in the 1990s on plant closings in general, and reemployment effects in particular, is lacking. The studies available on the mental health effects of reemployment are largely from plant closings in the 1980s. We do not have a clear understanding of the mental health consequences to individuals who are reemployed in the service economy. There is also a dearth of literature that examines in depth the impact of plant closings and subsequent reemployment on mental health by demographic risk factors. Surprisingly few studies have causally linked minorities and women to economic pressure and, in turn, linked economic pressure to increased disparities in mental health.

Finally, there have been no studies that examine the process of retraining dislocated workers. What effect does the period of retraining have on workers' financial and emotional well-being? Does this vary by demographic characteristics? In an economy where there are many jobs available, are workers better off if they are immediately reemployed, rather than in training?

The Conceptual Framework of the Study

Given the gaps in knowledge listed above, the purpose of this study is two-fold. The first purpose of the study is to document the financial and mental health consequences of employment dislocation in the 1990s, immediately after job loss and six month later, on demographic sub-groups of workers. Which workers are more adversely affected? Who recovers more quickly? Does immediate reemployment assist in financial and emotional well-being more quickly than training? These questions have largely been left unanswered in the service economy of the 1990s.

Second, there are two competing hypotheses that this study will address. The first is our current national policy for workers, which suggests that “any job is a good job”, reflected by current welfare reform legislation and the Workforce investment act, both emphasizing quick job entry, job placement, job search assistance, and limited educational attainment (DHHS, 1998; Work Force Investment Act, 1998). Specific services to adults and discouraged
workers provided by these policies center on job search activities, while training is seen as a last resort. The second and competing hypothesis is reflected in Kessler, Turner and House’s (1989) speculation that the service economy is producing a new kind of job loss in the 1990s, with new jobs that cannot maintain the same standards of living as the old manufacturing industry did. If this is the case, than “any job” is not necessarily a “good job” if there is a decrease in wages and a lack of benefits. Therefore, if the emotional stress exhibited by reemployed workers is a function of financial distress, than Kessler, Turner and House’s hypothesis will be supported, and our current policies regarding reemployment and training will be put into question.

The Family Well-being Study

In November of 1997, a national garment manufacturer announced they would close their largest manufacturing plant in the southeast, laying off over 2000 workers. Unlike many industries, the manufacturer gave a very nice severance package to its employees and hired a national education firm to coordinate retraining activities for its workers. The union, the company and the contracting firm all worked closely together to iron out details of the severance package and retraining. By June, 1998, the plant was completely closed, although certain sections of the plant had been laying off since February, 1998. All employees received a check for their average income through June, a lump sum representing three weeks of pay for each year of service, and up to 18 months of health insurance coverage (King, 1998).

Methodology of the Study

Sample and Data Collection

The sampling procedure used for the study was a stratified systematic sampling technique with a random start. The sampling frame consisted of all blue-collar employees from the closed plant. Management and administrative personnel were excluded from the study. The project had six interviewers who received interviewer training. Respondents had the same interviewer for both data collection periods. Each interview took approximately 45 minutes to 1 and ½ hours to conduct. During May and June
of 1998, before the plant closed its doors, 10% of the plant's 2000 workers were sampled. One hundred and ninety five workers completed the first survey. Six months later, 188 subjects completed a follow-up interview, resulting in a 97% completion rate for the second wave.

**Measurement**

In this analysis, financial pressure was measured in three ways. First, a five point scale ranging from none to a great deal of difficulty measured the extent of difficulty paying bills each month. Second, we measured whether monthly credit card payments had gone up in the six months since the plant closed as a means to assess whether the worker used credit to make up for lost income. Finally, whether home ownership status had changed over six months would indicate either very severe financial problems if home ownership declined, or a substantial investment from their severance package if home ownership increased.

Emotional well-being was measured using the depression and anxiety subscales from the Symptoms Checklist-90-R (Derogatis, 1994). The depression and anxiety subscales consist of 10 items each that define depression and anxiety, with a response range from 1, not at all, to 5 extremely. The clinical cut-off for depression was a standardized score greater than 62 for both depression and anxiety. The reliability of the scale was found to be good, with a coefficient alpha of .88 (Simons, Beaman, Conger, and Chao, 1993).

Other measures include demographic characteristics of the displaced workers, including race (African American or White), marital status (married or unmarried), single parent status, and gender. Also measured was the plant wage per hour at the time of the closing, wages for those immediately reemployed at time one, and hourly wage for those employed by time two. Finally, whether the respondent was working at a new job or was in a training or educational program at the six month follow-up was measured dichotomously, yes or no.

**Data Analysis**

Univariate and bivariate statistics were used to describe the sample and compare the financial difficulties of respondents during the six month period. T-tests analyzed significant variation
in depression and anxiety scores from baseline to the six month follow-up. An Ordinary Least Squares multiple regression was used to predict financial difficulty, depression and anxiety at the six month follow-up.

Limitations

There are several limitations to the current descriptive study. The small sample size of workers who were reemployed by the six month follow-up make some of the analyses impossible to generalize to a larger population. Yet it is very instructive to see the wage shifts over time as more and more people begin to become employed.

Credit card debt was also particularly problematic because only 67% of the sample had credit cards. However, credit card debt is an important indicator that people are supplementing lost wages through increased personal debt with high interest associated with it. While it cannot speak to all of the blue collar workers in this study, it is an important issue for future financial stability.

To insure the power of the multiple regression models, power analyses were conducted on the follow-up sample size of 188. Power was calculated for a model containing two sets of variables (5 variables in the first set and 2 in the main set). Using the increments to the R-square generated by the current study and an alpha level of .05, the power was .95, more than sufficient for the study.

Results

Demographics of the Sample

Eighty-eight percent of the sample were female, 76.4% were white and the average age of the dislocated worker was 40. Sixty five percent were presently married or living with someone, the average family size was 2.9 and 52.9% of the sample had children presently in the home. Employees had worked at this plant an average of ten years at the time of the closing, with some employed by the company for as many as 30 years.

A majority of the dislocated workers had a high school education (56.2%) or a GED (8.8%), although there was still a large
Table 1

Demographic Characteristics of the Sample

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>21</td>
<td>11.2%</td>
</tr>
<tr>
<td>Females</td>
<td>167</td>
<td>88.8%</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>115</td>
<td>61.2%</td>
</tr>
<tr>
<td>Single</td>
<td>20</td>
<td>10.6%</td>
</tr>
<tr>
<td>Separated</td>
<td>4</td>
<td>2.1%</td>
</tr>
<tr>
<td>Divorced</td>
<td>30</td>
<td>16.0%</td>
</tr>
<tr>
<td>Widowed</td>
<td>7</td>
<td>3.7%</td>
</tr>
<tr>
<td>Co-habitating</td>
<td>12</td>
<td>6.4%</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>35</td>
<td>18.6%</td>
</tr>
<tr>
<td>Asian American</td>
<td>2</td>
<td>1.1%</td>
</tr>
<tr>
<td>Hispanic American</td>
<td>3</td>
<td>1.6%</td>
</tr>
<tr>
<td>White American</td>
<td>144</td>
<td>76.6%</td>
</tr>
<tr>
<td>Native American</td>
<td>3</td>
<td>1.6%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>Geographic Location</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>64</td>
<td>34.2%</td>
</tr>
<tr>
<td>Urban</td>
<td>123</td>
<td>65.8%</td>
</tr>
</tbody>
</table>

Average Age of worker: 40.52
Average Household Income: $1934.97 per month
Average Plant wage: $9.57 per hour
Average wage, new job: $7.81 per hour
Average Education level: 11.93

percent who had not completed high school (17%). Because the manufacturing plant hired an education-based consulting firm to assist in the closure, there has been a heavier emphasis on enlisting workers into training programs than one might find at other plant closures. The consulting firm provided remedial education, coordinated training activities, and provided placement counseling for employees. Forty-nine percent of the sample were
enrolled in a school or training program at the time of the first interview. Table one provides a breakdown of the demographic characteristics of the sample.

Financial Difficulty

Figure 1 describes the differences in our three subgroups in the financial difficulty they experienced during the six months since the plant closed. All groups reported some financial difficulty. Single persons reported a 22% increase, women a 26% increase, single parents a 20% increase, and African Americans a 17% increase. Single parents reported the highest percentage of financial difficulty, with a full 80% reporting financial problems at time two. Baseline measures at time one, however, show that over half of single parents and African Americans were already experiencing financial difficulty before the plant closed. In fact, their reported financial difficulty was higher at time one than male, white and married person’s financial problems at the six month follow-up.

Figure 1

Difficulty Paying Bills by Race and Gender
Figure 2 reports the second measure of financial difficulty, increased credit card debt. Again, all groups reported some increases in credit card debt, but African Americans and single parents experienced the greatest increases. This is at the same time that income dropped drastically for the 49% of previous employees who decided to attend school and were living on unemployment benefits at the time of the second interview.

In terms of home ownership, the most severe form of financial hardship measured, figure three shows the percentage of those owning their homes by race, gender and marital status over the six month time period. In total, eighteen people gained or lost home ownership during the six month period. Five white females and two white males bought homes in the six month period, while four white females and six African Americans, three of whom were single parents, lost home ownership during the same six month period.

Given the literature on the changing labor market, we wanted to assess whether reemployment offered similar wages, an indica-
Figure 3
*Home Ownership by Race, Gender and Marital Status*

![Bar chart showing percentages of home ownership by race, gender, and marital status.](chart)

Table 2

*Hourly Wages: Plant job, Immediate (T1) and 6 Month Reemployment*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Plant wage, n = 186</th>
<th>T1 wage, n = 32</th>
<th>T2 wage, n = 65</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>$9.41</td>
<td>$7.96</td>
<td>$7.68</td>
</tr>
<tr>
<td>Male</td>
<td>$10.84</td>
<td>$7.88</td>
<td>$8.48</td>
</tr>
<tr>
<td>African American</td>
<td>$9.27</td>
<td>$7.11</td>
<td>$7.13</td>
</tr>
<tr>
<td>Caucasian</td>
<td>$9.66</td>
<td>$7.07</td>
<td>$7.89</td>
</tr>
<tr>
<td>Married</td>
<td>$9.66</td>
<td>$6.89</td>
<td>$7.81</td>
</tr>
<tr>
<td>Single</td>
<td>$9.37</td>
<td>$7.75</td>
<td>$7.83</td>
</tr>
<tr>
<td>Single Parent</td>
<td>$8.96</td>
<td>$7.39</td>
<td>$7.49</td>
</tr>
</tbody>
</table>

...tor of whether chronic financial problems might plague the families, above and beyond the problems of unemployment. While the initial numbers of the reemployed are small, it gives an idea of what the labor market may hold in terms of hourly wages. For the overall sample, the plant wage averaged $9.57 per hour. For those who became reemployed immediately after the plant...
closing, their wage dropped an average of $2.41 to $7.16 per hour. For those who waited and were employed by time two, six months later, they received an average $7.81 per hour, still far short of their original plant wage. Table two compares wages by race, gender and marital status, both at their plant job and subsequent reemployment. The original plant wage for single parents was $8.96 and for African Americans, $9.27, the two lowest paid categories of our subgroups. They also reported the lowest reemployment wages six months later, at $7.49 and $7.13 respectively.

Also assessed was whether the dislocated workers had access to health insurance. All workers had private, employer-related insurance at the plant. After the closure, the employer also paid the premium for COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985, a continuation option on employer-provided health plans for laid off workers) for varying periods of time, depending on employee seniority. Six months after the closure, 16% of the overall sample were uninsured. Of those working at time two, 13.25% were uninsured. An additional 38% of those working at the six month follow-up were either still covered under COBRA or were on TennCare, the state’s Medicaid program.

Emotional Well-being

Table 3 illustrates how depression and anxiety changed in the six months since the plant closed. At the time of the plant closing, all of the groups studied were above the cut off for clinical depression, except for African Americans and married women. This is very interesting, considering that African Americans reported some of the greatest financial difficulty. Overall, the sample significantly declined in both depression and anxiety in the six months period. However, these declines were not evenly distributed demographically. Women’s depression and anxiety significantly declined while men did not. Married women, in particular, had significantly lower depression and anxiety scores at the six month follow-up then did single women. And African Americans, had significantly greater declines in both depression and anxiety than their white co-workers in the six months after the plant closed.

To test our two competing hypotheses regarding financial difficulty and its relationship to the emotional well-being of our demographic subgroups, three multiple regression models (Table 4)
Table 3

**Comparison of Depression and Anxiety Scores by Time Intervals**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Depression Score</th>
<th>Anxiety Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time One</td>
<td>Time Two</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>Total</td>
</tr>
<tr>
<td>Overall</td>
<td>62.36</td>
<td>60.30*</td>
</tr>
<tr>
<td>Men</td>
<td>62.70</td>
<td>60.95</td>
</tr>
<tr>
<td>Women</td>
<td>62.32</td>
<td>60.27*</td>
</tr>
<tr>
<td>Women Marital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>61.76</td>
<td>58.72**</td>
</tr>
<tr>
<td>Unmarried</td>
<td>63.62</td>
<td>63.77</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Af. American</td>
<td>61.54</td>
<td>58.37*</td>
</tr>
<tr>
<td>Caucasian</td>
<td>62.31</td>
<td>60.71</td>
</tr>
</tbody>
</table>

1 cut off for clinical depression and anxiety is > 62.

*p < .05, **p < .01.

were analyzed. The dependent variables of financial difficulty and the two emotional well-being measures (depression and anxiety), were regressed simultaneously on the four sub-groups, gender, race, marital status, and single parenthood. Having financial problems at time one and being in school at time two significantly predicted financial difficulty at time two. When looking only at demographics, being white and having financial difficulty at time two predicted depression at time two. However, when school or work is introduced, only financial difficulty predicts depression. The same situation occurred when predicting anxiety, with financial difficulty remaining significant and race falling out of the model when school and work are introduced.

It is clear that financial difficulty is the primary means by which stress is felt for these workers. If the hypothesis that any job is a good job holds then financial difficulty should not interact with current work to predict depression or anxiety at time two. However, if Kessler and associates' hypothesis holds, then those who have financial difficulty because of lower paying jobs should experience increased emotional stress. To test this hypothesis the two emotional distress variables, depression and anxiety
Table 4

Regression Analysis—Predictors of Wave 2 Financial Difficulty, Depression and Anxiety: Two Stage Analysis

<table>
<thead>
<tr>
<th></th>
<th>Financial Difficulty at Time Two</th>
<th>Depression at Time Two</th>
<th>Anxiety at Time Two</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$b$</td>
<td>SE</td>
<td>$T$</td>
</tr>
<tr>
<td>Demographics Only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>0.171</td>
<td>0.228</td>
<td>0.752</td>
</tr>
<tr>
<td>Marital</td>
<td>0.146</td>
<td>0.204</td>
<td>0.716</td>
</tr>
<tr>
<td>Single Parent</td>
<td>0.300</td>
<td>0.280</td>
<td>1.073</td>
</tr>
<tr>
<td>Financial Difficulty</td>
<td>0.634</td>
<td>0.064</td>
<td>9.931**</td>
</tr>
<tr>
<td>At Time One</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted R2</td>
<td>0.368</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>26.93**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>178</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demographics, School and Work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>0.198</td>
<td>0.227</td>
<td>0.876</td>
</tr>
<tr>
<td>Marital</td>
<td>0.223</td>
<td>0.207</td>
<td>1.080</td>
</tr>
<tr>
<td>Single Parent</td>
<td>0.261</td>
<td>0.276</td>
<td>0.9453</td>
</tr>
<tr>
<td>Financial Diff-T1</td>
<td>0.640</td>
<td>0.063</td>
<td>10.11**</td>
</tr>
<tr>
<td>In School</td>
<td>0.345</td>
<td>0.166</td>
<td>2.07**</td>
</tr>
<tr>
<td>Working</td>
<td>0.004</td>
<td>0.170</td>
<td>0.293</td>
</tr>
<tr>
<td>Adjusted R2</td>
<td>0.391</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>19.48**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>173</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < 0.5, **p < .01.
were regressed on the interaction between working and financial difficulty. The model with the interaction terms was significant in predicting depression \((F = 13.026, p. < .001, R^2 = .419)\). The interaction itself was significant at the .001 level, with a T-score of 3.54. Working, therefore, does not increase depression except under the conditions of financial difficulty. This lends support to Kessler and associate's hypothesis that lower wage work in the new economy will not serve to return workers to their previous standards of living and does not support the current policies which continue to decrease the opportunities for significant educational gains for dislocated workers and other unskilled labor.

Discussion

Given the research questions, which subgroups experienced greater financial adversity, all the groups experienced some financial difficulty. However, single parents had by far the largest percent reporting financial difficulty, while single females and African Americans followed a close second. Along these same lines, immediate reemployment did not avert financial difficulty of job loss in the short run, with an average job loss of more than $2.00 per hour, six months after the plant had closed. The fact that minorities and females, in particular female-headed households, also had lower original plant wage, supports previous research on the greater risk of financial adversity during economic downturns for these subgroups (Gordus & Yamakawa, 1988). Since they had lower pay to begin with and more financial difficulty when employed at the plant, they would have fewer resources to fall back on during the reemployment period. While those in training will continue to experience financial difficulty until their program is complete, follow-up will be needed to see if their training will serve to increase their hourly wage.

Who seems to have recovered emotionally more fully? Married women had the lowest overall depression and anxiety scores six months after the plant closure. Surprisingly, African Americans also seem to have greater emotional well-being, although they suffered more financial difficulty, as well as lower reemployment wages. African Americans, although exhibiting some of the greatest financial difficulty during the initial baseline interviews
while they were still receiving their plant wage, had the lowest overall depression and anxiety scores at baseline of all the sub-groups studied. The apparent resiliency of the African Americans in this group supports much of the coping and adaptation literature on African Americans (Denby, 1996; Daly, Jennings, Beckett, & Leashore, 1995).

The final research question, whether immediate reemployment made a difference in financial and emotional recovery, had mixed results. It is clear from the regression analyses that financial difficulty is the most important factor in predicting emotional well-being at time two, both for depression and anxiety. Support also exists for the hypothesis that accepting new jobs will not decrease depression if financial difficulty persists. All those who accepted new jobs at the six month follow-up had not received additional retraining. Therefore, immediate reemployment for those without financial difficulties did assist in emotional well-being. But those who became immediately reemployed but continued to have financial difficulty did not experience the same well-being.

**Implications for Social Welfare Policy**

There is evidence that job training and education have positive impacts on wages, if that training goes beyond basic education (Neenan & Orthner, 1997; Orr, Bloom, Bell, Doolittle, Lin & Cave, 1996). While policies to increase individual human capital investments are important strategies, we cannot deny that low-paying jobs requiring few skills and offering few benefits are presently a growing sector of the economy. Furthermore, the low unemployment rate has resulted in policies which downplay the importance of training, as can be seen in the decreasing significance given to training in both the latest welfare reform efforts, as well as the Workforce Investment Act ((P.L. 105-220) which repeals JTPA and sees training as a last resort. While the current low unemployment rate will force wages up somewhat, they will not provide the same benefits and security as the manufacturing jobs of the past. It is evident in this analysis that while all unskilled workers will continue to suffer disadvantage in the current labor market, our most vulnerable workers, minorities and single parents, will suffer disproportionately.
Furthermore, we must be cognizant of the fact that the unemployment rate is a transitory rate, and cannot be depended on to remain stable, particularly in a global economy. More than ever before, safety net programs, such as social security, the earned income tax credit and some form of national health care coverage take on a new importance for the well-being of families. With forty three million people in the U.S. without health insurance in 1997 (U.S. Bureau of the Census, 1998), it is again time to push for health insurance reform. At the same time, however, politically conservative forces are trying to dismantle current safety net programs, such as social security, exposing low income individuals to potentially disastrous market fluctuations (Mashaw & Marmor, 1996). Only through continued political participation, both individually and through coalitions, will social workers and other political practitioners be able to offset some of the negative effects of the labor market shifts currently affecting our most vulnerable workers.

References


after economic stress and unemployment. *Issues in Mental Health Nursing*, 16(1), 51–66.


Beyond the Rank and File Movement: Mary van Kleeck and Social Work Radicalism in the Great Depression, 1931–1942

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Richard Hunter
Portland State University
Graduate School of Social Work

In this article we critically examine the radical views and actions of Mary van Kleeck during the Great Depression. As the Director of Industrial Studies for the Russell Sage Foundation, van Kleeck was arguably the most prominent radical woman affiliated with social work during the Great Depression; however, current scholarship has limited her contributions to social work’s radical minded rank and file movement. In this study, we redress this situation through an analysis of her work both within and without the rank and file movement. We pay special attention to her efforts to promote social planning, organized labor, and advanced technology as ways to resolve the Great Depression, and we identify how her views were distilled from social work’s founding knowledge base within modern social science. We conclude by revealing both positive and negative implications of her work for contemporary social workers struggling to address various social issues associated with economic globalization, advanced technology, and America’s declining commitment to the welfare state.

Introduction

At the 1934 National Conference of Social Work (NCSW) meeting in Kansas City, Mary van Kleeck, Director of Industrial Studies at the Russell Sage Foundation, delivered three papers that encouraged social workers to oppose the New Deal, align
themselves with organized labor, and to promote the principles of social and economic planning (van Kleeck, 1934a, 1934b, 1934c).
Delivered during an intensely anxious period in American history when radical alternatives to capitalism, including socialism and communism, were considered serious and relevant solutions to the depression, van Kleeck’s presentations served to galvanize a budding form of social work radicalism known as the rank and file movement (Fisher, 1936, 1980; Leighninger, 1987; Spano, 1982). Recognized by most historians of social work and social welfare as the most significant radical movement in social work history, rank and file social workers such as van Kleeck, Harry Lurie (Director, Bureau of Jewish Social Research, New York City), Gordon Hamilton (Professor, New York School of Social Work), Eduard Lindeman (Professor, New York School of Social Work), Ewan Clague (Director of Research, Community Council, Philadelphia), Bertha Reynolds (Assistant Director of Social Work, Smith College), and Jacob Fisher (Editor, Social Work Today) helped develop social work’s first and most powerful unions in its history and forced the profession to examine its relationship with government, organized labor, and its own client base (Ehrenreich, 1985; Fisher, 1980; Gordon, 1994; Leighninger, 1987; Spano, 1982; Walkowitz, 1999). Indeed, the rank and file movement in social work managed to challenge the establishment sanctioned American Association of Social Workers (AASW) in both size and power through the early 1940s (Gordon, 1994; Walkowitz, 1999).

Although van Kleeck deserves the credit bestowed upon her by historians of social work for stimulating the rank and file movement, her experience and influence as a social work radical in the 1930s extends far beyond this movement and has yet to receive sufficient attention by historians of social work. For instance, van Kleeck directed numerous studies for the Russell Sage Foundation during the 1930s that produced wide-spread public debate on unemployment, crime, and the coal industry (van Kleeck, 1931, 1934d). In addition, she helped draft the Frazier-Lundeen Bill; a left-wing inspired measure that provided more generous and comprehensive coverage than the Social Security Act (Gordon, 1994; Walkowitz, 1999) and published numerous articles in a multitude of well-regarded liberal and radical journals such as the Nation, Common Sense, and the New Republic. In part-
nership with the International Industrial Relations Institute (IRI), she developed a radical social analysis that blended elements of Soviet Communism and the left-wing of American technocracy into an alternative social system called social-economic planning. Indeed, by the late 1930s she was recognized by individuals inside and outside social work as a leading figure in both the social work and American left (Alchon, 1991; Gordon, 1994; Walkowitz, 1999).

As the most prominent left-wing radical in social work during the Great Depression, a study of van Kleeck sheds light upon social work then and now. It provides important knowledge about how and why radicalism forms in social work and the historical antecedents that may give rise to its formation. It reminds us that social work did not unanimously support the New Deal and that the differences expressed by practitioners, educators, and activists reflected contrasting interpretations of social work's core mission and knowledge base. It also illuminates the power of women in general and van Kleeck in particular in both social work and society in an era often noted by historians for the declining power of the progressive era feminist coalition (Buhle, 1998; Cott, 1989; Gordon, 1994; Muncy, 1991; Ware, 1981). We believe an understanding of Mary van Kleeck's views and activities in the 1930s provides valuable insights for contemporary social workers struggling to understand their place within a global economy characterized by rapid technological change.

In this article we examine the views and activities of Mary van Kleeck within the context of the three themes that most characterized her work during the Great Depression: the need for social work and society to advance the goals of social planning, organized labor, and modern technology. Everything van Kleeck did and said during the 1930s was related to one or more of these themes and her work cannot be properly understood in any other context. Drawing extensively upon her private papers held in the Sophia Smith Collection at Smith College and her published writings, we provide a critical history of van Kleeck that recognizes both her strengths and limitations. Our focus is upon her views and activities that represent her experience both inside and outside the general boundaries of professional social work; though we pay considerable attention to her experiences outside the traditional realm of social work to illuminate the
diverse ways van Kleeck practiced and represented radicalism in social work. We conclude by providing contemporary social workers with lessons designed to inform future initiatives in practice and research.

Mary van Kleeck's depression era radicalism took root at the International Industrial Relation Institute's (IRI) second tri-annual World Social Economic Congress (WSEC) held in Amsterdam, Holland in 1931. Founded in 1925 by an international coalition of mostly women personnel workers, social workers, reformers, and social scientists; the IRI was a private, non-sectarian, research and advocacy institute formed to address an intensifying international debate, stimulated by observers and employees of industry, that the post-World War I developments in corporate welfare programs, scientific management techniques, advanced technology, open-shop campaigns, and social and political conservatism threatened to empower employers to an extent that jeopardized worker security, standards of living, and government protection of free speech (Alchon, 1985, 1991; Chambers, 1963; Dumenil, 1995; Hawley, 1979). A variation of the technocratic wing of American progressivism, the IRI did not reject developments in technology or scientific management that were contributing to economic growth, but desired to harness their power as a means to reduce economic and political inequality, improve the conditions of labor, and guarantee employment security. IRI members believed that their independent status, scientific outlook, and international composition provided a basis where creative yet practical solutions could be developed, placed under intense scientific scrutiny, and publicized through publications and international conferences (Aiken, 1977; Alchon, 1991, 1998; McClymer, 1980).

Mary van Kleeck was elected the IRI’s Associate Director at its founding meeting in 1925. Van Kleeck was attracted to the IRI because it both reflected her views and provided an opportunity to explore those views outside the confines of conventional institutions. Van Kleeck had served as the Director of Industrial
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Studies at the Russell Sage Foundation since its founding in 1908. In this position she established herself as a leader among the social and political reform set in New York City for her well documented and publicized investigations that exposed the dangerous work conditions and low pay of female laborers employed in New York City's industrial trades (van Kleeck, 1913a, 1914b, 1914). Despite her early popularity and success within the mainstream of the mostly male held field of social science research, van Kleeck's views drifted leftward throughout the war and postwar period, and it became increasingly difficult for her to give full expression to these views within the constraints of the modest liberal and reformist halls of the Sage Foundation (Aiken, 1977; Alchon, 1991, 1998; Glenn, Brandt, and Andrews, 1947).

By the mid 1920s van Kleeck's scientific investigations of female labor conditions in the industrial trades of New York City, combined with a brief stint as director of the Women's Branch of the Industrial Service Sector of the Army's Ordnance Department during World War I and involvement in Secretary of Commerce Herbert Hoover's Committee on Business Cycles and Unemployment, convinced her that social justice for the lower classes in general and women in particular was possible only if the objectives of business were 'social' and not 'individualistic' (Alchon, 1991; Ball, 1991; van Kleeck, 1913a, 1913b, 1914, 1924). By "social" van Kleeck meant government sponsored social planning that relied on production models for "use" and not "profit." Only under such a model, van Kleeck and other leading technocratic progressives such as economists Thorstein Veblen and Simon Patten believed, could the benefits of advanced science and technology be organized to promote progressive goals such as higher standards of living for all individuals, safe workplaces, and social and political equality (Alchon, 1985, 1991; Lerner, 1948; Patten, 1907; van Kleeck, 1924). What separated technocratic progressives from more traditional Marxists and socialists was their strong belief in science and that expert social engineers were required to lead the economy (Aiken, 1977; Alchon, 1985; Lasch, 1965; Lerner, 1948). That is, technocratic progressives shared the progressives faith in science, liberalism, education, and politics and Marxists and socialists beliefs in social and economic planning; however, they parted ways with each through their strict belief that expert
driven social planning and modern technology could overcome social questions regarding class conflict, political corruption, and entrenched inequality.¹ To address the anti-democratic implications entailed in a system directed by expert scientists and advanced technology, many technocratic progressives, including van Kleeck, suggested that labor needed to 'manage' industry and that the social engineers would work cooperatively with them to establish acceptable production 'plans' (Aiken, 1977; Furner, 1975; Pittenger, 1993). Thus, van Kleeck believed that under these arrangements American society would become fully "socialized."² Indeed, van Kleeck believed that social work's, “social”, and “scientific” outlook, combined with its strategic position between business and labor, made it an ideal institution to both advocate for the needs of labor and marshal public support for social planning (Alchon, 1991, 1998; van Kleeck, 1924, 1932, 1934a). Thus, van Kleeck viewed the independent and internationally configured IRI as an opportunity to undertake and disseminate empirically based research studies that examined various dimensions and issues associated with social and economic planning.

The WSEC opened on August 23, 1931 to a large contingent of journalists and writers representing major newspapers and journals from around the world. The conference boasted an eclectic mix of well-known and controversial presenters and participants including, Dr. H.S. Person (Managing Director of the Taylor Society, New York), Edward A. Filene (William Filene’s & Son’s Co., Boston), Dr. Lewis Lorwin (Institute of Economics, Brookings Institution, Washington, D.C.), Paul Kellogg (Editor-in-Chief, Survey, New York), Otto Neurath (Director of the Social Economic Museum, Vienna), and Mr. V.V. Obolesky-Ossinsky (Institute for Economic Research of the State Planning Commission (GOSPLAN), Soviet Union). The breadth of presenters and participants reflected both the IRI's respectable status in 1931 and the depth of dissatisfaction in capitalism that was spreading throughout liberal, progressive, and radical circles as a result of the intensifying world economic depression (Aiken, 1977; Cook, 1999; Fischer, 1990; Gordon, 1994; Leuchtenburg, 1963). The majority of Conference papers focused on the depression and many advanced solutions that reflected van Kleeck's interest in a planned economy, a strong organized labor sector, and the
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application of technological innovations to improve both efficiency and conditions of work (Fledderus, 1932). The conference highlight, however, was provided when representatives from the Soviet Union presented a series of papers discussing their experience with social planning under Communism in general and the results from their Five-Year Plan in particular.

The Soviet presenters were advertised as independent scholars and scientists and not as "official" representatives of the Soviet Union. This was an important attribute to van Kleeck as the reliability and validity of Soviet scientists, academics, and policy representatives was generally regarded as quite poor due to the Soviet Union’s closed and secretive character. Adding to the excitement was the fact the WSEC was the first public meeting where preliminary results were to be disseminated regarding the Soviet Union’s Five-Year economic plan. The Five-Year Plan was developed under the leadership of Joseph Stalin to address Russia’s ongoing struggles with the transition to Communism following the Bolshevik revolution of 1917. The Five-Year Plan was established in 1928 as an attempt by Soviet officials to improve industrial and agricultural efficiency and production levels by encouraging rural to urban migration, agricultural collectivization, and broader input from labor within the centralized planning process (Lewen, 1994; Skocpol, 1979).

The Soviet scientists presented findings indicating that unemployment had been essentially eliminated and that standards of living were rising throughout the country. They attributed the improvements to careful planning, advances in technology, the spread of collective industrial and agricultural enterprises, urbanization, and managerial involvement by labor (Lewen, 1994; Obolensky-Ossinsky, 1932). This was happening, the Soviet representatives reminded their audience, while economic depression continued to ravage nations dependent upon industrial capitalism (Obolesnsky-Ossinsky, 1932).

Van Kleeck was measurably influenced by the Soviet presentations. More than any other paper or discussion, the Soviet presentations provided van Kleeck evidence that social and economic planning worked. Although she had arrived at the conference a supporter of social and economic planning objectives; the opportunity to interact, discuss, and absorb information from
Soviet social scientists both reinforced those views and situated her in the camp of liberals, progressives, and radicals commonly referred to in the 1930s and beyond as "fellow-travelers", "communist sympathizers", or small "c" communists (Caute, 1973; Heale, 1998; Schrecker, 1998). This meant she supported the Soviet Union in principle, but was not an official member of the Communist Party. Although van Kleeck was not a Communist Party member, her views and actions following the 1931 WSEC were filtered through the lens of social planning and Soviet communism.

Van Kleeck Confronts Social Work and the New Deal, 1932–1934

Over the next three years, Mary van Kleeck established herself as a leading force in the American left in general and the social work left in particular. She established close ties with Soviet officials, worked diligently against Administration backed New Deal initiatives, and gave form and direction to the burgeoning rank and file movement in social work (Alchon, 1991, 1998; Gordon, 1994). In the summer of 1932, van Kleeck’s personal commitment and connection to the Soviet Union was strengthened when she embarked on a conducted tour of Russia. In 1932, it was fashionable for committed American radicals, disillusioned liberals, and intellectuals to visit the Soviet Union to observe the inner workings of communism, advance contacts with Communist officials, or to simply get away from the worsening economic depression (Caute, 1988; Heale, 1990; Hollander, 1981). Indeed, it was even common to see advertisements for conducted tours of Russia in popular social work journals such as the Survey (Chambers, 1971; "When We Choose to Plan", 1932).

Van Kleeck arrived in early July eager to observe the Soviet Union’s approach to social planning and to make contacts with Soviet academics and officials. Although she understood the towns, factories, and institutions she encountered were far from representative, van Kleeck remained impressed by what she observed. In a letter to John Glenn, Director of the Russell Sage Foundation, van Kleeck noted her, “5½ weeks in the U.S.S.R. were completely satisfactory” (van Kleeck to Glenn, July 9, 1932,
Mary van Kleeck. She noted observing that unemployment had virtually disappeared and that standards of living appeared to be on a steady rise. She was especially impressed with the attention given by Soviet planners to the process of collective decision making in industry. Van Kleeck wrote to Glenn: “The procedure of planing is developing on fundamentally sound lines in that it is being decentralized in such a way as to ensure the participation of those who are closest to the actual work in a given unit of industry” (van Kleeck to Glenn, July 9, 1932, MVK Archives). Determined to make an objective assessment of the Soviet Union, van Kleeck wrote to Glenn that they were still struggling to bring prices in line with quality. “Of course the difficulties in the U.S.S.R. are tremendous to-day. . . . For example the Russian peasant no longer wishes to be barefoot. They all want shoes but the manufacture of shoes is insufficient and hence high prices are paid for poor quality” (van Kleeck to Glenn, July 9, 1932, MVK Archives). Van Kleeck returned to the United States further convinced that the basis for a just society and the solution to America’s depression existed in the principles of social planning.

The influence of van Kleeck and social planning in social work and the American left expanded throughout 1932 and 1933. In 1932 van Kleeck delivered a well received paper encouraging social work to embrace social planning at the National Conference of Social Work (NCSW) meeting in Philadelphia. Paul Kellogg, Editor-in-Chief, of the social work affiliated journal the Survey devoted the entire March 1932 issue to a discussion on social planning and its potential as a solution to America’s depression (“When We Choose to Plan”, 1932). On August 3, 1933 she received national attention and acclaim from left-wing sources across the nation when she resigned from the National Recovery Administration’s (NRA) Advisory Council following President Roosevelt’s decision to eliminate a clause in the New Deal initiative that protected organized labor’s right to strike within industries covered by NRA codes (Daniel, 1980; The Nation, 1933;). Van Kleeck was incensed by Roosevelt’s decision to erase his pledge of support to organized labor in regards to the NRA legislation and resigned after only one day of service to the applause of left-wing organizations and journals around the country (The Nation, 1933).
Van Kleeck's most profound and influential moment in social work did occur, as many historians have pointed out, at the NCSW annual meeting of 1934 held in Kansas City, Missouri (Ehrenreich, 1985; Gordon, 1994; Leighninger, 1987; Spano, 1982; Walkowitz, 1999). The economic depression was in its fifth year and despite New Deal initiatives and President Roosevelt's pledge to restore stability and growth, leading economic indicators continued to move downward (Leuchtenburg, 1963, Patterson, 1986). Social and political agitation was on the upswing as labor demonstrations, especially those initiated by the communist inspired unemployment councils, were becoming commonplace and membership in the American Communist and Socialist Parties were reaching record levels (Diggins, 1992; Heale, 1990; Lipset, 2000; Warren, 1966). Although most social workers continued to support the liberal reform path of the New Deal, an increasing number of social workers were attracted to radical alternatives, including Soviet communism, that promised to put a permanent end to economic depressions and improve their own economic and professional security (Ehrenreich, 1985; Fisher, 1980; Leighninger, 1987; Spano, 1982; Walkowitz, 1999; Wenocur & Reisch, 1989). Collectively identified in social work as the rank and file movement, this dissenting contingent had formed discussion clubs and protective organizations between 1931 and 1934 in major urban areas including New York City and Chicago (Fisher, 1980; Spano, 1982; Walkowitz, 1999). The essential purpose of these organizations was to protect their tenuous employment security, support radical movements, and encourage social work to adopt a radical position and mission in American society (Fisher, 1936, 1980; Gordon, 1994; Leighninger, 1987; Spano, 1982; Walkowitz, 1999; Wenocur & Reisch, 1989). Thus when van Kleeck arrived at the NCSW meeting in Kansas City, many of the attendees were eager to hear her radical views; particularly as a contrast to the New Deal inspired conference agenda.

Van Kleeck's presentations at the conference drew overflow crowds. In her most influential and widely debated paper titled "Our Illusions Regarding Government", van Kleeck cautioned social workers about rushing to support the New Deal. Van Kleeck argued during her address: "This reliance upon government commits social work to the preservation of the status
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quo and separates them from their clients . . . leading them . . . into . . . defense of the politicians in an effort to protect political institutions” (van Kleeck, 1934a, p. 474). She asserted social work’s support of the government was blind and based upon, “the theory which has largely dominated the political programs of social work . . . that government stands above conflicting interests and in a democracy can be brought, by majority vote, to decide between those conflicts and compel . . . policies which are in the public interest” (van Kleeck, 1934a, p. 475). She informed her audience that this position is illusory as it fails to recognize that capitalist processes compel government to support business interests. She boldly stated her position as follows: “Government is essentially dominated by the strongest economic power and becomes the instrument to serve the purposes of the groups possessing that power . . . If all groups in the community have common interests then the government . . . will have united support. If, however, there be conflicts of interest between groups in the community, . . . then the community is . . . a house divided. The government will then represent the strongest power . . . Our illusions regarding government arise out of a refusal to recognize these conflicts” (van Kleeck, 1934a, pp. 476–477). Van Kleeck suggested to her audience that social and economic planning was the only alternative to existing arrangements that incorporated the objectives of social work including higher standards of living and steady rates of employment (Van Kleeck, 1934a).

Van Kleeck’s presentations drew loud ovations and stirred raucous debate (Springer, 1934). In a society fraught with tension and plagued by doubt regarding the eternal viability of capitalism, van Kleeck challenged her audience to have the courage and foresight to abandon the status quo and accept the radical path of social and economic planning. Although van Kleeck’s presentations at the 1934 NCSW meeting garnered nationwide media attention and spurred formidable growth in social work’s rank and file movement, it ultimately failed to provide social workers a basis upon which they could distill her radical views throughout the ranks of professional social work. This was the case since her analysis left social workers with essentially no place to practice.
Van Kleeck's suggestion that social workers should avoid actively supporting government social programs because it had been corrupted by the profit motives of business also automatically excluded most social workers from practicing within private social agencies. The majority of private social welfare agencies in 1934 were funded through the surplus profits of corporations or individuals (Ehrenreich, 1985; Walkowitz, 1999; Wenocur & Reisch, 1989). Thus, if the business industry is fundamentally corrupted by the profit motive than how could social workers justify working for private social agencies? Her argument that social workers should align themselves with labor to counter these arrangements did not offer a realistic solution to this dilemma. While social workers could theoretically align themselves with the principles of labor by supporting their causes and forming social work unions, organized labor was not in the habit of employing social workers to provide social services to union members and they had not expressed any interest in doing so (Polsky, 1991; Walkowitz, 1999). Thus, this left social workers with private practice as their only potential source of financial support and stability. However, since social work's mission and existence in 1934 was still predicated on serving low income individuals, despite the growth of clinical practice during the 1920s, this was an unrealistic option; especially given the severe economic depression that encompassed America in 1934. The only practical recourse for social workers, then, was to engage in revolutionary practice designed to usher in a socially planned society that would either make room for them on their terms or prevent the demand for their services. While van Kleeck wanted social workers to accept that a social and political revolution might be necessary to achieve her radical objectives, few social workers had expressed interest in, or had experience with, revolutionary activities (Crocker, 1992; Fisher, 1980; Polsky, 1991; Walkowitz, 1999). Thus, despite the overwhelming response she received in favor of her views at the 1934 NCSW meeting, much work remained for van Kleeck to identify practical ways to translate that enthusiasm into actual social work policies and programs; a process that would be made more complicated by ongoing developments in Europe.
Van Kleeck, Social Work, and the United-Front, 1935-1942

Van Kleeck’s efforts to advance the goals of social planning and radical social action within social work and society following her appearance at the 1934 NCSW meeting in Kansas City was shaped by the Communist Party’s decision to pursue a popular-front strategy in 1935 (Diggins, 1992; Heale, 1990; Warren, 1966). The popular-front, also commonly referred to as the united-front, was established to stem the momentum and power of Fascist regimes in Europe; most notably represented by Mussolini in Italy and Hitler in Germany (Warren, 1966). Communists in particular and radicals in general worried that a Fascist Europe would possess the economic and military power required to threaten the existence of the Soviet Union (Heale, 1990; Schrecker, 1998; Warren, 1966). To address this situation, Soviet officials announced in mid-1935 the creation of a united-front between communists, liberals, progressives and radicals in an effort to bolster resources and eradicate political divisions that Fascist governments could exploit for their own gain (Leuchtenburg, 1963; Warren, 1966). In practical terms, the popular-front required communists to de-emphasize the divisive and conflictual character of their revolutionary doctrine and replace it with an ideology rooted in gradualism; an approach that encouraged support for liberal democracies and New Deal style social programs (Heale, 1990; Spano, 1982; Warren, 1966).

To accommodate the popular-front, van Kleeck pushed aside her radical and revolutionary rhetoric and adopted a more modest liberal and progressive platform that advanced gradual economic and political reforms. In social work, van Kleeck directed her reformist impulse toward the bustling union movement. Social work unions were established in both private and public agencies in the early 1930s as a means for social work practitioners to improve deteriorating working conditions, employment security, and salaries (Alexander, 1976; Haynes, 1975; Hunter, 1999; Spano, 1982). Drawing on the increased levels of agitation and political power expressed by industrial and agricultural unions, left-wing social workers who were increasingly identifying themselves in working class terms began forming unions...
to advance their personal and professional interests (Alexander, 1976; Haynes, 1975; Hunter, 1999; Fisher, 1936; Hunter, 1999). The largest number and most active social work unions were in New York City, though strong unions also existed in Chicago, Philadelphia, and St. Louis (Alexander, 1976; Haynes, 1975; Fisher, 1936; Spano, 1982). The majority of social work unions grew out of the discussion clubs and protective organizations that emerged in the early 1930s and were considered part of a broader strategy to increase class consciousness for the purpose of stimulating fundamental economic and political change (Fisher, 1936, 1980; Haynes, 1975; Spano, 1982). With the onset of the popular-front most social work unions, the majority of which were affiliated with United Office and Professional Workers of America (UOPWA), shifted their focus from promoting fundamental social change toward advancing worker rights and supporting the New Deal (Alexander, 1976; Fisher, 1980; Gordon, 1994; Haynes, 1975; Walkowitz, 1999). The expansion of social work unions raised questions amongst leaders in the field about ethics, tactics, and purpose.

In the latter half of the decade professional journals including the *Survey* and the rank and file movement's *Social Work Today* published an assortment of feature articles addressing the ethics of strike tactics in social work agencies, the role of private interest in public organizations, and the extent social work unions served as fronts for communist activity (Gambs, 1936; Lurie, 1935; "Should Social Work", 1936; Taylor, 1936). As a staunch defender of organized labor, van Kleeck argued in support of social work unions and the use of conflict tactics. Although van Kleeck recognized that unions in the popular-front era could encourage unwanted divisions within liberal oriented agencies, she justified their existence and tactics by suggesting social work unions would foster alliances and coalitions with the broader organized labor movement and were a necessary means for workers to protect their interests given the expanding influence of business and political forces throughout the social agency network. She argued in an article published in *Social Work Today*: "Upon the labor movement devolves the responsibility for support of measures which social workers naturally advocate. By becoming part of the labor movement, they are strengthened in their advocacy, and they may in time broaden the scope and increase the effectiveness
of the trade unions in the development of a social program” (van Kleeck, 1936, p. 6).

As an effort to further both the cause of labor and the popular-front strategy, van Kleeck in 1936 enrolled in the American Labor Party (ALP). The ALP was founded in 1936 by a cross-section of union members, intellectuals, and professionals to address the immediate needs of labor and to establish a radical political basis to challenge the existing two-party system through the ballot instead of revolution (Heale, 1998; Leuchtenburg, 1963; Warren, 1966). The ALP’s objectives were broad and included passage of the Lundeen-Frazier Bill, government protection for unions, higher wages, better job security, a more progressive tax system, and more generous government support for farmers (Gordon, 1994; Hunter, 1999; van Kleeck, 1936; Warren, 1936). Although the ALP envisioned itself as an eventual challenger to the Democratic and Republican parties; in concert with the united-front strategy they channeled their energies in 1936 toward the re-election campaign of President Roosevelt as a means to ensure the defeat of the reactionary Republican Presidential candidate Alf Landon (Gordon, 1994; Heale, 1990, 1998; Leuchtenburg, 1963; Warren, 1966). Van Kleeck explained her interest in the ALP in the following manner: “I am convinced that it [ALP] is vital to American democracy and in the best interests of the people as a whole that a labor party should be built, organized by the trade unions and farmers organizations and supported by professional groups by small business men and by individuals active in civic and social movements. All these must unite . . . for the maintenance of civil liberties . . . and against the undermining of general standards of living by the lowering of wages and salaries” (“van Kleeck joins,” 1936). Few rank and file social workers joined the ALP, though van Kleeck viewed it as a fundamental means to challenge the status quo and she retained her membership through the late 1940s and eventually ran for local political office on the ALP ticket in New York City during 1948 (Alchon, 1991, 1998).

Beyond defending the principles of union action, van Kleeck spent considerable time and effort defending their rights and actions in practice and supporting a wide range of social and political causes. For example, She defended social workers who went out on strike for better pay and work conditions at several
New York City hospitals, she endorsed the controversial and conflictual 1937 sit-down strikes staged by Detroit area auto workers, and she supported the formation of an employees union at the Russell Sage Foundation (Alchon, 1991, 1998; Hunter, 1999; Miller, 1935; "Sit-in", 1937; "Sit-Downs", 1937; van Kleeck, 1936b). Moreover, van Kleeck supported the Loyalist cause in the Spanish Civil War, publicly denounced efforts by Congress to institute an oath of allegiance in the United States, criticized federal immigration officers attempts to deport the noted British writer John Strachey for allegedly belonging to the Communist Party, participated in public debates in support of the proposed Fair Standards and Labor Act of 1938, advocated for a liberalization of benefits and eligibility requirements for Aid to Dependent Children (ADC), and published a positively reviewed book in 1936 advancing the goals of social and economic planning titled, Creative America (Alchon, 1991, 1998; Paulsen, 1996; "Protest Rises", 1935; Spano, 1982; "Summary of Main Provisions", 1938; van Kleeck, 1936a, 1939).

In August, 1939, the announcement of the Nazi-Soviet Pact splintered the popular-front and pushed van Kleeck to the outer margins of American radicalism and the social work rank and file movement. The Pact signed between Hitler of Germany and Stalin of the Soviet Union entailed a nonaggression clause between the nations and the development of economic cooperation (Warren, 1966). Overnight, the Pact turned Russia into an enemy of America. The basis of the popular-front was to defeat, or at least hold in check, the advancement of Fascist Germany across the political landscape of Europe. The signing of the Pact implied Russia and Germany had joined forces and that Russian communism was moving toward fascism and totalitarianism and away from liberalism and democracy (Diggins, 1992; Leuchtenburg, 1963; Warren, 1966). Feeling betrayed, scores of American liberals, professionals, and radicals, including many small "c" communists, abandoned the popular-front and became staunch anti-Communists and anti-Stalinists (Heale, 1990, 1998; Schrecker, 1998; Warren, 1966).

The Pact, however, did not turn every radical against Russia and communism. Although it aroused suspicions regarding the motives, ethics, and intentions of the Soviet Union, a minority of American liberals, intellectuals, professionals, and radicals
remained faithful to both communism and the Soviet Union (Schrecker, 1998; Warren, 1966). Van Kleeck was among the crowd that remained loyal to the Soviet Union and she defended the Pact as a strategic maneuver by Russia to protect their own political interests. She did not believe that Russia had entered into an alliance with Germany and she remained convinced that the Soviet Union had no interest in Fascism. Indeed, van Kleeck and other radicals who remained faithful to the Soviet Union, interpreted the Pact as a, “necessary step for peace and democracy in these countries . . .” (Warren, 1966, p. 194).

Although the rank and file movement initially reserved judgement on the Pact; it eventually divided the movement and was a significant contributor to its dissipation in the early 1940s. Many rank and filers, especially those with Jewish roots, simply could not fathom an alliance with Hitler and Germany under any circumstances (Fisher, 1980; Hunter, 1999; Spano, 1982; Walkowitz, 1999). Moreover, many rank and filers were pacifists and the Pact signaled to them that Russia had more serious imperialist intentions than they previously believed was the case and, thus, it threatened to bring America into the escalating World War as an enemy of Russia (Warren, 1966). The majority of rank and file members were also only marginally attached to the Soviet Union and communism. They were drawn to the many variations of communism and socialism floating about in the 1930s and were angry over the seemingly depression inducing nature of capitalism; but their primary interest tended toward economic stability, liberalism, and peace (Gordon, 1994; Ehrenreich, 1985; Walkowitz, 1999; Wenocur & Reisch, 1989). Without the establishment of a clear and practical plan to advance radicalism, most rank and filers in the wake of the Nazi-Soviet Pact returned comfortably to the New Deal; this time not as part of a popular-front strategy but as committed enthusiasts.

At the outset of the 1940s, van Kleeck found herself on the far margins of the American left in general and social work in particular. Rather suddenly, van Kleeck recognized her views supporting social and economic planning, which had galvanized the social work left in 1934, were reinterpreted as a prescription for illiberalism and totalitarianism (Alchon, 1991; Haynes, 1975; Hunter, 1999; Walkowitz, 1999). Nevertheless, van Kleeck
continued to promote social and economic planning throughout the 1940s until her retirement from the Russell Sage Foundation in 1948. To her the Pact was a bump in the road and not an iceberg. She had never professed to be a pacifist as her support for World War I and her speeches and writing on revolution during the 1930s indicated. She opposed imperialism and violence in principle, but accepted the Marxist position that violence may be necessary to eradicate the capitalist impulse from society. Moreover, she had never held to a strict interpretation of Soviet communism and she believed that social and economic planning could exist without the Soviet Union (van Kleeck, 1934d, 1936a). Although her specific prescriptions of how social and economic planning would actually differ in practice from Soviet communism remained vague, as it did for most noncommunist social planners in the 1930s, her commitment to the ideals never wavered (Aiken, 1977; Warren, 1966).

Lessons for Contemporary Social Workers

Mary van Kleeck’s views and activism regarding social planning, organized labor, technology, and the role of government within a democratic-capitalist society during the 1930s provides important lessons for contemporary social workers struggling to understand the social and political disinvestment in the American welfare state, economic globalization, and rapid technological change (Brooks, 2000; Greider, 2000; Houppert, 1999; Jannsson, 1997; Prigoff, 1999; O’Meara, Mehlinger, & Krain, 2000). For example, given declining social and political support for the welfare state, social workers may benefit by revisiting van Kleeck’s views on the nature of government in a democratic-capitalist society and consider adopting a critical stance toward government sponsored social programs that questions their intentions and adequacy to meet the needs of social work clients. Although few individuals are suggesting a need for extensive social and economic planning as a solution to contemporary concerns expressed by social workers and other liberal and progressive minded professionals regarding the declining scope of the welfare state, there is growing public interest in the organized labor movement and third-party politics as a means to counter discontent among progressives and
radicals with the direction of American politics, economics, and culture (Ards, 1999; Borosage, 1999; Cooper, 1999; Moberg, 2000; Schakowsky, 2000; Sifry, 1999). Thus, it may be an opportune time for social workers to revisit van Kleeck's suggestion developed in the 1930s that they align themselves more closely with organized labor and third-party political candidates and causes.

Van Kleeck's depression era experiences, however, also reminds contemporary social workers the importance of establishing strong coalitions, maintaining philosophical flexibility, and understanding the practical needs and objectives inherent in professional social work practice. For example, van Kleeck argued in convincing fashion that social workers should align themselves with organized labor. She failed, however, to establish a sufficient plan that social workers could utilize to obtain employment opportunities within the labor movement. We believe that if social work is to obtain a genuine presence within the organized labor movement it will require both an increase in the number of social work unions and a formal partnership with organized labor that firmly establishes social work services and programs within the arena of organized labor.

Van Kleeck's unwavering belief that modern technology possessed both the power to raise the standards of living and to emancipate the working class from industrial drudgery is a stark reminder of the utopian character technology has possessed in American culture (Alchon, 1998; Featherstone, 1999; Shapiro, 1999). Technology has not, in either communist or noncommunist societies, been the harbinger of social justice, economic equality, or full employment. Indeed, van Kleeck's experience in the 1930s reminds us the importance of adopting a critical approach toward new technological developments that promise to resolve pressing social, political, or economic problems.

Taken together van Kleeck's activities in the 1930s provide contemporary social workers a powerful female role model. She was a first rate left-wing agitator and researcher who wielded substantial power and achieved the respect of her peers in social work and beyond. In a time when many social workers blindly accepted the New Deal, van Kleeck dared to question its merits and challenge the motives and intelligence of its architects. Thus, her activities in the 1930s remind contemporary social workers
that political dissent and radicalism have deep roots in social work history; and that women have been at the forefront in establishing those roots.

NOTES


2. Technocratic progressives, as did the left-wing of progressivism in general, shared and borrowed many principles, ideals, and objectives with Marxism. Like Marxists, technocratic progressives believed that the profit motive undermined the social potential of capitalism and that advanced technology—the motive force of modern capitalism—had to be organized along social and not individual lines. Moreover, most technocratic progressives agreed with Marx and Engels argument that modern capitalism produced alienated labor through the institution of mass production and wage labor. Technocratic progressives and radicals believed under a fully socialized economy with labor participation in management that advanced technology could be used to eliminate alienated labor, enhance leisure for all classes, and raise the standards of living. Where technocratic progressives differed from Marxists was in their outlook on revolution and the role of working class in stimulating a revolution. Technocratic progressives in the 1920s clung to the hope that social-economic planning could be ushered into America, in true progressive fashion, through the dissemination of research findings proving its rationality and social worth that would lead to fundamental legislative reforms or through political elections. What eventually transformed technocratic progressives into technocratic radicals was their support during the early 1930s for working class revolutionary activity. For scholarly accounts on the similarities and differences between technocratic progressivism and Marxism and the emergence of technocratic radicalism in the 1930s see, William E. Aiken (1977), *Technocracy and the American Dream: The Technocratic Movement, 1900–1941*. Berkeley, CA: University of California Press; Christopher Lasch (1965), *The New Radicalism in America, 1889–1963: The Intellectual as a Social Type*. New York: W.W. Norton; Shlomo Avineri (1968), *The Social and Political Thought of Karl Marx*. New York: Cambridge University Press; Guy Alchon (1998), "The ‘Self-Appraising Sincerity’ of Overreaching Theory, Biography as Ethical

3. Although the Soviet presenters were “independent”, they were approved by Soviet officials. Thus, while they were free to present their research findings as they saw fit, it was probably the case that Soviet officials approved their participation because it was believed they would provide supportive comments on the Soviet Union’s experiment with communism. Moreover, one can speculate that Soviet officials were comfortable with allowing social scientists to represent “themselves” and not “Russia” since they recognized the conference was a gathering of individuals who generally held favorable views on social planning and communism.


5. The terms fellow-traveler and communist sympathizer attained a pejorative character during the anticommunist fervor of the late 1940s and 1950s to an extent that even today it is impossible to separate these terms from that era. Thus, we have decided to avoid their usage in this study and in their place we will either use small “c” communist or more generic terms such as communist supporter. The term social-economic planning was applied by van Kleeck and others in the 1930s to avoid the tag of “fellow-traveler” or “communist sympathizer” whenever it was possible, and because she and others believed it represented a social system unique in its own right. For scholarly works that address the political sensitivity of fellow-travelers and communist sympathizers see, Ellen Schrecker (1998), *Many are the Crimes: McCarthyism in America.* Princeton, NJ: Princeton University Press; M. J. Heale (1990), *American Anticommunism: Combating the Enemy Within.* Baltimore: Johns Hopkins Press; Frank Warren (1966), *Liberals and Communism: The “Red Decade” Revisited.* Bloomington, Ind: University of Indiana Press.

6. A rare example of social work services provided to union members occurred in the 1940s when the National Maritime Union employed social workers on its staff. For an account of this experience see Bertha Capen Reynolds (1963), *Uncharted Journey.* New York: Citadel Press.
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Survey and interview data about life after welfare reform were collected from food pantry clients in upstate New York in 1997 and 1999. By 1999, respondents were increasingly likely to have no work or benefits. Having no work or benefits was also associated with having been penalized (sanctioned) for not working or for noncompliance with welfare rules. Sanctions for not working averaged 89 days. Clients sanctioned for job loss tended to report problems with health (including children’s health). Sanctioned individuals reported relatively high levels of financial strain, unstable housing, children’s changing schools, and lack of a phone. Implications for policy and practice are discussed.

Since national implementation of welfare reform through passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, many states have reported substantial decreases in welfare caseloads (USDHHS, 1998a). Generally it is assumed that welfare caseloads are decreasing as clients enter the work force. Yet one post-welfare-reform study conducted at social service agencies and charities in 10 states (NETWORK, 1999) found a sharp rise in the number of people who had neither welfare nor work. Food pantry and soup kitchen users were most likely to report unmet health and utility needs, and going without food. The present study asks to what extent food pantry clients’ reports of receiving wages or benefits changed from 1997 to 1999. Using quantitative and qualitative data, the study also asks if welfare penalties (sanctions) involving cuts
or reductions in benefits were associated with clients' reporting life strain or financial strain, and asks about reasons for sanctions.

**Welfare Reform, the Work-Participation Formula, and Sanctions**

Once a federal entitlement for the poor—Aid to Families with Dependent Children—welfare has been restructured as Temporary Assistance to Needy Families (TANF) run by states [Eitzen & Zinn, 2000; National Governors’ Association, National Conference of State Legislatures, & American Public Welfare Association (NGA et al.), n.d.]. TANF rules are meant to move individuals from welfare to work. In exchange for welfare, TANF recipients are asked to take part in job search activities or to perform community service work (workfare), and to find paid work within 24 months of first receiving benefits. Those who do not find paid work within two years must take workfare. There is a 5-year lifetime cap on receipt of TANF benefits.

TANF rules also push states to move people from welfare to work. States only get full TANF block grants from the U.S. government if they raise welfare recipients' participation in work to acceptable levels, which rise over a 5-year period. To count as workers in state totals, individuals must work at least 20 hours a week, two-parent families a combined 30 hours a week (family caretakers with children under three are exempted). Work may include community service or vocational training but not college, unless states make exceptions. State access to TANF funds is calculated using a work-participation formula: states must show a sufficiently high ratio of TANF workers relative to all TANF recipients. If the number of TANF recipients in the formula denominator is reduced, states look more successful in putting welfare recipients to work. As one way to subtract non-workers from the denominator, states may subtract people who have "refused to work" within the past month and been penalized (sanctioned) for no more than three months in the past year with cuts or reductions in welfare and food stamps. Where sanctions take people off the welfare rolls for the short or long term, they can also make state welfare reform look more successful (Rogers-Dillon & Skrentny, 1999; Tyson, 1998).
Leaving the Welfare Rolls but not Getting Work: Job Loss and Sanctions

Although TANF pushes welfare recipients to work, some may have trouble with employment. Those individuals could start work, go off welfare, and then lose work; thus, although people might leave the welfare rolls, they would not necessarily be getting work. Those who might have trouble getting or keeping work include those who have little education, low self-esteem, or medical, mental health or substance use problems (Danziger, Corcoran, Danziger, Heflin, Kald, et al., 2000; Olson & Pavetti, 1996). In 1996, not only was welfare reform implemented but Supplemental Security Disability Insurance (SSDI) benefits for substance use were cut and renewed for only about 35% of those who reapplied (Lewin & Westat, 1998). Those who turned to TANF might have had trouble meeting its work rules due to substance use or other barriers; in general, substance users have relatively high rates of unemployment (see Metsch, McCoy, Miller, McAnany, & Pereyra, 2000).

In 1996 criteria for granting Supplemental Security Insurance (SSI) benefits to children with disabilities were also tightened (Eitzen & Zinn, 2000). Mothers who have been on welfare are especially likely to have children who are chronically ill, and may find it difficult both to take care of children and work at jobs with inflexible schedules and few sick days (Heymann & Earle, 1999); 79% of the welfare mothers in Puntenney’s (1998) sample were caring for a family member or network member with a serious health problem. Childcare and transportation are other great needs of poor working families (Edin & Lein, 1997), yet some states provide little assistance for those needs (Tufts Center on Hunger and Poverty, 1998). Such problems—and especially health issues—help explain 25% to 40% rates of job loss among workers just off welfare (Hershey & Pavetti, 1997; USDHHS, 1998b).

When other work is not available, welfare recipients may take community service workfare in exchange for benefits; however, the U.S. Conference of Mayors (1997) found that 92% of cities surveyed did not have enough low-skill jobs to put welfare recipients to work (see Jensen & Chitose, 1997). Katz (1989) described
workfare as work for relatively short periods in jobs that offer no training or remedial education, and tend not to boost wages enough to lift people out of poverty. Some may not wish to take or keep such work, leading to noncompliance with workfare and sanctions. In general, sanctions have been applied more often and for longer periods than in the past, but do not improve compliance with work programs (USDHHS, 1997).

The extent to which states or caseworkers cut welfare benefits for noncompliance with welfare rules varies widely (Associated Press, 1999; Froomkin, 1998). Even when unemployed individuals want to work, some states may construe “refusal to work” broadly and may impose sanctions. Writing about a Florida state welfare reform program (implemented prior to national reform), Rogers-Dillon and Skrentny (1999) noted that it received national media attention and intense pressure to succeed from the start. Because supervisors thought “having an unemployed compliant participant would reflect a failure within the program” (p. 19), they defined noncompliance as not having gotten work within the welfare reform time limit, and structured review of cases and penalties accordingly. Thus, even for compliant welfare recipients, not working could be associated with a greater likelihood of being penalized with cuts in benefits.

Financial Strain. Upon losing welfare, people may in turn lose resources useful for getting or keeping work—for example, cash for rent and other needs. Tightened welfare reform restrictions on eligibility for food stamps may also increase strain. Little is known about how sanctions or welfare cuts affect welfare recipients. One study (cited in Tweedie, 1998) found that 53% of sanctioned workers planned to get jobs, but only 30% could; 47% then depended on relatives, although only 23% had planned to; 38% reapplied for benefits. In a study of state welfare reform, sanctions saved programs money but did not lead to higher worker earnings (Riccio & Orenstein, 1996). Given a shortage of available jobs, sanctioned individuals may not be able to get work to make up for lost benefits and may experience serious financial strain.

Work and Welfare in the Area Studied Here

In the upstate New York city studied here, the economy has stagnated since the decline of three major manufacturing in-
dustries, including I.B.M.; nor does the nearby rural area offer much work (Fitchen, 1995). Applicants for work include better-educated displaced workers, students, and retirees, as well as people moving from New York City, which has a 9% unemployment rate that has helped raise the state rate to 5.5% (Children's Defense Fund, 1998). In December of 1996 Broome County began implementing welfare reform legislation; 20-25% of county welfare recipients have gotten work in each year since. Work sites vary in whether they provide mentorship and training; some assume workers come ready to work. In 1997, 5% of county welfare-to-work participants were sanctioned, with numbers dropping to 4% since—a change attributed to growing acceptance of workfare. Tufts' Center on Hunger and Poverty (1998) ranked New York in the middle of states for welfare reform incentives and penalties.

**Hypotheses:** This study asked to what extent receipt of benefits and wages changed for two independent samples from 1997 to 1999. NETWORK (1999) found that over time, social service clients were increasingly likely to have neither welfare nor work, with food pantry clients being especially likely to lack resources. This study hypothesized that (1) compared to food pantry clients in 1997, by 1999 clients would be less likely to receive welfare and other benefits (e.g., SSI or food stamps) but would not be more likely to work. Further, because sanctioned individuals might be especially likely to have had benefits cut as a result of not working, (2) they might be especially likely to have neither work nor benefits, and (3) might report more financial and life strain than others did. (4) Those sanctioned for not working might tend to report problems with health, substance use, childcare, and workfare. Qualitative data from interviews will also be cited to illustrate perceptions of reasons for and the impact of sanctions.

**Method**

**Procedure and Sample**

The agency conducting the study was located downtown, near poor neighborhoods, in a small city in upstate New York. Surveys about welfare reform were conducted in July and August of 1997, and again with a new group of clients in March and April of 1999. The agency's food pantry supplied a free bag of groceries
per family once a month. Clients were asked to volunteer to take the confidential 20-minute survey as they waited for food, clothing, or services. About 60% of clients asked to participate did so. Trained volunteers orally administered surveys in a quiet room near the waiting room, and took notes as respondents spoke of life after welfare reform in unrecorded interviews. The notes were used as the basis for coding narrative themes.

Demographic characteristics of the 1997 \((N = 131)\) and 1999 \((N = 160)\) samples did not differ significantly and thus are presented together. Because this study pertains to people eligible for welfare, data from 11 people aged 65 or older were omitted; only one person in that group (a caretaker grandparent) received welfare. To conduct analyses on independent samples for 1997 and 1999, 4 people surveyed in both years were omitted. Demographic characteristics of the remaining group \((N = 270)\) are given in Table 1. The sample was 60% female and 73% non-Hispanic White, of average age 37.2 \((SD = 10.1)\); 1999 data showed that clients had about 11.4 years of education \((SD = 2.2)\), and 44% less than a high school degree. Half of clients (51%) had children. Agency data showed that most clients made less than $10,000/year. People getting substance use treatment were less likely than others to report working, \(X^2(1) = 3.84, p < .05\).

Measures and Data Analysis

A somewhat more extensive set of measures was collected in 1997 than in 1999. In 1997 respondents completed survey items about life strain or financial strain in the past six months—whether they had moved due to lack of rent, or had a child change schools; and whether it was easier, about the same, or harder to pay for adult health care, rent, food, or bills (e.g., for utilities or the phone) than it had been six months before. The latter items were recoded to indicate increased financial difficulty or not. Respondents also noted whether they had gone without food for a day in the past month, and in both years noted whether they had a phone. In both years, respondents reported whether they had received wages, unemployment benefits, substance use treatment, welfare, SSI/SSDI, housing benefits, food stamps, government child care, or government medical benefits in the past six months. Welfare recipients could have received TANF or General
Table 1

Demographic Characteristics of the Sample

<table>
<thead>
<tr>
<th>Demographic item</th>
<th>n</th>
<th>Percent or Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>161</td>
<td>60%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>197</td>
<td>73%</td>
</tr>
<tr>
<td>African-American</td>
<td>47</td>
<td>17%</td>
</tr>
<tr>
<td>Latino</td>
<td>14</td>
<td>5%</td>
</tr>
<tr>
<td>Other ethnicities</td>
<td>12</td>
<td>5%</td>
</tr>
<tr>
<td>Recoded age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18–34</td>
<td>124</td>
<td>46%</td>
</tr>
<tr>
<td>35–49</td>
<td>111</td>
<td>41%</td>
</tr>
<tr>
<td>50–64</td>
<td>35</td>
<td>13%</td>
</tr>
<tr>
<td>Number of adults in household</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(mean)</td>
<td>270</td>
<td>1.6 (0.8)</td>
</tr>
<tr>
<td>One</td>
<td>146</td>
<td>54%</td>
</tr>
<tr>
<td>Two</td>
<td>101</td>
<td>37%</td>
</tr>
<tr>
<td>Three or more</td>
<td>23</td>
<td>9%</td>
</tr>
<tr>
<td>Number of children in household</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(mean)</td>
<td>270</td>
<td>1.3 (1.8)</td>
</tr>
<tr>
<td>None</td>
<td>132</td>
<td>49%</td>
</tr>
<tr>
<td>One</td>
<td>43</td>
<td>16%</td>
</tr>
<tr>
<td>Two</td>
<td>35</td>
<td>13%</td>
</tr>
<tr>
<td>Three or more</td>
<td>60</td>
<td>22%</td>
</tr>
<tr>
<td>Number of children (Parents only)</td>
<td>138</td>
<td>2.6 (1.7)</td>
</tr>
<tr>
<td>Age of children (mean in years)</td>
<td>138</td>
<td>7.5 (4.5)</td>
</tr>
</tbody>
</table>

Assistance. A No work/No benefits item was coded for whether people received wages or any of the benefits above (except substance use treatment or child care), or had no such resources. Respondents also noted if they had been sanctioned and how many times; in 1997 lengths of sanctions were noted. Reasons for sanctions were coded from narratives into three categories: (a) Not working—losing work or being fired, not taking welfare, or quitting work; (b) Noncompliance—such as unreported
income, not complying with job search rules, or breaking rules (e.g., selling food stamps); and (c) Minor infractions—missing job appointments or interviews, or leaving drug treatment early. The first author coded all narratives; a second rater 20% of them; inter-rater reliability exceeded .90.

To compare 1997 and 1999 data on receipt of wages and benefits, a first set of logistic regressions was estimated in which dependent variables were receipt of earnings or each of the benefits (coded 1 if received, 0 if not) and independent variables were year (1997, 1999), sanction status (sanctioned or not), and demographic controls—gender, age, minority status (White, Non-White), number of children in the household, and number of adults in the household. Analyses were not estimated for unemployment benefits or government childcare, which only 3% and 4% of the sample received. An interaction term for Sanctioned status x Year was tested in regressions and retained as a predictor if significant. Also, a logistic regression was estimated to predict the likelihood of being sanctioned; independent variables were year and demographic controls. Next, to examine correlates of increased financial strain and life strain in 1997, a second set of logistic regressions was estimated with sanction status and demographic controls as predictors. To see if the prevalence of reasons for sanctions differed in 1997 and 1999, cross-tabulations with chi-squares were conducted. For 1997 data, an analysis of variance (ANOVA) was used to see if sanction lengths differed by the reason for the sanction.

Results


Table 2 shows results of logistic regressions that asked if reported receipt of wages or benefits differed by year (1997 or 1999) or for those who had been sanctioned compared to those who had not. Confirming Hypothesis 1, compared to respondents in 1997, those surveyed in 1999 were more likely to report having neither work nor benefits. They were less likely to report getting welfare but not more likely to report working. They were also less likely to report receiving SSI/SSDI, housing benefits, food
Table 2

Receipt of Earnings and Benefits: Percentages and Correlates, by Year and Sanction Status

<table>
<thead>
<tr>
<th>Benefits</th>
<th>All (n = 265)</th>
<th>Sanctioned (n = 40)</th>
<th>Not Sanctioned (n = 225)</th>
<th>r</th>
</tr>
</thead>
<tbody>
<tr>
<td>No work/No benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1997</td>
<td>7%</td>
<td>25%</td>
<td>3%</td>
<td>.17**</td>
</tr>
<tr>
<td>1999</td>
<td>23%</td>
<td>38%</td>
<td>21%</td>
<td>.21***</td>
</tr>
<tr>
<td>Welfare</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1997</td>
<td>47%</td>
<td>46%</td>
<td>50%</td>
<td>.00</td>
</tr>
<tr>
<td>1999</td>
<td>26%</td>
<td>31%</td>
<td>25%</td>
<td>-.18***</td>
</tr>
<tr>
<td>Earnings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1997</td>
<td>21%</td>
<td>13%</td>
<td>22%</td>
<td>-.08*</td>
</tr>
<tr>
<td>1999</td>
<td>26%</td>
<td>6%</td>
<td>28%</td>
<td>.00</td>
</tr>
<tr>
<td>SSI/SSDI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1997</td>
<td>38%</td>
<td>21%</td>
<td>41%</td>
<td>-.06</td>
</tr>
<tr>
<td>1999</td>
<td>28%</td>
<td>19%</td>
<td>29%</td>
<td>-.10*</td>
</tr>
<tr>
<td>Housing benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1997</td>
<td>31%</td>
<td>46%</td>
<td>29%</td>
<td>.00</td>
</tr>
<tr>
<td>Food stamps</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1997</td>
<td>67%</td>
<td>50%</td>
<td>71%</td>
<td>-.10*</td>
</tr>
<tr>
<td>1999</td>
<td>44%</td>
<td>50%</td>
<td>44%</td>
<td>-.20****</td>
</tr>
<tr>
<td>Medical benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1997</td>
<td>78%</td>
<td>58%</td>
<td>84%</td>
<td>-.14**</td>
</tr>
<tr>
<td>1999</td>
<td>54%</td>
<td>56%</td>
<td>53%</td>
<td>-.24****</td>
</tr>
<tr>
<td>Substance use treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1997</td>
<td>10%</td>
<td>21%</td>
<td>7%</td>
<td>.19**</td>
</tr>
<tr>
<td>1999</td>
<td>5%</td>
<td>19%</td>
<td>3%</td>
<td>.00</td>
</tr>
</tbody>
</table>

Note: Correlation coefficients (r) for receipt of earnings or benefits from logistic regressions with Year of receipt (1 = 1997, 2 = 1999) and Sanction status (0 = No, 1 = Yes) as predictors.

*p < .05  **p < .01  ***p < .001  ****p < .0001

stamps or medical benefits. Confirming Hypothesis 2, those who had been sanctioned were also especially likely to report having neither work nor benefits. They were less likely than others to report receiving wages and more likely to report receiving substance use treatment. There were two significant interactions of Sanctioned status x Year. In 1997 (but not 1999), people who had
been sanctioned were less likely than others to report receiving food stamps \([F(1, 116) = 3.98, p < .05; 1999, F(1, 145) = .24, \text{ns}]\) or government medical benefits \([F(1, 116) = 7.95, p = .006; 1999, F(1, 145) = .05, \text{ns}]\). Early in welfare reform in 1997, people may not have realized that even if their welfare had been cut due to sanctions, they might still be eligible for food stamps or medical benefits. A greater proportion of clients (20%) was sanctioned in 1997 than in 1999 (11%), \(r = -.09, p < .05\); in 1999, relatively fewer people received welfare or food stamps and could be sanctioned. Demographic items did not predict sanction prevalence.

Among demographic correlates of benefits receipt, those with more children were more likely to report getting welfare \((r = .17, p < .0007)\), food stamps \((r = .13, p < .005)\), and government medical benefits \((r = .16, p < .001)\). Those with more adults at home were less likely to report getting welfare \((r = -.11, p < .02)\) or food stamps \((r = -.11, p < .01)\). Minorities were more likely than Whites to report getting welfare \((r = .15, p < .002)\), food stamps \((r = .15, p < .002)\), medical benefits \((r = .12, p < .008)\), housing benefits \((r = .15, p < .003)\) and substance use treatment \((r = .25, p < .001)\), with no difference between Blacks, Latinos, or others on the items. Men were especially likely to report getting substance use treatment \((r = .11, p < .03)\), older people to report getting SSI/SSDI \((r = .12, p < .009)\). Not having work or benefits was less likely among people with more children \((r = -.15, p < .007)\) and minorities \((r = -.11, p < .03)\).

Hypothesis 3 had predicted that sanctioned individuals would be especially likely to report financial and life strain. In general, those in the 1997 sample reported increased financial strain in the first six months after implementation of welfare reform (Table 3). Yet people who had been sanctioned were especially likely to report that it was harder to pay for bills, rent, and adult health care; were marginally more likely to report that it was harder to pay for food; and were more likely to say that they had moved due to lack of rent, or that their children had changed schools. The groups did not differ in reports of having gone without food for a day in the past month, which more than half of each group reported. In both years, those who had been sanctioned were less likely to report having a phone. Interviewer notes also revealed client financial strain. Of one person sanc-
Table 3
Relation Between Having Been Sanctioned and Financial or Life Strain in 1997: Correlation Coefficients from Logistic Regressions

<table>
<thead>
<tr>
<th>Financial or life quality items</th>
<th>All (n = 118)</th>
<th>Sanctioned (n = 24)</th>
<th>Not Sanctioned (n = 94)</th>
<th>r for Sanction Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>In past 6 months, harder to pay for...</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food</td>
<td>80%</td>
<td>96%</td>
<td>76%</td>
<td>.12+</td>
</tr>
<tr>
<td>Bills</td>
<td>63%</td>
<td>83%</td>
<td>60%</td>
<td>.13*</td>
</tr>
<tr>
<td>Rent</td>
<td>49%</td>
<td>67%</td>
<td>46%</td>
<td>.10*</td>
</tr>
<tr>
<td>Adult health care</td>
<td>36%</td>
<td>67%</td>
<td>28%</td>
<td>.23**</td>
</tr>
<tr>
<td>Lacked food in past month</td>
<td>53%</td>
<td>54%</td>
<td>52%</td>
<td>.00</td>
</tr>
<tr>
<td>Moved due to lack of rent</td>
<td>17%</td>
<td>33%</td>
<td>14%</td>
<td>.07*</td>
</tr>
<tr>
<td>Child changed schools^a</td>
<td>27%</td>
<td>54%</td>
<td>22%</td>
<td>.17*</td>
</tr>
<tr>
<td>No phone (1997 and 1999)</td>
<td>44%</td>
<td>60%</td>
<td>41%</td>
<td>.07*</td>
</tr>
</tbody>
</table>

Note: Correlation coefficients (r) for financial or life strain items from logistic regressions with Sanction status (0 = No, 1 = Yes) as a predictor along with demographic controls.

^a Parents in 1997 only, n = 74
^b n = 270 + p < .10 * p < .05 ** p < .01.

tioned six months, an interviewer wrote, “The family had to move, the children had to change schools. It’s harder to get food. The partner needs an operation.” Of another person sanctioned 75 days, the interviewer wrote, “They cannot pay the rent, they are afraid of eviction, the children are sent to other homes for food.”

Reasons for Sanctions and Length of Sanctions

Asked why they had been sanctioned (Table 4), respondents mentioned not working (43%), especially losing a job; minor infractions, such as missing job appointments or leaving substance use treatment early (18%); and noncompliance with rules, including not reporting income or not complying with job search rules (39%). Reasons for sanctions did not differ by year [Fisher’s exact t (two-tailed) = .65, ns]. For 1997 data, sanction lengths differed according to reasons for sanctions [F(2, 23) = 46.93, p < .0001]. Sanctions for noncompliance were longest (about 5–6 months), followed by those for not working (3 months), which in
turn differed from those for minor infractions (about 1.5 months). Sanctions averaged 106 days, or over three months \((SD = 52; \text{Range, } 3-180 \text{ days})\); 5 people’s second sanctions averaged 67 days \((SD = 29)\).

**Not working:** *Health, childcare and transportation.* Of 19 people sanctioned for losing work or not working, six did not explain; two had missed work and then lost a job due to lack of childcare or transportation, and 11 (58%) had lost work (for one, a temp job) or not taken work due to being ill or caring for a relative who was ill. For example, a man who took his fiancée to the emergency room for pneumonia was fired for coming to work

<table>
<thead>
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<th>Table 4</th>
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**Percentage of Reasons for Sanctions, and Mean Length of Sanctions**

<table>
<thead>
<tr>
<th>Reason for Sanction</th>
<th>1997 and 1999</th>
<th>1997 Sanction Length</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Category</td>
<td>Within Category</td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>n %</td>
</tr>
<tr>
<td><strong>Not working</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lost job/Fired</td>
<td>19</td>
<td>11</td>
</tr>
<tr>
<td>Didn’t take workfare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quit job</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor infraction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missed appointment/interview</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Left substance use treatment early</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Noncompliance</strong></td>
<td>17</td>
<td>8</td>
</tr>
<tr>
<td>Unreported income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Broke rules</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not fulfill job search rules</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alleges social service error</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t know</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*a* Significant difference in sanction length in Scheffe post-hoc contrasts: Sanctions for noncompliance longer than sanctions for not working, which are longer than sanctions for infractions, \(p < .05\).
late and was sanctioned. A mother who stayed home to take care of a sick daughter also lost work and was sanctioned. One woman who had a doctor’s note saying she was too ill to work was still sanctioned six months for not reporting for workfare. Another respondent who had been in an accident could not get a note from a doctor who refused to deal with social services and was sanctioned for not working.

People with substance use problems were also sanctioned, including a man who quit his job because he was addicted to cocaine. A substance-using woman subject to panic attacks quit a workfare job after an upsetting incident at a men’s shelter; nor could she deal with the on-the-spot decision making at the security job she got next.

It was frustrating to her that her workfare assignments didn’t take into account what she can or can’t handle. There is no choice, just an assignment to show up somewhere. She said, “Put me in a women’s shelter or let me work with old people.” She seemed willing to work but frustrated that her circumstances weren’t given any credence.

Another woman spoke of a friend with HIV who risked sanctions if she did not attend workfare even if she might feel very sick on a particular day. “Anyone that sick should be given SSI,” the friend said. “Her health may be compromised just to return the little benefits she does get.”

Lack of childcare raised problems also. One woman missed work and lost her job when the child’s father did not come to take the child to the babysitter; nor did she have other resources for childcare. “The interview was difficult to conduct,” the interviewer wrote, “because the child was very active and trying to ransack the office.” With no money for bus fare, another woman walked miles to work daily. One rainy day she did not want to walk to work, lost her job, and was subsequently sanctioned.

**Workfare.** Five people (including three noted above) were specifically sanctioned for not taking or continuing with social services workfare; it is also possible that some among the six who did not give reasons for not working were included in this group. Workfare jobs—described as offering little advancement—included crossing guard, security guard, work at a men’s shelter, maintenance, and other unskilled work. Assigned to move boxes
all day, a woman asked why she could not get job training. Her interviewer wrote, "She would love some skills to help her get a job she would enjoy. She would like to work with children." "At workfare they change your job so often there isn't enough training to learn," another person said. "They feel workfare just puts them to work to pay for a living, but they can't keep the job after, so they feel no better off," an interviewer wrote. One man felt "upset about working through social services workfare and not recognized as a real worker. He wants to be hired and get off welfare."

One woman was told that social services would pay for day care as she attended workfare classes and job interviews: "She never got the money, and with what she received a month, the child care bill made things worse." Applying for government childcare, she learned that she would need to work 30 hours a week. Her interviewer noted, "She does not want to be away from her son that long each week. She feels he still needs the love and care only a mother can give her own child. She does not want a stranger raising her son. She felt it is why children are so violent." When the woman refused workfare, she was sanctioned.

Noncompliance with welfare rules. Sanctions were also imposed for not complying with welfare rules—including not reporting income or not performing job search requirements—e.g., missing a job seminar. Some sanctioned for unreported income may not have known that they had to report workfare earnings to DSS; receiving benefits contingent on participating in workfare, some may have thought of workfare pay as benefits, not income. In 1999, a woman who did not report $151 in income was sanctioned 12 months. Another person sanctioned three months for job loss was sanctioned an additional six months for unreported income. Others who were sanctioned included a respondent whose family member did not have a birth certificate and a woman who had not reported a niece living with her. People in substance use treatment were 50% of the group of 8 who were sanctioned for leaving treatment early or missing appointments.

Other issues in implementing TANF. Welfare rules could also be problematic in other ways. Work requirements could come at the cost of completing college. One man left college just short of getting a B.A. to work for benefits to support his family. A
woman returning to school was also pressed to take workfare. Her interviewer wrote,

She has been manic-depressive since age 11. She is having difficulty finding the right medication. With all her depression, her husband was able to obtain full custody of the children. She has started college this summer taking computer science and is very excited. She is a full-time student who has ten hours-a-week work-study. DSS wants her to work an additional 20 hours-a-week to work off her grant.

It was not clear if the woman would be sanctioned for not working the 20 hours a week.

People whose benefits were cut when they got work also spoke of rapid cuts that sometimes did not give them enough time to get back on their feet financially, and may have contributed to some people’s then losing work. An interviewer wrote of one man,

Shortly after starting work, Social Services took away benefits. . . . . He could not pay next month’s rent. He, his pregnant wife and a two-year-old daughter had nowhere to live. They moved from family to family. They could not afford the $24/night that Salvation Army charged. They are now back to any empty apartment, but at least it’s shelter.

Discussion

Decreased Resources Over Time and for Sanctioned Individuals

Despite reports that welfare-to-work is a success (Hobbs, 1996; USDHHS, 1997, 1998b), states have not been required to track those who leave welfare (McClintock & Colosi, 1998), and little is known about the effects of sanctions or benefits cuts. In this study, the proportion of food pantry clients who said they had no work or benefits rose from 1997 to 1999 (see NETWORK, 1999). By 1999 clients were less likely to report getting welfare, SSI, food stamps, medical benefits, and housing benefits. Since 1996, policy changes have made it harder to get welfare, SSI, and food stamps—reducing the number of people getting these benefits nationally (see Lawton, Lester, Todd & Smith, 1999). People who lost work and reapplied for TANF may also not
have been granted it. Further, at welfare offices people may not have been told they were eligible for TANF, Medicaid, or food stamps—also helping to explain national declines in receipt of these benefits since welfare reform (Keigher & Fendt, 1998; Lawton et al., 1999).

Because the object of welfare reform is to move people from welfare to work, one might expect decreases in receipt of welfare to be matched by increases in the percentage of people who work. Yet study participants were not more likely to work in 1999 than in 1997. In a non-metropolitan area where available jobs tend to be low-wage or part-time—and where many people compete for work—people may have had trouble getting or keeping jobs (Jensen & Chitose, 1997). Working poor are also susceptible to losing work due to layoffs or jobs ending, including temporary or seasonal work ending (Riccio, Friedlander, & Freedman, 1994). Lack of a high school degree—noted by 40% of the group—may have hindered getting work too (Metsch et al., 2000). Further, people in this poor food pantry sample may have needed more intensive help with childcare, transportation, health care, counseling, or job training to get and keep jobs.

Sanctioned individuals were especially likely to have neither work nor benefits. People sanctioned for job loss noted problems with health, caring for sick partners or children, and arranging childcare and transportation. After being sanctioned, respondents noted greater hardship paying for adult health care, bills and rent; a greater likelihood of moving due to lack of rent; and less likelihood of having a phone—conditions that could make it even harder to work.

Implications for Policy and Programs

If sanctions impose financial strain on vulnerable people, including those who are already trying to work, one can ask if there might be better ways to help people work. Tufts Center on Hunger and Poverty (1998) suggested two alternatives to sanctions: policies to help people work and to help develop income and assets. States might also benefit from new definitions for “worker” and “nonworker” as they calculate work-participation rates and apply for TANF funds.
Providing time and resources for health care. Stereotypes hold that welfare recipients are too lazy to get off welfare and need to be pushed to work (Katz, 1989). Yet research suggests that many welfare recipients do want to work and that intensive and multifaceted interventions help make that possible (see Strawn & Martinson, 2000, for a review.) In this study, respondents tended to report losing work or not taking work because employers or welfare offices had not been flexible when respondents encountered problems with individual or family health concerns. Findings suggest the importance of broad policy changes to give employees personal, medical, or vacation time off when necessary, since low-wage jobs tend to be inflexible about giving workers such time (Heymann & Earle, 1999). For example, people with chronic health problems (such as HIV) might better work if they could take time off to deal with illness as it arose.

Substance users may also need enough time to get back on their feet. In this study, people who had recently been in substance use treatment were over-represented among sanctioned individuals; perhaps they had trouble meeting welfare rules due to addiction and disorganized lives, or had trouble getting work. Metsch et al. (2000) found that substance-using women were more likely to make a successful transition from welfare to work when they received at least a year of treatment and aftercare. Programs that try to put substance users to work fast may be less successful than those permitting people to increase work gradually and get aftercare as they do.

Respondents also reported decreased receipt of medical benefits and food stamps over time; yet some might have been eligible for those benefits had they been informed. An application for AFDC used to automatically trigger an application for Medicaid. However, TANF and Medicaid have been unlinked so that separate applications are now needed for each (Ellwood & Ku, 1998). Some who thought they were ineligible for TANF may not have realized they could still get Medicaid or food stamps. Those who left welfare due to work or time limits may also not have realized they could get a year of transitional Medicaid. In
turn, adequate access to health care or food might have prevented health problems that interfered with work. Research suggests that welfare recipients are more likely to keep work when they know what transitional benefits (e.g., transitional medical benefits) are available, have help with paperwork (Rangarajan, 1998), and have stronger case management before and after starting work, so that they may better foresee and forestall problems (Hobbs, 1996; Iversen, 1998). Further, communities that provide more options for low-cost substance use treatment, health care, childcare, and transportation may help workers stay in jobs and develop job experience that promotes attachment to the community work force (USDHHS, 1997).

Making workfare more attractive. For people who could not get regular work, social services did offer community service workfare, with which recipients tended to express dissatisfaction. It was not clear to what extent such dissatisfaction led to clients’ noncompliance with workfare—a topic for further research. Brock, Butler and Long (1993) noted that unpaid community service jobs do not generally lead to increased skills and wages, consistent employment, or reductions in welfare; the researchers called for investment of funding and staff commitment in service jobs to ensure adequate work opportunities and clear procedures for job placement. Caseworkers may also benefit from learning to assess individual needs and talents before placing people in jobs (see Iversen, 1998). However, those who have the least education and job experience or who are least able to adapt to work may be the most likely to take social services workfare. Slipping up in that system, they may be subject to sanctions and penalized further. Those individuals may come under greater pressure as states try to raise work participation levels after having placed “easier” cases. States and agencies may need to make greater investments in training, counseling, and substance use treatment to help those clients.

In imposing sanctions, welfare offices might also try to assess why clients are not meeting requirements, instead of simply punishing them if they do not (see Meyers, Glaser & MacDonald, 1998), Riccio and Orenstein (1996) found that caseworkers who spent more time with clients were less likely to sanction them, perhaps because staff knew clients’ issues better. Agency use of
“integrated” case managers who simultaneously handle welfare eligibility, social services and work issues (USDHHS, 1998b) may also help prevent social service errors and client infractions, and better help clients keep their jobs.

**Protecting Income and Assets**

People who had been sanctioned were also especially likely to report financial strain; such strain and unhappiness associated with it could have made it harder to work. For example, people who moved due to lack of rent or who could not afford a phone may have been harder for employers or caseworkers to call, reducing opportunities to work. Greenberg and Savner (1999) have suggested revising requirements for unemployment insurance so that part-time workers are eligible for it, and so that “good cause” for losing work may include reasons associated with loss of child care, caring for sick children, or domestic violence. Strawn and Martinson (2000) have also noted that TANF maintenance-of-effort funds used outside of TANF cash assistance may be used as income support for people between jobs. In general, allowing individuals on welfare to keep a larger part of their earnings and more valuable assets—including more valuable cars, business equipment, and savings accounts—would help give welfare recipients a better chance to earn a living and stave off financial setbacks. Provision of health insurance after people leave welfare—possibly for periods longer than a year—would also help prevent health care costs from further draining poor people’s pocketbooks (Tufts Center on Hunger and Poverty, 1998).

**Redefining “Worker” and “Nonworker”**

In implementing welfare reform law, legislators might also consider ways to redefine “worker” and “nonworker” in counting workers for the TANF work participation formula. For example, a broader range of activities—such as educational activities, counseling, substance use treatment, or some combination of these and work—might count as work for the 20-hour-a-week requirement. In Illinois, completion of post-secondary education may be counted as work (see Strawn & Martinson, 2000). Legislators might also lower state work quotas or might calculate work
participation more flexibly. For example, for those on workfare who have chronic health problems, one might count a certain number of days of work per three months, rather than per one month, as work. In terms of defining nonworkers, the language of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 only calls for reducing benefits to people who refuse work, and need not include those who lose work. States might exempt some who lose work for good cause from nonworker totals, or might be allowed to modify work quotas in response to a wider set of conditions, including regional unemployment rates.

Limitations of the Study and Areas for Further Research

Finally, limitations of this study should be noted. Its somewhat imprecise, retrospective measures made it hard to assess the impact of sanctions on receipt of benefits. People could have said both that they had been sanctioned and had received welfare in the past six months, even if they also lost welfare within the 6-month window. (Sanctions could also have involved benefits reductions.) Future studies might prospectively measure the amount and kind of assistance lost to better assess changes in financial status and strain. Further, food pantry users may tend to report more money strain than other social service recipients do (NETWORK, 1999). Compared to the upstate New York county as a whole, which had 5% and 4% rates of sanctions in 1997 and 1999, people with sanctions were over-represented in this sample (20% in 1997, 11% in 1999). In a more typical welfare sample, it is likely that more people would have been working and might have felt less financial strain. The study also was not longitudinal; 90% of those who had been interviewed in 1997 could not be reached in 1998 for follow-up by phone—whether because they had moved or did not originally or later have a phone; a new sample had to be recruited in 1999. In NETWORK's (1999) study, many clients also had no phone. Yet this would indicate that food pantries may be a good place to study poor people who fall between the cracks.

Future studies should ask what happens to those without work or benefits over time. In this study in 1997 sanctioned individuals were especially likely to move due to lack of rent, to have children change schools, and to have greater difficulty paying for adult health care. By 1999, the sample was generally less likely
to get housing or medical benefits. Increased hardship meeting needs for housing, education, and health care may contribute to deeper poverty, and stress other parts of the service sector. It is crucial that states track what happens to people who leave welfare, as well as assessing the impact on agencies (such as food pantries) to which people turn. Researchers could also ask to what extent states are using sanctions to get fixed TANF block grant funds (see Tyson, 1988). Where state have low employment rates but still get full TANF grants, do the states tend to have higher sanction rates? Do they use a broader range of reasons for imposing sanctions? Administrative data linking employment rates, sanction rates, and receipt of TANF funds might address such questions in this under-researched area of the relation between policy initiatives and program implementation (McClintock and Colosi, 1998).

To conclude, this study found that food pantry clients were increasingly likely to have neither benefits nor work, with this being especially true of sanctioned clients too. These results may be specific to the economically depressed area in which the research was conducted, but may also be more geographically widespread, as one study (NETWORK, 1999) suggested. Clearly, much more has yet to be learned about the effects of welfare reform on people and communities (see McClintock & Colosi, 1998) to see if and for whom "welfare-to-work" works.

References


The purpose of this article is to explore the role of the clinical social worker in a time of unprecedented change. The events of the last decade have transformed health care delivery as well as professional performance expectations. To facilitate understanding, the environmental considerations that surround these changes are traced and discussed. A direct linkage is made to clinical social work practice and suggestions for the future survival of the profession is discussed. These suggestions include: (1) a greater focus on behaviorally-based outcomes that result in cost-beneficial service provision; (2) increased marketing of social work services to health care providers; (3) promotion of social work services as an integral part of the success of the interdisciplinary team, (4) incorporate a macro perspective into micro or clinical practice approaches; and, (5) explore non-traditional roles for social work professionals to expand their current practice arena.

Managed Care: The Beginning

In the later part of the 1980s it became clear that the cost of health care delivery had reached a national crisis. Although, there may have been multiple reasons for this major contributions included: (1) the results of better health care with many people living longer; (2) increased technological advances and the costs associated with it; (3) the use of heroic measures to maintain life beyond its traditional boundaries; (4) the lack of health care approaches formulated and implemented on a national level that
promote prevention, wellness and health education; (5) a desire to have "state-of-the-art" medical care complicated by the resistance to pay more for medical services through insurance programs or taxes; (6) a fragmentation of the insurance and/or health service reimbursement system; (7) fears by professionals of increasing malpractice claims and the cost related to negligent practice; and, (8) the cost of providing inpatient health care (Edinburg & Cottler, 1995; Epstein & Aldredge, 2000; Shortell & Kaluzny, 1994).

As difficult as these factors were to identify, change and control, plans to address them became paramount (Hernandez, Fottler, & Joiner, 1994; Shortell & Kaluzny, 1994; Skelton & Janosi, 1992). Additionally, what exemplified this concern was the population trend prediction that as the baby boomers aged health care spending would reach an astonishing peak of 16 trillion dollars or 30% of the gross domestic product (GDP) in 2030 (Burner, Waldo & McKuskie, 1992).

In the late 1970s into the middle 1980s it was estimated that the number of employed individuals without health insurance in the United States increased from 28.7 million to 35.1 million (U.S. Bureau of Census, 1984). This left an estimated 37 million Americans who might have experienced health problems with an inability to afford needed health care (Roland, Lyons, Saltanicoff & Long, 1994). In addition, in 1988, the nations top 12 health insurers reported financial losses of 830 million dollars (Edinburg & Cottler, 1995). In review, the 1980's represent a time where environmentally the nation was in the midst of economic stagnation/recession (Mizrahi, 1995). At the time, health care reform strategies suggested to alleviate this unprecedented burden were considered successful only where cost containment and/or reduction ultimately resulted.

During the early 1990s politicians vigorously campaigned to be viewed as responsive to the American people's concern for health care reform. Election strategies included possible solutions designed to address health care reform. In fact, President Clinton in his 1992 election made health care reform his highest domestic priority (Mizrahi, 1995). Numerous proposals were considered for health care reform from a single payer system approach to limited policies for universal health care coverage.
Subsequent to the 1992 election President Clinton proceeded to address his campaign goal by establishing a task force to complete a plan for health care reform. The proposed model was different than the single payer approach that he had originally supported early in his campaign. Consequently, Clinton's intended health care reform proposal was not successful within his administration or the American public. Therefore, a modified plan was adapted that resulted in changes to health care that were designed to improve access and quality of care incrementally, rather than a more comprehensive plan to reorganize the health care system (Gilbert & Terrell, 1997). This later approach is exemplary of a managed health care competition where purchasing alliances were formed which would have the power to certify health plans and negotiate premiums for certain benefit packages (The Presidents Health Security Plan, 1993). In 1995, Edinburg and Cottler predicted that the future of most health care delivery (70% of all coverage) would be provided by managed care plans. Based on this method, managed care plans would require the following: pre-authorization for service by qualified consumers; pre-certification for a given amount of care with concurrent review of the treatment and services rendered; continued determination of the need for hospitalization through a process of utilization review; and, pre-discharge planning to ensure proper after care services are identified and made available (Hiratsuka, 1990). Examples of legislation that have improved access and quality of care include the Family and Medical Leave Act and the Health Insurance Portability and Accountability Act.

Despite these efforts, the number of American people without health insurance increased to an estimated 41.7 million people in 1996, a rise of 1.1 million from the previous year (Bennefield, 1997). In the 2000 presidential campaign Al Gore continued to support health care reform efforts with a patient bill of rights. Specifically, he advocated for the inclusion of prescription drugs by Medicare, access and improved health care for rural areas and individuals with Alzheimer's, HIV/AIDS, breast cancer, and other chronic illnesses (Gore 2000). Furthermore, the Republican presidential candidate George W. Bush promoted the importance of patient choice in managed care and pushed for less governmental intervention in medical care (George W. Bush...
for President, 2000). Groups such as the National Association of Social Workers (NASW) remain firm in their commitment for overall health care reform based on universal access to care (Social Work Speaks, 2000, Trattner, 1999). Clearly more broad-spectrum advocacy is a requisite to improved reform strategies. Ultimately, the 1990s have proved that the implementation of managed health care is here to stay. Incremental change strategies that highlight less liberal reforms can ameliorate managed care, and professional social workers must continue to encourage and represent innovative methods that advocate for change in the current system.

Understanding Managed Care

The complexity and diversity required to define the current concept of managed care cannot be underestimated. This very elastic term has been utilized to define a variety of health care service and delivery options that quickly change (Wernet, 1999). However, it is probably safe to say that a managed care plan is an integrated delivery system that manages health care services by approving services and following patients through the system rather than by simply financing or delivering without supervising the services (Epstein & Aldredge, 2000).

According to Dziegielewski (1996) in this high-pressure health care environment the following issues need to be considered. To begin with, the public demands quality for service and “state of the art care” (Shortell & Kaluzny, 1994). Politicians, researchers and consumers have advocated strongly for repair and reform (Comer, Mueller & Blanenau, 2000; McKinney, 1995; Mizrahi, 1995); however, America’s insured are approaching health care reforms with hesitancy and trepidation in fear of ending up with “less for more.” Although Americans want quality service, they do not want the increased costs especially from a health care system they believe is plagued by waste. Not surprisingly, Americans envision gaining access to state of the art technology that clearly links medical knowledge and technology to the provision of quality service. Health care delivery systems are expected to hire and retain the most qualified personnel, as well as, purchase
the most sophisticated equipment. The pressure from the public to secure these services is intense allowing intense competition for “covered” or “reimbursable” client resources.

Second, in this era of interdisciplinary service provision, it has become difficult to tell what specific skills each professional contributes to overall patient care (Dziegielewski, 1998; 1997). It is expected that knowledgeable and competent professionals working together as a team provide health care services. It is easy to see how the number of social workers has grown along with physician assistants, nurse practitioners, multi-skilled health workers, laboratory technicians, occupational therapists, physical therapists, etc. Unfortunately, this may cause the social worker to be viewed as just one of many “adjunct” professionals involved in health care delivery. Often the roles that social workers perform overlap with these other disciplines (Davidson, 1990, Holliman, 1998). For example, today nurses are being taught specifically how to run therapeutic support groups in health care settings (Arnold, 1996). Traditionally, however, most group leadership was considered the realm of the social work professional (Toseeland & Rivas, 1984). Based on the sheer numbers of allied health care professionals and the overlapping of skills, tasks, and roles, one thing remains certain, all trained professionals will be forced to continue to compete and strive to locate a solid niche in this new and emerging managed care market (Dziegielewski, 1996; 1997).

Third, managed care has created a competition for survival among health care providers. In the past, health care organizations/providers facilitated expansion of their services by increasing marketability through the specific services they provided; however, managed care may prove this strategy futile if insurance reimbursement for each service is not ensured (Shortell & Kaluzny, 1994). To be considered viable each health care delivery organization must take the necessary steps to ensure its own survival, and be able to record progress in attaining both agency and societal missions (Shortell & Kaluzny, 1994). Competition to accomplish this task has created an arena for providing quality and competitive services for all. According to Hernandez, Fottler and Joiner (1994) this includes: (1) the provision of low cost traditional health services; (2) the provision of superior service
through technology or client service; (3) specialization into certain areas of practice (i.e., centers of excellence); (4) the diversification outside of the traditional bounds of health care delivery (i.e., wellness centers); and (5) creating new and ingenious ways to rework traditional service to be more reflective of current needs and trends. For example, under the influence of managed care many hospitals have opened health and wellness centers that reflect a full continuum of health care services (Dziegielewski, 1998).

As with all incremental societal change, numerous changes will occur at the most basic levels. For example, changes in terminology such as the term “patient” are being re-evaluated. Originally, the adoption of the term “patient” in the medical community caused many social workers to stop using the word “client” when referring to the individuals they served (Dziegielewski, 1998). Social workers, like other professionals, learned quickly that they needed to adopt the dominant label used in the medical environment. This use and acceptance of the term “patient” is obvious when reading articles in the social work health care literature (Alperin, 1994; Brown, 1994; Coursey, Farrell & Zahniser, 1991; Cowles & Lefcowitz, 1992). This term, however, has become somewhat outdated and remains in conflict with the concept of wholeness that is integral to marketing services in this competitive environment. Terms now being utilized include: “client” (a term familiar to social work), “consumers” (to represent those receiving a service) and “covered persons” (reflecting those who have some type of medical insurance coverage). Those in favor of the euphemism “covered persons” argue this term is indicative of the universal care perspective assuring that an individual has the security of medical coverage (Dziegielewski, 1996). Regardless, of what the individual who receives service is called, it makes sense for social workers to adapt this term and follow suit especially if they expect to compete as part of the system.

Finally, quality of care balanced with maintaining cost control is often hailed as the two most powerful driving forces in managed care (Shortell & Kaluzny, 1994; Ginter, Swayne & Duncan, 1998). Unfortunately, under most of the capitation models being proposed revenue schemes that increase quality of care cannot increase the cost of health care services (Flood, Shortell & Scott, 1994; Hernandez, Fottler & Joiner, 1994; Ross, 1993). This delicate
balancing act of quality of care and cost containment has resulted in cost containment as clearly tipping the scale (Ginter, Swayne & Duncan, 1998).

In terms of social work practice and managed health care, many social workers are feeling increased pressure to contain costs. This requires that social workers constantly and actively advocate for maintaining the provision of quality services. It is at this point that micro practice cannot be separated from macro practice in terms of identifying and supporting state and federal legislation that provide basic standards of quality care. Service provision needs to be endorsed that allows for universal accessibility, affordability, and service comprehensiveness (NASW, 1994). Social workers need to do more than simply ensure the provision of quality services. They need to recognize the macro aspects of practice that affect all Americans, and monitor policies and programs that will affect not only the clients they serve directly. For social work practitioners, it may help to think about working in the managed care system as similar to working with a client that has a different value system. Similar to practice, the social worker needs to start where the client is and treat the client as part of a system. It is critical to develop strategies that will improve overall care and access for those being served by the system. Viewing managed care from this perspective may take extra creativity and patience; however, it can enhance the awareness of the micro and macro level elements inherent in social work practice (Kirst-Ashman & Hull, 1997).

Social Work Practice and Managed Care

Traditionally, social workers have always worked closely with individuals, groups and families in regard to understanding situational and environmental concepts within their practice structure (Hepworth, Larsen, & Rooney, 1997). In order for social work practice and managed care to co-exist a marriage of sorts needs to occur. Unification is essential for professional social workers to remain a viable link in the health care environment. The current state of social work practice mirrors the turbulence found in the general health care environment (Dziegielewski, 1998). Social workers, similar to other health care professionals, are
being forced to deal with the numerous consequences of cost containment policies such as declining hospital admissions, reduced lengths of stay, reduced physician to patient contact, and numerous other restrictions and methods of cost containment. Struggling to work within these restrictions has become necessary based on the inception of prospective payment systems, managed care plans and other changes in the provision and funding of health care (Johnson & Berger, 1990; Ross, 1993; Simon, Showers, Blumenfield, Holden & Wu, 1995; Wernet, 1999). Not receiving services has been linked to increased rates of high-risk patient relapse where clients are more likely to be readmitted after discharge; and, although high-risk screening is typically in place, the pressure for quick dispositions remains problematic (Bywaters, 1991; Resnick & Dziegielewski, 1996; Holliman, 1998).

According the Ross (1993), employees who are at the greatest risk of losing their place in the delivery of health care services are those who: (1) do not create direct hospital revenues; (2) are not self-supporting parts of the health care delivery team; (3) hold jobs where productivity is not easily measured or questionable; (4) provide service where the long-term benefit for cost of service is not measured; and (5) engage in a service where the professionals role is often misunderstood, challenged and under-rated in the system. Therefore, emphasis needs to be placed on how social work professionals are an essential part of the health care delivery team providing both needed direct clinical services as well as fiscal support for the agency setting (Spitzer & Kuykendall, 1994).

Today, rapid change and flexibility is required as administrators are forced to try to cut costs by eliminating “expendable services” such as mental and preventive health, discharge planning and other supportive services. Social workers often assist clients in these areas, and because of this linkage often feel the brunt of initial dollar-line savings attempts. The sheer numbers of allied health care professionals who are moderately paid provide an excellent hunting ground for administrators pressured to cut costs (Dziegielewski, 1998). These administrators may see the role of the social worker as adjunct to the delivery of care, and may decide to cut back or replace them with poorly trained nonprofessionals simply to cut costs. Since substitute professionals often do not have either the depth or breadth of training when compared
to social work professionals, substandard care can result. For example, a trained paraprofessional in hospital discharge planning may simply facilitate a placement order, neglecting issues that respect the individual's culture, sense of personal wellbeing, ability to self-care or level of family and environmental support. Specifically, if a client is discharged home to a family that does not want to care for her, she is at higher risk for abuse and neglect. Social workers recognize that culture and environmental factors are paramount to efficient and effective practice, and the de-emphasis or denial of this consideration can result in the delivery of inefficient, ineffective, and potentially harmful sub-standard care (Dziegielewski, 1998). Although the employment of paraprofessionals can appear to be initially cost-effective, it may not result in quality care. When personal/social and environmental issues are ignored, clients are at risk of unequal, inequitable, and inadequate care or recovery.

Future Perspectives

The intention of this article is to help exemplify how managed care relates to social work practice. Most professionals agree that the last decade has truly transformed health care delivery. Work expectations for professional social workers; however, are not entirely new. The concepts of managed care clearly have its roots in the social programs that date back to the Great Society programs (Wernet, 1999). These incremental and "piecemeal" changes will indeed require constant flexibility and readjustment—if this marriage of sorts is ever to survive.

Dziegielewski (1996) summarized several steps for survival when presented with the numerous changes bequeathed with managed care. First, social workers are encouraged to address behaviorally based outcomes and clearly link these outcomes to cost effectiveness (Dziegielewski, 1997). Many times social workers are torn when they feel that their heritage of the "person in environment" stance is being discounted by a limited system that measures success by concrete outcomes alone. This is further complicated by the fact that many clients find little personal comfort in behaviorally based concrete outcomes determined for service provisions. Unfortunately, the result of pre-determined
impersonal provisions are a lack of listening, lack of rapport between service provider and client that may in turn be interpreted as disinterest. This may translate into dissatisfaction with all services and care. From a legal and financial standpoint, a case could be made to reintroduce the elements of listening, rapport building and availability as a means of diverting potential lawsuits.

Social workers who take the time with the client and family to answer questions and to deal with discomfort and loss help facilitate a viable discharge plan. A good rapport is essential in an environment where tolerance and flexibility is essential. In haste, it is easy to place blame on the client for blocking the completion of concrete goals required to show service effectiveness or to transfer feelings of powerless when stressed and limited within the managed care framework. The social worker must be vigilant in exploring the adequacy of the services provided and implemented. Although it is understandable to want to mourn the loss of “patient care” as it was before, the introduction of managed care and other cost containment strategies make direct social work practice critical.

It can be expected that the future rising of health care costs in conjunction with the need for cost containment will continue to be a practice reality (Alperin, 1994). Therefore, it is essential to link the provision of each service the social worker provides with the cost saving it invokes. For example, traditional services such as provision of hospital discharge planning should emphasize dollars saved in the overall prospective payment reimbursement system. The provision of counseling to assist a family to understand and manage illness limitations and reimbursement procedures could save a hospital countless dollars in potential lawsuits and legal proceedings. Dollar amounts should be calculated for justification of overall savings related to service provisions. For example saving costs through prevention can involve a home health care social worker that assists with psychosocial issues supporting the family to maintain their loved one at home. Social workers can assist clients and family members to acquire needed counseling, to defuse stressed situations, provide needed social support, as well as access to services to maintain community placement. The cost cutting feature of living in the community is phenomenal when compared to inpatient institutionalized care.
The provision of psychosocial services by a qualified professional can serve to create and maintain more options of this nature.

In general, a new mindset needs to be established with psychosocial service provision with each service being related to income generated and/or cost savings. In addition, services without direct income being generated can be valued based on the preventive costs they can save the organization.

Second, for social workers to compete successfully in the managed care market they need to present themselves as an essential ingredient to the success of the health care interdisciplinary team. Social workers need to negotiate for themselves and be equipped with the necessary skills of self-marketing (Gibelman, 1999). This requires professional self-marketing that emphasizes the myriad of services that social workers can provide. In managed care, it has been stated that social workers are viable and effective providers when compared to psychiatrists, psychologists and nurse practitioners (Consumer Reports, 1995). Now social workers need to "toot" their own horns about what they provide (Dziegielewski, 1996; 1998). To start this process the social worker needs to identify each service performed (e.g., discharge planning, referrals, direct clinical work) and to make the client aware that the service is being coordinated or completed by a social work professional. Laypersons may mistake social workers for nurses, teachers, or counselors. Many times social workers become so task oriented that they forget this simple but essential point. It is important for professional social workers to state that they are social workers.

When working within an interdisciplinary team, social workers need to ensure that all members are aware of their contributions toward the overall success of the intervention. This may be done by documenting the services provided and ensuring that other team members are aware of the psychosocial information about clients and families that can help them to complete their jobs assessing risk management and decreasing client dissatisfaction, complaints and lawsuits.

A third aspect for the survival of social work in managed care rests in the macro aspects of the larger environment. Essentially, social workers need to support and lobby for political and social recognition, acknowledging the value of social work services based on the principles of quality care and cost-effectiveness. In
this turbulent environment a clear representation of how social workers can contribute to improve outcomes must be made visible in order to ensure the continuation of current and future positions. Lobbyists are well aware of social works goals and missions and need to be strategically placed as these managed care decisions are being made. Managed care planners need to be made aware of and encouraged to include, the services that social workers can provide.

Lastly, social workers need to continue to grow beyond the traditional social work roles. Social workers need to continue to assume positions such as managers, owners of companies, employees, administrators, supervisors, clinical directors and case managers (Edinburg & Cottler, 1995). In these positions social workers will have increased power to influence specific agency policy and procedure.

In closing, the consistently changing cultural and political environment of modern health care delivery—is not necessarily the downfall of professional social work. Although crisis can be intimidating, it is also a catalyst to change (Roberts & Dziegielewski, 1995). In times of crisis, changes that could never have been made in the previous system may now become possible. Social workers need to acknowledge and accept this challenge swiftly and eagerly. New frontiers that can increase marketability need to be explored and pursued. Today, managed care has created a practice revolution in which social workers must face many challenges, opportunities, and subsequent risks. In spite of these changes, social work’s perspective of “treating the total person” and “the person-environment stance” fits well with the current demand for a holistic medical practice with a focus on wellness and prevention. Now the task of health care social workers is not whether they can survive in managed care, it is how to best utilize their own talents while remaining ethical, active and assertive while providing outcomes driven services.

References

Managed Care and Social Work


Changing Patterns of Acute Psychiatric Hospitalization under a Public Managed Care Program

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This study evaluates changes in patterns of acute psychiatric hospitalization under Massachusetts' Medicaid-funded Mental Health and Substance Abuse (MMHSA) carve-out program. The data consists of the Case Mix Database, for FY 1996 and FY 1997, compiled by the state's Division of Health Care Finance and Policy, on all acute hospital episodes in the state. Key comparisons involve hospital utilization during the nine months preceding the 1996 implementation of the current expanded carve-out program and the subsequent 15 months of its implementation. Secondary comparisons are made between patients funded by the state's two major Medicaid programs, its behavioral carve-out and its contracted HMOs, as well as with other cohorts. Key variables include demographic and diagnostic measures, length of stay and recidivism, source of referral, insurance, socioeconomic characteristics of zip code of residence, and transfers between programs.

Findings include lower than anticipated rates of transfer from the free-care program to the behavioral carve-out program and higher than average and increasing levels of recidivism for patients in the behavioral carve-out program. The final model, based on a Cox regression analysis, correctly predicts 62.9% of the rehospitalization experience, a statistically significant portion of which was attributable to type of insurance coverage. The study also shows that neither the carve-out nor the HMO model of managed care are clearly superior one another.

Managed care strategies for cost-containment and quality control in health care have been used for several decades now,
but it has only been in the last ten years that such initiatives have made significant inroads in the field of public mental health. This has largely been a result of the increased willingness of recent administrations to grant states waivers from the provisions of the Social Security Act which govern the Medicaid and Medicare programs, most typically, a waiver of section 1915b which protects the freedom of consumers in the selection of medical vendors.

In 1992 Massachusetts was the first state to receive such a waiver, permitting it to limit consumer choice (see Hudson, 1999). This enabled the state to contract with a private corporation for the management of its Medicaid program for mentally ill and substance abusing persons. Enrollees in the state's Medicaid program—MassHealth—were at that time given the option to join one of several traditional HMOs or to select a personal care clinician (PCC) who would coordinate their medical care. If the second option was selected, any required mental health or substance abuse care would be provided through the Massachusetts Mental Health and Substance Abuse Program (MMHSAP). This is a behavioral carve-out program contracted to a private corporation which in turn subcontracts with selected hospitals, community agencies, and practitioners for needed services.

The initial vendor responsible for managing the carve-out, Mental Health Management of America, Inc. (MHMA), lost its contract in 1996 to a partnership of Value Mental Health and Options, entitled the Massachusetts Behavioral Health Partnership (MBHP or "the partnership"), despite objections from many in the mental health service and advocacy communities. As extensive as the initial implementation of the program was, it was a partial effort. During the initial period, from 1992 to 1996, the Commonwealth continued to contract directly with many private acute psychiatric units for the care of its most seriously mentally ill citizens. However, on July 1, 1996, Massachusetts not only shifted the contract for the behavioral carve-out to MBHP but substantially expanded the program, including acute psychiatric units which formerly were financed by the state's Department of Mental Health (DMH) through its "replacement program." In addition, emergency outpatient services, previously offered by DMH, were folded into the new carve-out program. In exchange for the additional funds provided to MBHP, this organization
agreed to provide acute service not only to Medicaid recipients but also DMH recipients without Medicaid, as well as those receiving inpatient psychiatric care through the state's free care program. In effect, a parallel mental health system was formalized, one designed to provide acute services rather than continuing care services which the state mental health authority would be restricted to. Despite the magnitude of this change, and the efforts of DMH, as well as the mental health advocacy community, to evaluate this change, only minimal data has been forthcoming from the managed care vendor.

This article will report on the results of an analysis of the Commonwealth's annual casemix database, consisting of records of approximately 750,000 acute hospitalizations each year, for the purpose of assessing changes in the patterns of psychiatric hospitalization—their rate, frequency, length, and periodicity, as well as inpatient services provided and referral patterns upon discharge. Specifically, this study focuses on the FY 1996 and FY 1997 data (from 10/1/95 to 9/30/97) which covers the last nine months of the operation of the initial Medicaid managed care corporation, Mental Health Management of America (MHMA), and the first 15 months of implementation of its successor program, the Massachusetts Behavioral Health Partnership (MBHP). This study, thus, permits a comparison the hospitalization experience under the original and the expanded MMHSA Program.

Specifically, the study addresses the following questions: (i) How are the patterns of psychiatric hospitalization under the state's carve-out Medicaid program different than those in its long standing Medicaid fee-for-service program? (ii) Has the introduction of the expanded managed care program under Medicaid increased the availability of and access to psychiatric hospitalization? (iii) How do psychiatric hospitalization patterns differ under alternative managed care providers, i.e. the partnership versus those contracted HMOs which also serve Medicaid clients? (iv) To what extent are clients who formerly received support through the Commonwealth's free care pool able to access Medicaid? A key area of concern involves comparisons in recidivism rates with the initial vendor, Mental Health Management of America (MHMA), with competing financing options such as the Medicaid fee-for-service program, as well as with the Medicaid-
financed HMOs. However, to do so requires controls for the differing demographic and diagnostic profiles of the populations enrolled under the various plans. To achieve this, this study has used both traditional statistical adjustments as well as a Cox regression in its analyses.¹

The Research Literature. Although there is a growing body of research on managed care in mental health, there are few clear patterns in the findings and many methodological problems limiting their generalizability. Areas typically examined include rates of hospitalization, outpatient service use, social functioning, and costs. One of the few consistent findings from these studies is that levels of psychiatric hospitalization are clearly reduced, compared with fee-for-service arrangements (Finch, Lurie, Christianson, and Moscovice, 1992; Babigian, Mitchell, Marshall, and Reed 1992; Manning, Stoner, Lurie, Christinbason, Gray, and Popkin 1993; Reed, Hennessy, Mitchell, and Babigian 1994. See Mechanic, Schlesinger, and Alpine 1995). Measures of hospitalization include admissions, numbers of days hospitalized, length of stay, and occasionally, recidivism. While two of these studies used random assignment, they were nonetheless limited by the small percentage of eligible patients who could actually be included in the study.²

Findings on the impact of managed care on outpatient service use include few clear-cut improvements, and more typically, no change, declines, or ambiguous outcomes. In one review of these results, Mechanic noted that capitated programs provide “comparable or even improved access to mental health care when compared with the traditional system (1998, pp. 7–8). However, an earlier review concluded that “A substantial body of research suggests that the average use of mental health services in prepaid plans is significantly lower than that under unmanaged fee-for-service insurance.” (Schlesinger, 1989). Most of these studies did not, however, control for self-selection of enrollees. A study of repeated outpatient service requests among users of the City of Baltimore EAP program found considerably heightened levels of recidivism under the managed care option, compared with the fee-for-service alternative. However, controls for diagnosis and similar variables were not used (Fishel, Janzen, Bemak, Mryan, and McIntyre 1993). Another study found increased use of up-
to-date medications among fee-for-service users, compared with those in Medicaid plans. This study did not clearly identify the extent of managed care use among the Medicaid enrollees. One of the only studies to use random assignment produced mixed findings, indicating greater use of outpatient services, but services which were less intensive than those in the fee-for-service arrangement (Wells, Marguis, and Hosek, 1991).

Findings on the impact of managed care on social functioning include even fewer clear-cut improvements or declines, and more results involving no differences or an ambiguous mix of outcomes. The Monroe-Livingston study reported improvements on many psychosocial measures over a two year period, including greater independence and less use of supervised living arrangements (Reed, et al, 1994). Others have interpreted the Monroe-Livingston study as having equivocal findings (Mechanic, et al, 1995). This study was limited by the very small proportion of eligible clients from whom data was successfully collected, despite its use of random assignment. In contrast, the Medical Outcomes Study (MOS) patients treated under the prepaid option developed greater limitations in both physical and role functioning (see Mechanic, et al, 1995). A key study which produced results involving no difference or mixed findings include the RAND project.

While most studies show declining costs under managed care (Chandler, Meisel, Hu, McGowen, and Madison, 1998; Mechanic, 1998; Luft, 1987; Miller and Luft, 1994), some other reports indicate that when total outpatient and inpatient costs are considered together, differences between fee-for-service and capitated programs tend to disappear (Reed, et al. 1994). Mechanic summarizes several of the earlier studies and observed that, “... studies of most types of medical care suggest that the savings emerge primarily through substituting less expensive forms of treatment (typically outpatient services) for most costly (typically inpatient) treatments.” (1995). Concerns have also been expressed that managed care programs reduce costs by displacing them to families and the community, including the social service and criminal justice systems (Mechanic, 1998). Furthermore, there are additional costs associated with the enhanced coordination of services (Frank & McGuire, 1998, p. 46).
The initial formal evaluations of the Massachusetts’ Medicaid-funded MHSA Program found that it reduced costs and maintained access to and quality of services (see Callahan, Shepard, Beinecke, Larson, and Cavanaugh, 1994, 1998; Beinecke, Goodman, & Rivera, 1995). These studies only focused on the first two years of the program, and many of the trends identified did not hold up in the third and fourth years. Unfortunately neither of these studies provided data which was directly relevant to the quality of services, as the studies relied on service providers rating their quality in a time of diminishing resources and competitiveness for managed care contracts, a hardly convincing methodology. In addition, data has not been collected on consumer outcomes, other than recidivism rates. The only consistent increase in community services throughout the period appears to have been in medication utilization; while there were initial increases in crisis care, even this subsided by the end of the program (see Fendell, 1998; Hudson, Dormant, and Wieman, 1998). Thus, while there is some data to suggest that the program saved money, the data on service trends reveal a pattern of reduced utilization of most types of services, except medication prescription. Despite overall provider approval of MHMA, one of the most frequent complaints of the advocacy community has been its failure to share information. Perhaps this illustrates one of the central limitations of the privatization of the oversight of services, that policy decisions and resulting trends become increasingly inaccessible, crippling the ability of advocates to monitor the system.

The most recently published evaluations of the Commonwealth’s Medicaid mental health program (MMHSAP) have focused on the third and fourth years of the work of MHMA, the initial vendor, and have been largely positive, though they have identified several areas of concern. In an informal case study, Sabin praised improvements in the contracting process (Sabin and Daniels, 1999). Similarly, Dickey and her colleagues, argued that MHMA did not let price dictate their selection of hospitals, and that quality considerations tended to dominate these decisions (Dickey, Norton, Normand, Azeni, and Fisher 1998). Based on an analysis of several public data bases, Dickey, et al. concluded that “Positive findings in our study outweigh negative ones. The approach to cost-containment was effective in reducing expendi-
tures for disabled beneficiaries, mental health care, primarily by limiting the price and utilization of inpatient hospital treatment.” (1998, p. 120). In a survey of 98 provider liaisons with MHMA, Beinecke found that “Providers felt that the most positive changes were: (1) reductions in appropriate inpatient admissions and too long lengths of stay; (2) the utilization review process forced many clinicians to look at each client individually, . . . ; (3) changes were beginning to improve the integration of services; and (4) managed care was creating a greater continuum of care by increasing the variety and availability services and developing new specialized services.” (1996, p. 383). In contrast, areas of concern of researchers and their interviewees included the finding that most the savings came merely in the initial stages of the program and only from one subcontract and could not be sustained (Sabin and Daniels, 1999, p. 40); that there was too little follow-up of discharged patients (Dickey, et al., 1998); that lengths of stay were being shortened too much, especially for children; and that recidivism was increasing (Beinecke, et al., 1996). In one of the more exhaustive case studies of the program, Fendell states that “One of the main reasons for concern about the private management of health care systems is the inherent incentive to distort care decisions to meet bottom-line goals.” (1998, p. 35).

Most of these findings pertain to the initial vendor for the Massachusetts Mental Health and Substance Abuse Program (MHM-SAP) — MHMA Inc.—whose contract was not renewed in 1996. Of the many gaps in the research to date, perhaps the most significant is that involving a study of the implementation period of the MBHP vendor, as well as its predecessor—the first and largest of its kind in the nation—so as to determine in a consistent manner the impact of the program on hospital utilization, selected outcomes, and costs, including the possible displacement of psychiatric patients to medical units.

Methods. This study is based on a secondary analysis of the Commonwealth of Massachusetts’ Case Mix database which is maintained by its Division of Health Care Finance and Policy (formerly known as the “Rate Setting Commission”) (see Massachusetts Division of Health Care Finance and Policy [MD-HCFP], March 1998). This division is responsible for implementing provisions in Massachusetts law which require that each acute
care facility annually report data on every discharge. Several major steps have been involved in this analysis: (i) data transfer and file preparation, (ii) aggregation and data transformation, (iii) computation of descriptive statistics; and (iv) use of bivariate and multivariate statistics to examine the key questions of the study. The selection of cases and transformation of the data resulted in a reduced data set of all patients who had one or more psychiatric episodes as well as all their associated medical episodes. This population consists of 40,542 individuals who experienced 105,701 acute care episodes, and these included 34,827 psychiatric stays and 70,874 medical stays of these same individuals.

The preliminary analyses relied on descriptive statistics for the initial review of the data and exploration of key bivariate relationships. This was done through the computation of subgroup means, cross tabulations, zero-order correlations, and survival analyses. Analyses of recidivism have focused on the subgroup of patients who are between 18 and 65 and who were discharged to the community, excluding those who died. In addition, because 30 day and 6 month recidivism rates are reported, all episodes for the final one or six months of the period were excluded so as to permit the possibility of readmission for those at the tail end of this period.

When questions concerned length of stay, recidivism, and referral patterns, the units of analysis involved hospital episodes. An exception is the final Cox regression which was conducted with the first recorded episode of each individual so as to assure independence of the observations, a fundamental requirement for the procedure. However, some of the questions investigated involved individuals rather than episodes. Typically either one of two procedures were used in these situations to generate unduplicated statistics on individual patients. In cases in which only basic descriptive statistics are required, a weighting factor was used which consisted of the inverse of the number of episodes for the particular individual. In cases requiring computation of individual change scores, the data set was aggregated to the individual level after sorting by the patient identifier which was valid for 95% of all records of psychiatric episodes. These typically involved comparisons of diagnoses, severity ratings, insurers,
facilities, or doctors, between the first and last episode of the individual in a given period.

In several analyses an adjustment weight was used to control for the varied demographic and diagnostic profiles of each of the groups of patients receiving various types of insurance. This procedure in effect makes each insurance group comparable to the overall population, controlling for their different age, gender, and diagnostic profiles (see Lee, Forthofer, and Lorimor, 1989, p. 16).

Finally, it should be noted that, in most cases involving preliminary descriptive statistics, tests of statistical significance have not been used. There are two principal reasons for this: (i) we are usually dealing with a population and not a sample, and (ii) because of the large number of cases, if tests of significance were used, most correlations and group differences would be significant, even when they are substantively negligible. Thus, it was decided to focus on the substantive interpretation of group differences, comparing them to the overall population experience whenever possible.

**Reliability of the Data.** Any analysis of administrative databases is inevitably confronted with questions about the reliability of the data, especially when it is obtained through multiple sources. Fortunately, several studies have been conducted, both by the author and by the Division of Health Care and Finance, which provide evidence of the data’s reliability in several important areas. The reliability of data on demographic characteristics of patients, such as age, sex, and race, was investigated by the author through an analysis of the consistency of these fields across multiple hospitalizations of the same individuals. This analysis demonstrated a very high level of reliability or agreement among the three facilities (different for each patient) which provided information on these fields. While gender, age, and Veteran’s status had nearly perfect agreement, agreement about patient’s racial affiliation was also very high, at 0.93 (see Hudson, et al., 1998).

A parallel procedure was used to examine for agreement between separate facilities as to patients’ diagnoses. The resulting Kappas reliabilities range from the slight (0-.19) to the substantial (.60 to .79), most typically falling in the Fair (.20-.39) to Moderate (.40-.59) range. Substantial reliabilities were found with Senile/
presenile organic psychosis (.67), as well as schizophrenia (.74), and moderately strong reliabilities were found with Affective disorders (.54), Adjustment reaction (.48), Alcohol dependence (.59).

Particularly important are variables involving the identification of the patient's insurer. The Division of Health Care Finance and Policy recently completed an analysis of these fields, comparing their own data with that of selected facilities and insurers, including Medicaid, for 1994 (MDHCAP, May 1998). This analysis indicated a good to very good level of agreement. The insurer with the lowest level of agreement was Medicaid, but even in this case, there were precise matches in 69.4% of the cases, and in almost all the remaining cases, 28.9%, there was agreement as to the general insurer, but not the specific plan.

The reliability of several other fields has yet to be investigated, however, it needs to be noted that a few of these lack face validity. These include the presence of a zip code for the employer, treatment procedures used, and the external cause of accident codes, especially those involving self-injury and suicide. All of these have extraordinarily low frequencies which may very well reflect under reporting. Nonetheless, research to date indicates that the key variables, especially the demographic, and to a lesser extent the insurance and diagnostic fields, typically have a good if not excellent level of reliability.

Results

This analysis focuses on the 40,552 individuals who were hospitalized in an acute psychiatric facility within the state in either 1996 or 1997, about 0.66% of the state's population. Of particular interest is the experience of those patients who received services from the Massachusetts Mental Health and Substance Abuse (MMHSA) Program's vendor, either MHMA (n = 805) or MBHP (n = 1,594), as well as those enrolled in the Medicaid HMO option (n = 679).

The Population. In each of the Medicaid carve-out programs, close to two-thirds are female (see table 1), which is considerably higher than the regular Medicaid program in which just under three-fifths (58.2%) are female. In contrast to the Medicaid program, the Commonwealth's free care programs redress this imbalance, as 61.8% of its hospitalized recipients were male.
Table 1

Selected Patient Characteristics, By Type of Insurance, FY 1996–1997

<table>
<thead>
<tr>
<th>Patient Characteristics</th>
<th>MBHP (N = 1,594)</th>
<th>MHMA (N = 805)</th>
<th>Medicaid Managed Care (N = 679)</th>
<th>Medicaid Fee-for-Service (N = 4,790)</th>
<th>Free Care (N = 2,746)</th>
<th>Other Government Program (n = 239)</th>
<th>All Other (31,920)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENDER</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>36.8%</td>
<td>33.1%</td>
<td>30.3%</td>
<td>41.8%</td>
<td>61.8%</td>
<td>54.8%</td>
<td>44.5%</td>
</tr>
<tr>
<td>Female</td>
<td>63.2%</td>
<td>66.9%</td>
<td>69.7%</td>
<td>58.2%</td>
<td>38.2%</td>
<td>45.2%</td>
<td>54.8%</td>
</tr>
<tr>
<td>AGE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–17</td>
<td>11.4%</td>
<td>8.6%</td>
<td>3.5%</td>
<td>16.5%</td>
<td>2.4%</td>
<td>4.6%</td>
<td>6.9%</td>
</tr>
<tr>
<td>18–64</td>
<td>77.5%</td>
<td>77.7%</td>
<td>79.4%</td>
<td>70.4%</td>
<td>86.6%</td>
<td>88.2%</td>
<td>69.8%</td>
</tr>
<tr>
<td>65+</td>
<td>11.1%</td>
<td>13.7%</td>
<td>17.1%</td>
<td>13.1%</td>
<td>11.0%</td>
<td>7.2%</td>
<td>23.3%</td>
</tr>
<tr>
<td>Mean</td>
<td>34</td>
<td>35</td>
<td>38</td>
<td>34</td>
<td>35</td>
<td>38</td>
<td>46</td>
</tr>
<tr>
<td>Median</td>
<td>34</td>
<td>35</td>
<td>37</td>
<td>34</td>
<td>34</td>
<td>36</td>
<td>41</td>
</tr>
<tr>
<td>RACE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Am. Indian</td>
<td>0.6%</td>
<td>0.3%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Asian</td>
<td>1.8%</td>
<td>2.1%</td>
<td>1.5%</td>
<td>1.3%</td>
<td>2.6%</td>
<td>0.4%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Black</td>
<td>7.1%</td>
<td>8.3%</td>
<td>14.0%</td>
<td>11.3%</td>
<td>14.4%</td>
<td>8.3%</td>
<td>6.2%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>19.4%</td>
<td>17.9%</td>
<td>17.3%</td>
<td>12.2%</td>
<td>8.8%</td>
<td>16.5%</td>
<td>4.0%</td>
</tr>
<tr>
<td>White</td>
<td>69.3%</td>
<td>68.8%</td>
<td>65.5%</td>
<td>73.0%</td>
<td>72.8%</td>
<td>73.0%</td>
<td>87.6%</td>
</tr>
<tr>
<td>Other</td>
<td>1.9%</td>
<td>2.6%</td>
<td>1.7%</td>
<td>2.1%</td>
<td>1.3%</td>
<td>1.7%</td>
<td>1.1%</td>
</tr>
<tr>
<td>EMPLOYMENT</td>
<td>4.3%</td>
<td>2.7%</td>
<td>3.0%</td>
<td>9.9%</td>
<td>7.0%</td>
<td>10.2%</td>
<td>11.5%</td>
</tr>
</tbody>
</table>

Unlike MMHSA's lead organizations (MHMA and MBHP) which had a disproportionate percentage of children represented on their caseloads (11.4% & 8.6%), only 3.5% of the HMOs inpatient caseload consisted of children. In contrast, only between 11% and 13% of these program's caseloads consist of persons over 65, considerably lower than the 23% for the remaining programs in the state, however, it is unexpected that the percentage should be this high since persons over 65 are technically not eligible for these particular managed care programs (see table 1). It should also be pointed out that particularly high proportions of the caseloads of the Medicaid managed care programs are persons of color, especially blacks and Hispanics.

A comparison of the diagnostic profiles of the various insurance cohorts reveals that patients under both MHMA and MBHP have a similar profile, clearly more severe than for those under the other plans. At least a fifth (20.0% to 23.2%) of these patients have the diagnosis of schizophrenia (either on a primary or secondary basis), and three-fifths (58.8% to 60.2%), have affective or bipolar conditions, compared to dramatically lower figures for each of the other insurance cohorts.

**Service Coverage.** Although two-fifths of a percent (0.38%) of the state's population are hospitalized each year in an acute psychiatric unit, the chance that any individual will be hospitalized varies considerably throughout the state. The highest rates are found mainly in central Boston, the Northshore, and the urban areas of central and western Massachusetts. The lowest levels of hospitalization are found throughout the Southeastern part of the state, as well as the surrounding suburbs of Boston (see "Service Access" for discussion of socioeconomic correlates).

One of the goals of the state's expansion of the MMHSA Program in 1996 was that it would enroll the seriously mentally ill population whose hospitalizations were previously subsidized by the Commonwealth's free care program. In the first 6 months of the program there was no evidence of any changes in caseload size as would be expected if this mandate were successfully implemented. However, beginning in February 1997, a consistent upward trend in caseload bed day sizes was found resulting in an increase of about 50% in the monthly number of bed days. At the same time, the caseloads of the regular Medicaid, Medicaid HMO,
and free care programs all began to drop (see figure 1). When numbers of patients hospitalized are examined, similar increases were found in the MBHP caseload, but only negligible declines were found in the free care program. Rather, most of the corresponding declines were found in the state’s regular fee-for-service Medicaid program. Thus, case transfers from this program are considerably more likely, yet the associated declines and increases may instead simply reflect the possibility that hospital coding departments are better able to differentiate these the two programs.

Admissions. One of the original goals of managed care was to provide preventative and early intervention services so as

Figure 1

*Individuals Hospitalized per Month, By Type of Insurance*

*Note:* Data represents unduplicated count of individuals, regardless of number of episodes.
to reduce reliance on more expensive emergency and intensive treatment services. In this respect, the Commonwealth's MMHSA Program appears to have done well as only a third (34.1% & 32.9%) of its psychiatric admissions were on an emergency basis, compared with 81.1% for the Medicaid HMOs, and between 44.2% (Other Government) and 69.2% (Free Care) for the other programs. Likewise, the MMHSA Program, compared to all other programs, received the lowest percentage of emergency room referrals and, along with the regular Medicaid program, the highest rate of physician referrals, as well as higher than average referrals from "Other" sources (which include Level 4 nursing facilities).

**Accessibility.** In recent years the pursuit of cost containment goals under managed care has led to widespread concerns about geographic and economic access of impoverished populations to services. With the use of increasingly restricted provider circles it would be expected that service facilities—inpatient units—will be located at increasing distances from patients' homes. This possibility was investigated in this study through the computation of straight line distances between the center point of the patient's home zip code and that of their hospital. The results of these calculations were broken down by time period and type of insurer. Median distances since mid-1996 were typically 4.6 miles, 10.7% greater than they were the year before. However, under the Medicaid managed care programs they ranged from 1.9 to only 3.2 miles, considerably less than most of the other programs. The MMHSA program (MHMA/MBHP) saw a similar 10% increase as was the overall experience. In contrast, the Medicaid HMOs became 57.9% more distant, though this was a increase from only 1.9 to 3.0 miles, hardly a cause of alarm. Thus, while managed care hospital services are becoming more geographically more distant, it would be difficult to argue that they have reached a point of geographic inaccessibility or that the trend was any more serious under the Medicaid program than in other areas.

When the MMHSA program was reorganized in 1996 it was agreed that the new vendor (MBHP) would assume responsibility for the seriously and acutely mentally ill who formerly were hospitalized either under the Department of Mental Health "replacement unit" or the state's free care program. It was possible to investigate the question of whether MBHP has been as-
assuming responsibility for these groups since the state’s case mix database contains a universal patient identifier—an encrypted social security number—which permits tracking patients not only between hospitals but between insurers. The analysis focused on that subgroup of patients who had at least one psychiatric hospitalization prior to the implementation of the new program, and one subsequent to it. Specifically examined were the designated insurers during the first of the hospitalizations during the Oct. 1, 1995 to June 30, 1996 period and the first hospitalization under the subsequent period for which there is available data. In total 4,316 individuals qualified for inclusion in this analysis. The results, summarized in table 2, reveal that a scant 6.7% of the former free care psychiatric population were able to receive MBHP funding during their subsequent hospitalization. An even smaller number under “Other Government Funding”, which would include the DMH replacement program, made the transition to MBHP funding. In contrast, about a seventh of the HMO population (13.6%) and over a fifth of the regular Medicaid caseload were able to make the transition. About four-ninths (44.8%) of the free care group continued on free care; about a third were able to switch to another, presumably private, form of insurance, assuming they became gainfully employed. A negligible number enrolled in the Medicaid HMO program.

An additional analysis of overall economic accessibility was conducted to determine the extent that acute inpatient psychiatric services, and especially those funded by the Medicaid managed care program, are targeted at low-income areas, particularly those with substantial poverty. This was done by aggregating the numbers of hospitalizations to the zip code level, converting them to population rates, and computing zero-order correlations with key indicators of socioeconomic conditions. Table 3 reports these results, and reveals that, as expected, Medicaid coverage rates are substantially correlated with both median family income and poverty rates. To a lesser extent, both the MBHP and HMO hospitalization programs also have the highest rates of coverage in the poorest communities. In contrast, the Commonwealth’s free care program is only marginally targeted at these communities as the correlation with income was almost negligible (median family income, -0.10; Poverty; 0.11; Extreme Poverty, 0.11).
Table 2
Case Transfers Between Insurers During Initial Implementation of the Massachusetts Behavioral Health Partnership (n = 7,460), FY1996–FY1997

<table>
<thead>
<tr>
<th>Primary Type of Insurance</th>
<th>Medicaid MHMA</th>
<th>Fee-for-HMOs</th>
<th>Medicaid Free Service</th>
<th>Government Care</th>
<th>Other All Program</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>MBHP</td>
<td>67.5%</td>
<td>13.6%</td>
<td>21.7%</td>
<td>6.7%</td>
<td>1.5%</td>
<td></td>
<td>10.3%</td>
</tr>
<tr>
<td></td>
<td>(226)</td>
<td>(8)</td>
<td>(139)</td>
<td>(16)</td>
<td>(44)</td>
<td></td>
<td>(436)</td>
</tr>
<tr>
<td>Medicaid HMOs</td>
<td>3.3%</td>
<td>49.2%</td>
<td>4.7%</td>
<td>*</td>
<td>0</td>
<td>1.0%</td>
<td>2.4%</td>
</tr>
<tr>
<td></td>
<td>(11)</td>
<td>(29)</td>
<td>(30)</td>
<td>(0)</td>
<td>(29)</td>
<td></td>
<td>(104)</td>
</tr>
<tr>
<td>Regular Medicaid</td>
<td>15.2%</td>
<td>16.9%</td>
<td>49.1%</td>
<td>13.4%</td>
<td>*</td>
<td>3.6%</td>
<td>12.1%</td>
</tr>
<tr>
<td></td>
<td>(51)</td>
<td>(10)</td>
<td>(315)</td>
<td>(32)</td>
<td>(109)</td>
<td></td>
<td>(522)</td>
</tr>
<tr>
<td>Free Care</td>
<td>*</td>
<td>0.0%</td>
<td>33%</td>
<td>44.8%</td>
<td>*</td>
<td>2.4%</td>
<td>4.8%</td>
</tr>
<tr>
<td></td>
<td>(0)</td>
<td>(0)</td>
<td>(21)</td>
<td>(107)</td>
<td>(73)</td>
<td></td>
<td>(207)</td>
</tr>
<tr>
<td>Other Government Program</td>
<td>0.0%</td>
<td>0.0%</td>
<td>*</td>
<td>0.0%</td>
<td>*</td>
<td>0.3%</td>
<td>0.3%</td>
</tr>
<tr>
<td></td>
<td>(0)</td>
<td>(0)</td>
<td>(0)</td>
<td>(0)</td>
<td>(8)</td>
<td></td>
<td>(15)</td>
</tr>
<tr>
<td>All Other</td>
<td>12.8%</td>
<td>20.3%</td>
<td>21.2%</td>
<td>33.1%</td>
<td>*</td>
<td>91.3%</td>
<td>70.1%</td>
</tr>
<tr>
<td></td>
<td>(43)</td>
<td>(12)</td>
<td>(136)</td>
<td>(79)</td>
<td>(2,760)</td>
<td></td>
<td>(3,032)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>(335)</td>
<td>(59)</td>
<td>(642)</td>
<td>(239)</td>
<td>(18)</td>
<td>(3,023)</td>
<td>(4,316)</td>
</tr>
</tbody>
</table>

Notes: This table reports on a sub-sample, only those persons who had two or more episodes of acute hospitalization in FY1996–FY1997, at least one of which was prior to and at least one subsequent to the implementation of the MBHP program. Caution should be used in generalizing to all persons insured.

* Cells with counts of between 1 and 7; not specified per agreement with Division Health Care Finance and Policy.
### Table 3

**Zero-order Correlations of Hospitalization and Insurance Accessibility with Indicators of Socioeconomic Conditions**  
(*n = 473 zip codes*)

<table>
<thead>
<tr>
<th>Indicators of Socioeconomic Conditions (1990 U.S. Census)</th>
<th>Median Family Income</th>
<th>% Under Poverty Line</th>
<th>% Under 50% of Poverty Line</th>
<th>% of Age 259 High School Graduation</th>
<th>% of House-holds One Person</th>
<th>% Living in Urbanized Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of individuals (undup.) hospitalized in acute psychiatric facilities, 1996–1997</td>
<td>−.41**</td>
<td>.42**</td>
<td>.35**</td>
<td>.35**</td>
<td>.39**</td>
<td>.13**</td>
</tr>
<tr>
<td>Percentage of hospitalized receiving Medicaid</td>
<td>−.51**</td>
<td>.54**</td>
<td>.45**</td>
<td>.56**</td>
<td>.35**</td>
<td>.22**</td>
</tr>
<tr>
<td>Percentage of hospitalized on MBHP</td>
<td>−.35**</td>
<td>.40**</td>
<td>.29**</td>
<td>.51**</td>
<td>.17**</td>
<td>.26**</td>
</tr>
<tr>
<td>Percentage of hospitalized on Medicaid HMO</td>
<td>−.28**</td>
<td>.27**</td>
<td>.18**</td>
<td>.33**</td>
<td>.09</td>
<td>.06</td>
</tr>
<tr>
<td>Percentage of hospitalized receiving free care</td>
<td>−.10*</td>
<td>.11*</td>
<td>.11*</td>
<td>.09</td>
<td>.02</td>
<td>.05</td>
</tr>
</tbody>
</table>

*Notes: The above represent Pearson r's computed based on aggregate zip code statistics, and weighted with relative population size of zip code.*

*α < 0.05  **α < .01*
Length of Stay. There is a widespread belief that cost-saving incentives under managed care contracts are leading to the curtailment of care. In particular, it is believed by many that the length of the stay for the typical psychiatric patient has fallen. This is, in fact, true as the median length of stay in Massachusetts institutions has fallen from 6.5 to 6.0 days just within the two year period of this study, or 7.7%. This represents a similar drop as that experienced under the MMHSA Program, or 6.8%, and considerably more than that under the Medicaid HMOs (3.4%). Other programs saw declines which ranged from a low of 2.7% in the free care program to 7.8% in “All Other”, mainly private insurance programs.

It may be that such differences mask differential discharge practices since each program has a somewhat different profile of patients. For instance, the MMHSA programs serve a higher percentage of patients with schizophrenia and other forms of psychosis. For this reason, median lengths of stay were recomputed, adjusted for the differential age, sex, and diagnostic profile of each group.6 The results of the recomputation of median lengths of stay, using these adjustments, reveals that the MMHSA Program saw the largest declines in median stay, from 7.5 to 6.2 days, a 17.3% decline, almost double that of the overall psychiatric population. Whether lengths of stay should be increased or shortened cannot be determined from this particular data. However, data to be reported under “Outcomes” suggest that the shrinking length of stay is being accompanied by increasingly unfavorable outcomes.

Service Integration and Continuity of Care. A major critique of the traditional fee-for-service insurance plans is that they promote fragmentation of patient care. Patients are reported to “shop around” and frequently change doctors and facilities. Managed care has been held up as a solution to such fragmentation. This question was investigated in this study by comparing doctors and facilities between patients’ earlier and later hospitalizations. To conduct this analysis, those patients who had two or more stays in either of the designated periods were selected for further analysis in which both the facility and assigned doctors were compared between the first and last hospitalization for each patient within the time period of interest. Finally, change rates had to be adjusted to account for the longer period (15 months) subsequent to the
implementation of the new program than that which preceded it (9 months), by multiplying the latter rate by 9/15.

Another analysis conducted involved rates that patients changed facilities between subsequent hospitalizations (see table 4). Just over a tenth (10.5%) of the patients in the MMHSA Program changed facilities, only slightly less than the 12.7% rate for all patients. However, this represented an increase of 3.3%, in contrast to the experience of patients generally which consisted of a 7.3% drop in facility changes. The Medicaid HMOs had, on the whole, the lowest levels of facility change, at .8% which was slightly up from 0% in the preceding period. Thus, while managed care appears to contribute to continuity of care in respect of facilities utilized, this benefit only marginally characterizes the MMHSA program, and is a benefit which appears to be disappearing.

Information on assigned doctors was available only for 1997. This data reveals that the MMHSA Program had the highest rate of doctor changes, at 47.0%, of all the types of insurance examined. The Medicaid HMOs had only a slightly lower rate at 45.8% which was identical as that of the regular Medicaid program, and also somewhat greater than the experience of all psychiatric patients in 1997, which stood at 44.2%. These represent rates of change of doctors, whether or not in the same facility, over the course of two or more hospitalizations during FY 1997 (see table 5).

**Selected Outcomes.** Recidivism rates were initially examined through the computation of percentages of patients who either were rehospitalized in designated periods of time, such as 30, 60, and 90 days, 6 months, and a year after discharge. The 30 day recidivism rates declined slightly, from 16.8% to 16.2%, by 3.4%. Similarly, the rates declined slightly in the transition from the MHMA to the MBHP program, from 18.0% to 17.6%, or by 2.2%. In contrast, there were considerably larger declines in the Medicaid HMO program, from 22.9% to 18.9%, or 17.5%. The only cohort to see significant increases was “Other Government Payments”, the small numbers in this group may lend themselves to considerable instability.

Table 6 reports the six month recidivism rates, broken down about time period and type of insurance. These reveals that the Medicaid managed care options, both the MMHSA Program and
Table 4

Percentage of Patients Changing Facilities, By Type of Insurance and Time Period

<table>
<thead>
<tr>
<th>Type of Primary Insurance</th>
<th>Oct. 1, 1995–June 30, 1996</th>
<th>July 1, 1996–Sept. 30, 1997</th>
<th>Change in Percentage (Col.3-Col.1)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Adjusted*</td>
<td></td>
</tr>
<tr>
<td>Massachusetts</td>
<td>17.5%</td>
<td>10.5%</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>(525)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partnership (MBHP)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>7.2%</td>
<td>3.3%</td>
<td></td>
</tr>
<tr>
<td>Management of America (MHMA)</td>
<td>(209)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Medicaid Managed Care</td>
<td>0.0%</td>
<td>1.3%</td>
<td></td>
</tr>
<tr>
<td>Medicaid Managed Care</td>
<td>(40)</td>
<td>(75)</td>
<td></td>
</tr>
<tr>
<td>Medicaid Fee-for-Service</td>
<td>20.2%</td>
<td>17.0%</td>
<td></td>
</tr>
<tr>
<td>Free Care</td>
<td>12.1%</td>
<td>29.3%</td>
<td></td>
</tr>
<tr>
<td>Other Government Payments(^b)</td>
<td>0.0%</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>All Other(^c)</td>
<td>20.9%</td>
<td>13.6%</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>20.0%</td>
<td>12.7%</td>
<td></td>
</tr>
</tbody>
</table>

Notes: This table is calculated on the basis of the subsample of patients who have had at least two hospitalizations in each of the two designated periods. Change in facility is figured by comparing the first and last facility for each patient within each period.

\(^*\) The “Adjusted” is calculated by multiplying the unadjusted figure by 9/15 to produce an estimate of the amount of changes which would have occurred had this second period been 9 months instead of 15. This is to assure comparability with the first 9 month period.
Table 5

Comparison of Hospital Utilization, By Type (Psychiatric or Medical) and Insurance, FY 1996–FY 1997

<table>
<thead>
<tr>
<th>Type of Insurance</th>
<th>MBHP</th>
<th>MHMA</th>
<th>Medicaid Fee-for-Service</th>
<th>Medicaid HMO</th>
<th>Free Care</th>
<th>DMH &amp; Misc.</th>
<th>All Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAL STAYS OF THOSE WITH PSYCHIATRIC STAYS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Length of stay</td>
<td>9.2</td>
<td>11.1</td>
<td>4.7</td>
<td>5.4</td>
<td>5.4</td>
<td>4.7</td>
<td>5.3</td>
</tr>
<tr>
<td>% Changing facility</td>
<td>0%</td>
<td>2%</td>
<td>3%</td>
<td>16%</td>
<td>5%</td>
<td>1%</td>
<td>19%</td>
</tr>
<tr>
<td>% Changing doctor</td>
<td>6%</td>
<td>9%</td>
<td>16%</td>
<td>9%</td>
<td>11%</td>
<td>22%</td>
<td></td>
</tr>
<tr>
<td>PSYCHIATRIC STAYS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Length of stay</td>
<td>8.4</td>
<td>9.4</td>
<td>6.9</td>
<td>10.5</td>
<td>6.8</td>
<td>7.7</td>
<td>8.8</td>
</tr>
<tr>
<td>% Changing facility</td>
<td>4%</td>
<td>1%</td>
<td>0%</td>
<td>6%</td>
<td>2%</td>
<td>0%</td>
<td>7%</td>
</tr>
<tr>
<td>% Changing doctor</td>
<td>11%</td>
<td>8%</td>
<td>10%</td>
<td>6%</td>
<td>1%</td>
<td>9%</td>
<td></td>
</tr>
</tbody>
</table>

Notes: Computed on subsample of patients who had 2 or more psychiatric episodes during the 1996–1997 period, and if they had medical episodes, had two or more. Changes in facility, doctor, and severity level computed between first and last episode of each individual, and the results of all individuals were then aggregated.

* Severity Levels: 1–Minor; 2–Moderate; 3–Major; 4–Extreme (unavailable for FY 1996).

the HMOs have the highest rates of recidivism, just about 50% (48% and 49%, respectively). These are up substantially from the earlier period, by about 20%. Likewise, they are almost 20% higher than that of the overall psychiatric population, which stood at 41% in 1997. These same rates were then recomputed, adjusting for the differential age, sex, and diagnostic profiles of the various insurance groups. These rates for the MMHSA Program are only slightly lower, and those for the Medicaid HMOs, slightly higher.
Table 6

Six Month Recidivism Rates, By Time Period and Type of Insurance, FY1996-1997

<table>
<thead>
<tr>
<th>Type of Primary Insurance</th>
<th>Oct. 1, 1995-June 30, 1996</th>
<th>July 1, 1996-Sept. 30, 1997&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Percentage Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Partnerships (MBHP)</td>
<td>48%</td>
<td>47.3%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Partnership (MBHP)</td>
<td>(1,564)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>40%</td>
<td>47.3%</td>
<td>24.1%</td>
</tr>
<tr>
<td>Management of America (MHMA)</td>
<td>38.1%</td>
<td>40%</td>
<td>24.1%</td>
</tr>
<tr>
<td>(1,450)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Medicaid Managed Care</td>
<td>41%</td>
<td>49%</td>
<td>19.5%</td>
</tr>
<tr>
<td>(350)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid Fee-for-Service</td>
<td>42%</td>
<td>47%</td>
<td>11.9%</td>
</tr>
<tr>
<td>(2,756)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Free Care</td>
<td>26%</td>
<td>30%</td>
<td>15.4%</td>
</tr>
<tr>
<td>(1,415)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Government Payments&lt;sup&gt;b&lt;/sup&gt;</td>
<td>25%</td>
<td>35%</td>
<td>40.0%</td>
</tr>
<tr>
<td>(102)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Other&lt;sup&gt;c&lt;/sup&gt;</td>
<td>36%</td>
<td>40%</td>
<td>11.1%</td>
</tr>
<tr>
<td>(12,440)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>37%</td>
<td>41%</td>
<td>10.8%</td>
</tr>
<tr>
<td>(18,513)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: This table represents percentage returning to an acute psychiatric facility (psychiatric unit or psychiatric ICU) in Massachusetts, within 6 months of discharge from one. It is computed based on all episodes of acute hospitalization in the Commonwealth, in the designated period, of adults aged 18-65, excluding those who were transferred to another hospital or died while in the hospital. The second figure in each cell is the same rate, but adjusted for age, sex, and psychotic diagnosis.

<sup>a</sup> To compute 6 month recidivism rates it was necessary to also exclude all cases with discharge dates less than 6 months from the end of the FY 1997.

<sup>b</sup> "Other Government Payments" excludes all Medicaid and Medicare, and CHAMPUS.

<sup>c</sup> "All Other" includes all Medicare, Non-managed care Medicare, and all forms of commercial insurance, both traditional and managed care.
However, in both cases the patterns of increasing recidivism are even greater. An examination of similar tables (not included) for 2 and 3 months, and 1 year, reveal the disparities between the various programs exemplified in this table, increase over time, from very minor differences at the one month level, to even greater differences at the one year mark.

A more in depth examination of the differential recidivism rates was possible through a survival analysis in which the likelihood of remaining in the community (or non-rehospitalization) is plotted against time from discharge for each insurance group. This plot (see figure 2) clearly indicates that the experience of MBHP is slightly less favorable than that of MHMA, which covered substantially the same population, and considerably less favorable than all other groups, including free care. While the MBHP experience, according to this analysis represent an almost 55% rehospitalization rate after 15 months, all other groups have rates between 35% and 52% at this point. Since this program has the greatest declines in length of stay and the lowest continuity of care and referral rates, it should come as not surprise that the recidivism rates are among the least favorable of the programs examined.

An important indicator of improvement occurs when patients who have been diagnosed for a particular disorder no longer receive such a diagnosis during a subsequent hospitalization. Of course, some disorders spontaneously remit, and others are persistent even with the best treatments. Complicating the picture is the moderate level of reliability that clinicians have demonstrated in diagnosing mental disorders. Nonetheless, a comparison of diagnoses of the same patients between the first and last hospitalizations during designated periods of time reveals important trends.

Table 7 reports the results of this analysis which are in the form of percentages of patients whose diagnosis was no longer present during the final hospitalization during the designated time period. In all but one of the diagnostic groups—personality disorders—the rates became somewhat less favorable during the most recent time period, despite the fact that this period was longer than the first. As is well known, schizophrenia was found to be the most recalcitrant, with a 16% remission rate, whereas depressive disorder remitted in over four-fifths of the cases (81%)
in the most recent time period. There appears to be few, if any, systematic differences in remission rates among the various insurance groups, other than a general decline in the rates over the two periods studied.

Another indicator of psychiatric outcomes involves changes in severity ratings which each hospital supplies (beginning in 1997) for discharged patients. These ratings consist of Mild (1), Moderate (2), Major (3), and Extreme (4), with a median at 1.4. Just about seven-tenths (69.1%) of all psychiatric patients had no reported change in the severity of their condition between the first and last hospitalization, with the median change score being .03, a very slight and probably negligible level of regression. While
Table 7

Changes in Selected Diagnoses among Patients with Multiple Hospitalizations, By Time Period and Type of Insurance

<table>
<thead>
<tr>
<th>Type of Insurance</th>
<th>Medicaid Fee-for-Service</th>
<th>Free Care</th>
<th>DMH &amp; Misc.</th>
<th>All Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MBHP</td>
<td>MHMA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Oct. 1, 1995 to June 30, 1996**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>MBHP</th>
<th>MHMA</th>
<th>Medicaid</th>
<th>Free</th>
<th>DMH &amp; Misc.</th>
<th>All Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>20%</td>
<td>33%</td>
<td>16%</td>
<td>18%</td>
<td>100%</td>
<td>17%</td>
</tr>
<tr>
<td>Affective Disorders</td>
<td>24%</td>
<td>22%</td>
<td>24%</td>
<td>19%</td>
<td>43%</td>
<td>21%</td>
</tr>
<tr>
<td>Neurotic Disorders</td>
<td>51%</td>
<td>83%</td>
<td>63%</td>
<td>73%</td>
<td>57%</td>
<td></td>
</tr>
<tr>
<td>Personality Disorders</td>
<td>42%</td>
<td>43%</td>
<td>31%</td>
<td>43%</td>
<td>0%</td>
<td>39%</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>50%</td>
<td>71%</td>
<td>100%</td>
<td>66%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>38%</td>
<td>75%</td>
<td>39%</td>
<td>25%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse/Dependence</td>
<td>50%</td>
<td>100%</td>
<td>86%</td>
<td>67%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>20%</td>
<td>0%</td>
<td>58%</td>
<td>100%</td>
<td>90%</td>
<td></td>
</tr>
</tbody>
</table>

**July 1, 1996 to Sept. 30, 1997**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>MBHP</th>
<th>MHMA</th>
<th>Medicaid</th>
<th>Free</th>
<th>DMH &amp; Misc.</th>
<th>All Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>19%</td>
<td>15%</td>
<td>22%</td>
<td>22%</td>
<td>0%</td>
<td>16%</td>
</tr>
<tr>
<td>Affective Disorders</td>
<td>24%</td>
<td>12%</td>
<td>28%</td>
<td>21%</td>
<td>6%</td>
<td>20%</td>
</tr>
<tr>
<td>Neurotic Disorders</td>
<td>44%</td>
<td>75%</td>
<td>54%</td>
<td>51%</td>
<td>100%</td>
<td>56%</td>
</tr>
<tr>
<td>Personality Disorders</td>
<td>39%</td>
<td>30%</td>
<td>44%</td>
<td>40%</td>
<td>67%</td>
<td>48%</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>75%</td>
<td>38%</td>
<td>100%</td>
<td>64%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>31%</td>
<td>41%</td>
<td>39%</td>
<td>23%</td>
<td>100%</td>
<td>28%</td>
</tr>
<tr>
<td>Substance Abuse/Dependence</td>
<td>57%</td>
<td>75%</td>
<td>46%</td>
<td>48%</td>
<td>100%</td>
<td>57%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>50%</td>
<td>0%</td>
<td>72%</td>
<td>33%</td>
<td>100%</td>
<td>81%</td>
</tr>
</tbody>
</table>

*Note:* This table is calculated using the subsample of individuals who have had at least two hospitalizations in either of the two periods. The two periods, thus, represent two overlapping samples. Each diagnosis is coded dichotomously (1—Present; 0—Absent), and diagnosis change is calculated from the first to the last hospitalization during each period in the following manner: From Present to Absent—1; from Present to Present—0. Those who did not have the condition at first hospitalization are, therefore, excluded from this analysis which does not take into account persons who did not have but developed the disorder. When averaged, 100% indicates that everyone who had the disorder at first hospitalization did not have it at the end of the period, and 0% indicates that all these people continued to have the diagnosis. Blank cells indicate there were no applicable individuals for this analysis.
14.1% were given less severe ratings at the final admission, the remainder (16.8%) saw increasing levels of severity (see table 8).

A comparison of these change scores in 1997 between insurance type revealed that the MBHP program had slightly higher levels of regression (.05) than was the case overall (.03), but not as high as the Medicaid HMOs (.14) or free care program (.08). Whether any of these levels of regression can be considered substantive cannot be determined from this data. However, because they point in a similar direction as many of the other indicators, they must be considered a basis for concern.

**Multivariate Analysis.** A central question of this study has been whether the MMHSA carve-out program (including both MHMA and MBHP) have been more or less effective in reduc-

Table 8

*Changes in Severity Ratings, By Type of Insurance*

<table>
<thead>
<tr>
<th>Type of Primary Insurance</th>
<th>July 1, 1996–Sept. 30, 1997</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts Behavioral Health Partnership (MBHP)</td>
<td>.05</td>
</tr>
<tr>
<td>Other Medicaid Managed Care</td>
<td>.14</td>
</tr>
<tr>
<td>Regular Medicaid</td>
<td>.00</td>
</tr>
<tr>
<td>Free Care</td>
<td>.08</td>
</tr>
<tr>
<td>Other Government Paymentsb</td>
<td>.00</td>
</tr>
<tr>
<td>All Otherc</td>
<td>.03</td>
</tr>
<tr>
<td>TOTAL</td>
<td>.03</td>
</tr>
<tr>
<td></td>
<td>(6,001)</td>
</tr>
</tbody>
</table>

*Notes:* All the above represent slight, probably negligible worsening. Numbers in the negative range would represent improvements, and 0, no change on average. This table is calculated on the basis of the subsample of patients who have had at least two hospitalizations in the designated period. Change in severity is figured by subtracting the first from the last severity rating for each patient within the period. Because higher numbers represent greater severity, positive numbers here indicate worsening. Data on severity ratings is not available for 1996 comparisons.
ing rehospitalization when compared with the Medicaid HMO and fee-for-service programs, as well as other options potentially available to this population. Simple comparisons of recidivism rates suffer from the problem of differential casemix which involves the problem of comparing populations with differing diagnostic and demographic profiles. In the descriptive stage of this analysis, this problem was confronted through adjustments for the differing age, gender, and diagnostic profiles of the various populations of interest. This procedures, however, only goes part way in confronting this problem since a limited number of variables can be statistically controlled for in this procedure. Current regression techniques, in contrast, can accommodate a far wider array of controls, and at the same time provide more in depth information on the contributions of each of these predictors in understanding variations in recidivism rates. Since traditional regression techniques can not be used for studies which use time-to-event data, as well as containing cases which have not experienced the terminal event (in this case, recidivism) by the end of the period of data collection, it was necessary to use techniques of Cox regression which represent a form of multivariate survival analysis.

This analysis reveals that when enrollees in the MMHSA Program are psychiatrically hospitalized in an acute facility, they are have a significantly higher than expected risk for rehospitalization. While those in the former MHMA program had a risk 19% higher than expected, those in the MBHP program experienced a 16% higher than normal risk (see table 9). This is after differences in diagnostic and demographic profiles, severity of condition, services provided, length of stay, employment, and distance to hospital are all controlled for. In contrast, in the residual fee-for-service Medicaid program had an 8% higher than expected risk, somewhat less than those in the carve-out program. The one group with a significantly lower than average risk were those in the state’s free care program, who had a 16% lower than expected risk of rehospitalization. Those in the Medicaid HMO program also had a lower than expected risk, of (10%), however, this result was not statistically significant.

Among the control variables, it was found that psychotic diagnosis, and in particular, schizophrenia and affective disorders, significantly increase a patient’s likelihood for rehospitalization.
Table 9

Acute Psychiatric Rehospitalization, Regressed on Selected Diagnostic, Treatment, Demographic, and Insurance Covariates, Using Cox Regression Analysis (n = 32,923)

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>S.E.</th>
<th>Wald</th>
<th>Sig</th>
<th>R</th>
<th>Exp(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenic Disorders Diagnosis</td>
<td>.67</td>
<td>.029</td>
<td>551.9</td>
<td>.00</td>
<td>.05</td>
<td>1.96</td>
</tr>
<tr>
<td>Affective Disorders Diagnosis</td>
<td>.24</td>
<td>.023</td>
<td>107.8</td>
<td>.00</td>
<td>.02</td>
<td>1.27</td>
</tr>
<tr>
<td>Neurotic Disorder Diagnosis</td>
<td>.06</td>
<td>.026</td>
<td>4.8</td>
<td>.03</td>
<td>.00</td>
<td>1.06</td>
</tr>
<tr>
<td>Personality Disorder Diagnosis</td>
<td>.29</td>
<td>.025</td>
<td>128.2</td>
<td>.00</td>
<td>.02</td>
<td>1.33</td>
</tr>
<tr>
<td>Alcohol Abuse/Dependence Diagnosis</td>
<td>.09</td>
<td>.025</td>
<td>13.7</td>
<td>.00</td>
<td>.01</td>
<td>1.10</td>
</tr>
<tr>
<td>Special Symptoms Diagnosis</td>
<td>.14</td>
<td>.066</td>
<td>4.7</td>
<td>.03</td>
<td>.00</td>
<td>1.15</td>
</tr>
<tr>
<td>Adjustment Reaction Diagnosis</td>
<td>.08</td>
<td>.027</td>
<td>8.1</td>
<td>.00</td>
<td>.01</td>
<td>1.08</td>
</tr>
<tr>
<td>Psychiatric Somatotherapy</td>
<td>.26</td>
<td>.055</td>
<td>22.1</td>
<td>.00</td>
<td>.01</td>
<td>1.30</td>
</tr>
<tr>
<td>Other Psychotherapy (than individual)</td>
<td>-.27</td>
<td>.086</td>
<td>9.6</td>
<td>.00</td>
<td>-.01</td>
<td>.77</td>
</tr>
<tr>
<td>Alcohol/Drug Detox or Rehabilitation</td>
<td>.14</td>
<td>.032</td>
<td>17.9</td>
<td>.00</td>
<td>.01</td>
<td>1.15</td>
</tr>
<tr>
<td>Employment (1–Yes; 0–No)</td>
<td>-.13</td>
<td>.033</td>
<td>16.4</td>
<td>.00</td>
<td>-.01</td>
<td>.88</td>
</tr>
<tr>
<td>Distance between Hospital &amp; Home (miles)</td>
<td>-.0012</td>
<td>.00029</td>
<td>17.0</td>
<td>.00</td>
<td>-.01</td>
<td>1.00</td>
</tr>
<tr>
<td>Gender (1–Male; 0–Female)</td>
<td>-.10</td>
<td>.021</td>
<td>22.9</td>
<td>.00</td>
<td>-.01</td>
<td>.91</td>
</tr>
<tr>
<td>Length of Stay (days)</td>
<td>-.00056</td>
<td>.00023</td>
<td>5.8</td>
<td>.02</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>RACE: OVERALL*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>109.1</td>
</tr>
<tr>
<td>TYPE OF INSURANCE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>64.8</td>
</tr>
<tr>
<td>MBHP (Medicaid carve-out, 1996-)</td>
<td>.15</td>
<td>.044</td>
<td>11.4</td>
<td>.00</td>
<td>.01</td>
<td>1.16</td>
</tr>
<tr>
<td>MHMA (Medicaid carve-out, -1996)</td>
<td>.17</td>
<td>.047</td>
<td>13.9</td>
<td>.00</td>
<td>.01</td>
<td>1.19</td>
</tr>
<tr>
<td>Medicaid HMO</td>
<td>-.10</td>
<td>.070</td>
<td>2.1</td>
<td>.14</td>
<td>-.00</td>
<td>.90</td>
</tr>
<tr>
<td>Medicaid Fee-for-Service</td>
<td>.08</td>
<td>.033</td>
<td>5.2</td>
<td>.02</td>
<td>.00</td>
<td>1.08</td>
</tr>
<tr>
<td>Free Care</td>
<td>-.16</td>
<td>.040</td>
<td>17.0</td>
<td>.00</td>
<td>-.01</td>
<td>.85</td>
</tr>
<tr>
<td>Other Government / DMH</td>
<td>-.08</td>
<td>.109</td>
<td>5</td>
<td>.47</td>
<td>.00</td>
<td>.92</td>
</tr>
</tbody>
</table>

Notes: 32,923 cases included for analysis—first hospitalization per subject, aged 18–65, excluding persons with outcome of death. Forward entry used; -2 Log Likelihood = 211,489; Overall Chi-square = 1039.6 (df = 26; Alpha = .0000); Change in -2LL from previous block Chi-Square = 1014.8 (df = 26; Alpha = .0000).

* The following racial categories were coded dichotomously: White, Black, Other, American Indian, Asian, and Hispanic, but are excluded here for brevity as none of the individual categories had significant Wald statistics.
Those with schizophrenia are almost twice (1.96) as likely to return to an acute unit, while those with affective conditions has a risk that is 27% above average (1.27). Similarly, those with a personality disorder are a third (1.33) more likely than those without such a diagnosis to be rehospitalized. Among the treatment variables, both psychiatric somatotherapy and alcohol/drug rehab or detox both increase risk of rehospitalization (1.30 and 1.15), even after the controls for diagnosis, whereas the provision of non-individual psychotherapies, i.e. group and family therapy, diminish the risk by 23% (.77). Also, important in diminishing the risk of rehospitalization are employment (−12% or .88) and being male (−9% or .91). As would be expected, living a greater distance from the hospital also diminishes the likelihood of rehospitalization, by slightly over a tenth of a percent (.12%) per mile.

Among the predictors which had a very small or negligible impact on the likelihood of rehospitalization, were length of stay and race. Controls were attempted for a range of other diagnostic and procedure variables but the contributions of these were so small that these were excluded from the final model. The overall model is highly significant, with a probability of .0000 ($\chi^2 = 1039.6; \text{df} = 26$). A final analysis was conducted for the purpose of assessing the predictive strength of the model. Predictions based on the model were generated for each case and these were then compared with the actual experience of rehospitalization. The model correctly predicted the overall rehospitalization experience for five-eighths (62.9%) of the patients. This figure, however, masks contrasting experiences in the ability of the model to predict rehospitalization among those who are rehospitalized versus those who are not. The sensitivity of model is 42.5%, which represents the percentage of the relapse predictions which were correct (see table 10). In contrast, the specificity of the model is 72.6%, which represents the percentage of predictions of non-relapse which were correct. It is, thus, clear that while the model has a moderately strong ability to predict non-relapse (72.6%), and only a fair ability (42.5%) to predict relapse, that considerable variation in the experience is yet to be explained by conditions not available for inclusion in the current model. Nonetheless, it presents the most comprehensive model available for examining the rehospitalization experience
of those under the Medicaid carve-out program, an experience which involves elevated rates of recidivism of patients in these programs, considering many of the differences in casemix in the various cohorts.

Discussion. Evidence concerning improvements in program accessibility and effectiveness under Massachusetts' Mental Health and Substance Abuse Program (MMHSAP) is mixed. By the last half of FY1997 there was a clear increase in both bed days and episodes of psychiatric hospitalization, at the same time that these decreased under the Commonwealth's free care program. Yet further analysis reveals other more likely explanations for this. When the numbers of individual patients hospitalized are analyzed over time, there were still significant increases in the current vendor's (MBHP) program participation, but negligible decreases in the free care program. Most of MBHP's increases are instead clearly associated with declines from the regular Medicaid fee-for-service program rather than transfers from the free care program. One explanation for this, in addition to that of case transfers, involves the possibility that only recently have hospital coding departments overcome some possible initial confusion concerning these Medicaid programs. An analysis of transfers of individuals between their programs revealed that while only 6.7% of free care patients transferred to MBHP it's the first 15

Table 10

Predictions of Rehospitalization, Based on Cox Regression Model
(n = 32,923)

<table>
<thead>
<tr>
<th>Prediction of Rehospitalization</th>
<th>No</th>
<th>Yes</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsequent Hospitalization?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>72.6%</td>
<td>57.5%</td>
<td>67.7%</td>
</tr>
<tr>
<td>(16,198)</td>
<td>(6,194)</td>
<td>(22,302)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>27.4%</td>
<td>42.5%</td>
<td>32.3%</td>
</tr>
<tr>
<td>(6,104)</td>
<td>(4,517)</td>
<td>(10,621)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>(22,301)</td>
<td>(10,621)</td>
<td>(32,923)</td>
<td></td>
</tr>
</tbody>
</table>
months of its implementation, 21.7% of the larger non-managed care Medicaid program did so.

Despite the marginal, if non-existent, ability of MBHP to pick up on the previously excluded indigent, there is some evidence that MBHP’s services are partly targeted at poor communities. This is no doubt due to the strict financial eligibility rules under the Medicaid program. It should be noted, however, that while the correlation of MBHP hospitalizations with poverty is less than that of the Medicaid program overall, it is considerably better than that of the Medicaid-funded HMO program, and a lot better than that of the Commonwealth’s free care program which is only marginally targeted at poor communities. The other and probably more important reason is the negative correlation between the rate of both mental hospitalization and of serious mental illness itself, on one hand, and poor socioeconomic conditions, on the other hand. This has been one of the most consistent findings in the social sciences (Hudson, C. 1988) and one which was found in this study to be at the $-0.41$ level (see table 3). Approximately 70% of the zip codes in Massachusetts have profiles which fit the pattern of either below average income and above average hospitalization rates, or the reverse.

The picture that the case mix data presents must be cause for concern. Both the continuing declines in lengths of stay, especially the 17% decline under the current vendor (MBHP), and the increasing recidivism rates are consistent with the finding that there is decreasing referral activity made at patient discharge under this program. Mental health professionals have hardly sufficient time to complete their intake assessments before discharge, let alone discharge plans. That 80% of patients over all are not referred—and 90% of those of MBHP’s—is a matter of significant concern, if true. Further research using independent data sources will need to verify their figures, as these could reflect under reporting of discharge planning activities. Whether the trends identified in this study are substantive will only be determined over the course of the next five to ten years. Most the annual shifts of 1% or 2% and greater are certainly important if they accumulate over the course of several years. However, many such changes are unstable and do not progress in a straight line fashion. Thus,
considerable caution must be exercised in interpreting the trends identified here.

The high rates of non-referral are consistent with the particularly high and increasing recidivism rates identified, especially under the current MMHSA Program. That almost a half of patients (48%) are rehospitalized within six months under the MMHSA program, a figure which is up by 20% since the contract with MBHP was issued, should also be cause of concern. The worsening recidivism rates are also consistent with data on declining remission rates in respect to changes in diagnoses and very slight increases in the severity levels of patient conditions. While no systematic differences between changes in diagnoses could be found based on program participation, slightly greater than average changes in severity levels were found with the MMHSAP patients, but not nearly to the degree as in the free care and Medicaid HMO programs.

Another area examined involves continuity of care, in respect to patients' continuation with their same doctor and facility over the course of two or more hospitalizations. In respect to changes in facilities, patients under the current MMHSAP vendor (MBHP) changed facilities slightly less than average (10.5% vs. 12.7%, in 1997), compared with only 0.8% with the Medicaid HMO patients. This MBHP figure (10.5%) was up by 3.3% percentage points from the 7.2% figure under the initial MMHSAP vendor (MHMA), compared with overall declines.

One area in which the MMHSA Program has been true to some of the original ideals of managed care has involved the admission process. Considerably fewer patients are admitted on an emergency basis or from emergency rooms than in the other programs examined, such as the Medicaid HMOs. Instead, the patients' physicians have played a considerably more important role. If, in fact, physicians are intervening earlier in the process of decompensation, it could be that shorter hospitalizations are sufficient. However, the data on discharge planning, continuity of care, recidivism, and other outcomes clearly suggest otherwise.

A central issue confronting policy makers is whether the seriously mentally ill are better served in a speciality carve out program as exemplified by the MMHSA carve-out program, or through a more traditional HMO structure. Clearly the HMO
model assures better continuity of care within the psychiatric sector as well as between medical and psychiatric sectors. Yet most other indicators of quality of care, both in its process and outcomes, are no better, and in some cases worse under the HMOs. Both programs create multiple causes for concern. For this reason, it may be best to continue to offer patients both options, and instead focus efforts on upgrading the quality of services under both plans. Particular organizations, such as the state's mental health authority, should advise its clienteles as to their desired alternative, based on the needs of the particular subgroup under consideration. For the most seriously mentally ill, there are many reasons to work toward improved specialty services which include a comprehensive range of carefully linked programs and other resources, despite many problems in its current implementation. At this point, it would clearly be a mistake to promote either model as the superior alternative for all populations of mentally ill persons.

NOTES

1. Parts of this article are adapted from a preliminary report of the findings: Hudson, C.G., Dorwart, D.R., and Wieman, D.A., 1998.

2. For example, a person with four stays would have a weight of .25 assigned to each stay. Analyses were then conducted on the weighted episodes to produce weighted means, percentages, and other statistics reflective of the underlying population of individuals.

3. This was done first by determining the relative percentage of all patients who fell into the possible combinations the following categories: gender (male/female), age (0–18, 19–34, 35–49, 50–64, & 65+), and diagnosis (psychosis/non-psychosis). Similar percentages were calculated for each insurance subgroup. The percentage of the insurance subgroup was then divided into the corresponding overall subgroup percentage to determine the weight for any individual fitting the designated criteria. One of resulting 140 weights (20 demographic/diagnostic groups multiplied by 7 insurance groups) were then assigned to each patient, based on that patient's particular group memberships in respect to their insurance, gender, age, and diagnosis. The effect of using such weights is the disproportionate stratification of the sample.

4. These reliabilities were evaluated through the use of the Kappa coefficient.

5. The low rates in the Southeastern part of the state may reflect a higher proportion of acute care provided on units in public mental health facilities which are not included in this database.

6. This was done by stratifying or by subdividing the overall population into 5 age groups, 2 genders, and 2 diagnostic groups (psychotic/not psychotic), or
20 strata in total. Relative percentages were calculated for each of the 20 strata, as well as the corresponding strata in each of the 7 generic groups based on insurance. Based on the relative size of these strata a weight was computed for each of the 140 possible combinations, and then assigned to each patient based on his or her personal characteristics and type of insurance. By using these weights, each insurance subgroup is made equal to the overall population in respect to its age, gender, and diagnostic (psychotic) profile.

7. In these analyses, only adults on psychiatric units, between the ages of 18 and 65, who did not die while in the hospital, were selected for analysis. In addition, all cases were excluded from a period of time, i.e. 30 days, at the end of the period of available data, for an analysis of the corresponding recidivism rate, i.e. 30 day. Otherwise, patients admitted during the final month would not have had the required 30 day chance to be rehospitalized, thus, artificially lowering the rates. The longer the period is, the more is the biasing effect, and the greater the cost of its correction through the exclusion of cases.

8. These include: age; the following diagnoses—senile/presenile organic psychosis, alcohol/drug induced psychosis, other organic induced psychosis, paranoid disorder, other nonorganic disorders, psychiatric disorder specific to childhood, sexual deviations, physiological malfunction resulting from mental disorder, acute reaction to stress, specific nonpsychotic disorder due to organic conditions, disturbance of conduct, disturbance of emotions, hyperkinetic syndrome, specific delays in development, psychological factors associated with disease, mental retardation; and the following procedures—psychiatric testing/evaluation, psychiatric interviews, individual psychotherapy, and referral to psychiatric rehabilitation, none of which had an probability of less than .07.

Reference


Book Reviews


Michael Engel is a political science professor in Massachusetts, president of his faculty union, and the author of an earlier text on state and local politics. This book is about his observations of trends in American public education, based on his service as a school board member in a small-town New England school system. Engel's book is a defense of public education and democracy as well as a caution against market-based ideologies which, in his opinion, are rapidly taking over education throughout the United States.

But it is even more than that. The book is deceptively complex. Although the theme is education, some of the concepts apply to every element of public services in the modern era. It appears to have great significance for social services, which are affected by some of the same trends that Engel observes about education.

In the book's 223 pages, the author reminds the reader of the precepts of progressive education, traces some of the great ideological disputes in education in American history, and comments perceptively on the implications of advances in technology as a part of education. Engel is a strong defender of government and the essential nature of local governmental bodies of which the school board is most pervasive and, perhaps, the most important.

He notes that Americans as they become more isolated, become least involved in public spirit, public governance, and politics. As many others have noted, participation and elections by Americans has been on the decline for years. Many Americans seem alienated from government and although they may be pleased with their private lives, they do not seem as concerned as they might be about public issues. If one examines current American social, political, and economic trends, many of which are discussed by Engel, those concerned about civic interests and participation find some disheartening trends. For example, human interactions are often fewer with other humans than with the Internet; children play video games more commonly than sports
and games with other children; the increasing popularity of home schooling; and the growing emphasis on corporate operations of schools. It is not difficult to think about and see the conflicts and likely consequences that Engel illuminates.

Engel's ideas are so complicated and his arguments so diverse, that it is difficult to report on all that he believes in a single book review. However, his one major point is that the effort to provide students and their families with school choice and education vouchers is ultimately a great threat to democratic values and the future of public education, which has, perhaps, been the most democratizing institution in American life. He points out that market ideology, which is inherent in school choice, is a step in the direction of privatizing schools and the corporate control of education. He thinks that school reform must fundamentally reject market ideology as a basis for improving education.

Engel argues that progressive educators such as John Dewey worked to build a egalitarian and democratic society and that the schools were the basis for achieving that goal. However, as Engel points out, the market approach and ideology would remove democratic control from schools and undercut the basic values of public education. Instead, he argues, schools would focus strictly on skills, especially skills that can be taught and eventually used by graduates in the market place. He finds the school choice proponents suggest that schools ought to focus on the basic skills and not be diverted from those pursuits into areas such as the teaching of democracy and social responsibility. Teaching citizenship and the like has little place in an educational system that would be geared to preparing people for specific jobs.

He notes that the approach is nothing new. The social efficiency movement of the 1920s also advocated educational programs that would prepare young people for their specific roles as adults in the social order.

Engel points out that free choice in selecting schools would mean that the more affluent families would choose and use the better schools while neighborhood schools, that may involve a range of socio-economic classes, would suffer under such arrangements. He includes the charter school movement, which is some ten years old, in the equation because those specific kinds of schools are authorized in the laws of most states in ways that
would attract and benefit the most affluent and most talented while neglecting everyone else.

Engel's well researched and clearly stated arguments for democracy and against the encroachment of the market ideology in schools has broader applications than simply public education. One notes that social agencies, both public and private, are increasingly involved in highly specific contracting for services and programs with decreasing emphasis on social reform and citizen involvement.

Many economic approaches would suggest that competition has no place in essential services that are not profitable but that can make all the difference in the quality of a civilization, such as education and social welfare. The increasing trends toward the corporatization of social welfare and the concomitant corporatization of public education suggest the potential for profits and profit motives in both. And, as Engel demonstrates, the long-term outcome is likely to be enhancement of the market and profits to the detriment of democratic processes and values.

Leon Ginsberg
University of South Carolina


Originating mainly in the latter half of the 19th century, philanthropic foundations became a major influence in American life in the 20th. Although historically foundations are among the oldest social institutions, the last fifty years of the twentieth century constituted a takeoff period in the US for the use of private, tax exempt funds for public purposes. Described more elegantly by Martin Bulmer as "the institutionalization of knowledge-based social engineering," there was a ten-fold increase in their number—from 4000 to over 40,000—and a growth in their assets from $3 billion to over $300 billion. While the modern American foundation as a social invention is thus barely a century old, substantial scholarly work did not appear until the late 1950s, with notable books by F. Emerson Andrews, Robert Bremner, Waldemar Nielson, Barry Karl and Stanley Katz, among others. The opening of the Rockefeller Archives gave a further impetus
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to research, and four types of foundations emerged in the US: independent (89%), company (5%), operating (5%), and community (1%).

As an introduction to the history and role of foundations in the US, this brief overview of 173 pages seems designed more for the general reader, rather than an audience of scholars or other professionals, although much can be learned from it. The book is well-written and contains substantial information which would be useful for those unfamiliar with the history, scope and function of philanthropic foundations in industrial societies.

The author, an emeritus professor of history at the University of Mississippi, began his career in 1952 as the research director of one of the first Congressional investigations of philanthropic foundations by the Cox Committee. This is his third book on the role of foundations in the US, and he has also served as the editor of two International Encyclopedias on Foundations, Learned Societies and Research Institutions during his fifty years of professional experience.

Concentrating on the dozen or so foundations with the largest assets, the eight relatively short chapters are clearly written, supported by notes, an extensive bibliography and a useful index. The author touches lightly on some of the most important features of the world of philanthropic foundations, and note their major strengths, as well as some of their more controversial features.

The opening background chapter summarizes in a few brief pages the history of foundations in the ancient and modern world in various countries. It is followed by a review of some of the leading studies and Congressional investigations of foundations in the US, including Walsh (1915), Cox (1952, Reece (1953–4), Patman (1961–72), Treasury Department (1965), Peterson (1969), and Filer (1977). It is notable that in the 25 years since publication of the Filer Commission’s Reports, there has been no further major study of public or private foundations in the US, despite the explosion in their number and enormous wealth. The author believes that the absence of more recent research may be due to the positive response of some of the larger foundations to the criticism of the elitist composition of their governing boards, and to their greater sensitivity to the public’s right to know. Subsequent chapters describe the processes of foundation growth
and change, the evolution of different types of organizational structures and their institutional development, the diversification and professionalization of staff, relationships with government, as well as parallel developments in other countries.

Serious readers who want more than a primer or an introduction to foundations, and seek a more substantial treatment of the subject, in addition to a more critical perspective, may wish to consult other studies such as the recently published *Private Funds, Public Purposes: Philanthropic Foundations in International Perspective* edited by Helmut Anheier and Stefan Toepler, (Klewer Academic/Plenum Publishers, New York: 1999. Also, chapter 20 by Paul Ylvsaker in an earlier work *The Nonprofit Sector: A Research Handbook* Yale University Press, 1987, edited by W.W. Powell, is even shorter, but has greater depth, is also more nuanced, critical but balanced in its assessment of the values, potentials and problematic features of philanthropic foundations.

Ralph M. Kramer
University of California, Berkeley


Is life fair? Is life just? Contemporary theories of social justice address such fundamental questions by setting forth certain principles and normative conditions that would ideally result in justice and fairness. They are grounded in abstract philosophy and provide a critical conception of social justice that paints a utopian picture of society. They challenge us to promote greater fairness in our institutions. In *The Principles of Social Justice*, David Miller starts with the practical and real pursuit of social justice rather than beginning with the usual vague propositions about what social justice is. Thus, the book is inevitably grounded in disagreement. As the author points out at the beginning of the book, while people may be committed to social justice, they still disagree bitterly about it in practice.

This groundbreaking book explores this disagreement and its sources in order to understand how extremely divergent views about what is required to bring about justice might be reconciled when they stem from shared beliefs at a deeper level. The goal of
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This groundbreaking book explores this disagreement and its sources in order to understand how extremely divergent views about what is required to bring about justice might be reconciled when they stem from shared beliefs at a deeper level. The goal of
the book is to discover the underlying principles that people use when they determine that a situation is either just or unjust. By examining empirical research on popular conceptions of justice, the author’s sensitivity to popular opinion opens the way to a closer investigation of the social contexts in which principles of justice are applied. This approach increases the political relevance of the theory of justice that is presented in the book. Yet Miller argues that, while there needs to be a culture of social justice that pervades the major social institutions and guides politicians and officials and voters, it must also constrain people’s everyday behavior even when they are not in a formal institutional role.

If social justice is to constrain everyday behavior, then who and what should be included? Miller addresses issues about the scope of social justice in terms of what resources should be distributed among members of a society and what a society means. In regard to the distribution issue, he concludes that certain core resources can be identified as being of central concern to any theory of social justice such as income and wealth, jobs and educational opportunities, and health care. Miller acknowledges that other benefits might be more arguably included, such as Rawls’ inclusion of self-esteem in his list of primary goods that should be justly distributed. While arguing that there is no canonical list of primary goods, in Rawls’ sense, he asserts that we must be prepared to listen to claims that being deprived of access to an adequate share of one resource makes the people concerned worse off. In regard to defining the scope of a society, Miller argues that the social justice principles that we use are always applied within bounded communities such as nation-states, with issues of distribution often focused on small units such as workplaces. Based on this and other arguments related to the practical application of social justice principles, he concludes that we must think of social justice as applying within national political communities.

Miller develops a sketch of a theory of social justice that argues why it needs to be grounded in evidence about how ordinary people understand distributive justice and addresses disputed practical questions of social justice. In Chapter 4, he raises provocative questions about and then reviews research studies that shed light on the answers. This chapter is the most fascinating in the book, in the opinion of this reviewer. It provides a comprehensive review
of the research related to issues such as: people’s attitudes about what people deserve based on effort expended, their beliefs about equality and inequities, their conceptions of fairness in the face of unmet needs, the impact of self-interest on how principles of justice are applied, and the effect of class membership on one’s general attitude toward social inequality. The conclusions that Miller draws from the evidence are particularly relevant for anyone interested in trying to influence social welfare policy based on awareness of public opinion.

The bulk of the rest of the book is devoted to analyzing three principles of social justice—desert, need, and equality—in a more focused way. People’s opinions about the application of these problematic principles are examined in order to show that a theory of justice rooted in popular beliefs can retain a critical edge and be connected to questions of political feasibility.

This is a complex and ambitious book. Instead of proposing a normative theory of social justice, Miller illustrates how different principles are used in different social contexts. His theory of justice does more than simply report popular beliefs, however. It presents principles of need, desert, and equality that are philosophically coherent and blended together to form a cohesive theory. Miller continues, in the final chapter, to be concerned about the practicality of social justice by returning to the question of political viability. He prospects for social justice in light of two tendencies—globalization and multiculturalism—and concludes, in part, that “the pursuit of social justice in the twenty-first century will be considerably tougher than it has been in the last half of the twentieth . . . and that we will have to think much harder about questions of scope, about what the universe of social justice should be in a world in which economic, social, and political boundaries no longer neatly coincide.”

Dorothy Van Soest
The University of Texas at Austin


What is a community? How do we identify a moral community? What criteria do we use to determine deserving communi-
ties from undeserving communities? Not only are these questions central to the development of modern-day communitarian thinking, but they are also important issues facing scholars, teachers, and researchers who are engaged in community work.

Communitarians espouse the view that the collapse of morality and community are the major problems of modern society. This point of view emphasizes a reciprocal relationship between individual rights and responsibilities in order to construct effective communities. Civic participation, morality, and the value of community over the individual are primary tenets of communitarian thought. In many ways, this emerging intellectual perspective gets at the heart of social work’s concern for rebuilding impoverished communities. Although the communitarian schema is still forming, it is impacting social policy in the areas of poverty, work, and social justice (See, McNutt, John. (1997), New communitarian thought and the future of social policy, Journal of Sociology and Social Welfare, XXIV, 4, 45–56).

The main thesis of Open Moral Communities is the problem of defining communities. The book confronts the unresolved tensions that exist in a community between rights vs. obligations, members vs. strangers, and discipline vs. socialization. Mandelbaum, an avid communitarian scholar, poses no clear answers to these dilemmas. Instead, this difficult-to-read essay challenges readers to think about the aspects of a community that lie below the surface of the neighborhood—that is, about what is essential to community life.

To explore these themes, Mandelbaum identifies three myths: contractual moral communities, deep moral communities, and open moral communities. The contractual myth maintains that a community is valid only if it originates by a voluntary contract among its members and is sustained and disciplined by a general social contract with the community. Contracts manage and control a “way of life” in order to prevent multiplicity and conflict. In contrast, the deep community regards all human beings as social. In the deep community, personal and collective choices correspond to an individual’s integrated place in the world. For example, “factory, family, mosque, club—are represented as parts of a single fabric so that a violation of one area endangers the entire skein” (p. 36). The deep community sets standards of true belief
and correct practice that define, for example, what it means to be an American, a Baptist, or a Wal-Mart employee.

In the narrow conceptual space between contractual and deep moral communities lies the open moral community. Open moral communities recognize that we are simultaneously members of many communities by rejecting the "fit" and "fabric" of deep communities.

Some members of community A also belong to B, but not all do. No members of C belong to A, but A and C are connected by members whom they share in D, and so forth throughout the chain. We move in a complex pattern—now emphasizing one group of claims and then another, leaving one identity and adopting a new one. The possibility that members will exit is implicit in every community. Images of routes of movement between communities and free spaces in which we can be anonymous or unidentified without being stigmatized sustain the openness of the entire structure (p. 40).

This concept of overlapping membership—that is, that we all belong to many different communities at the same time—is most useful because it helps resolve some of the inherent tension between contemporary communitarian thought and concerns for social justice.

The book falls short in suggesting how technological advances in communication can be used to help define a community when it is not place-based. I expected that the author's background in telecommunications and planning theory would merge (at least, theoretically) to offer some ideas for using new forms of electronic communication (e.g., email, web pages, community computer networks, etc.) to develop open moral communities. There are, however, only hints in this direction in the chapters covering community and communication and stories in communities.

*Open Moral Communities* is for serious, social science scholars of a community persuasion. The book is especially appropriate for teaching doctoral seminars to students who are required to build their community research upon a rigorous theoretical foundation. I would also recommend the book to those who plan to engage in public policy analysis.

Alice K. Johnson
University of Illinois at Chicago

This book attempts to make a contribution to the considerable discussion, debate, and documentation of education problems of the urban poor, and how they might be viewed and addressed from sociological perspectives as we end one century and move to another. This is an old and continuing debate that has long historical roots in both education and sociology. The book is divided into three main parts: I (Critical Issues in Urban Education), II (Empirical Issues on Urban Education), and III (In Conclusion: Reflections on the Dilemmas of Urban Education Reform). It is an *admixture* of perspectives of scholars, budding scholars (graduate students), and practitioners on philosophical/methodological issues in sociology and the problems and plight of the urban poor. The title of the book (Challenges of Urban Education) seems somewhat of a misnomer, since the various chapters do not detail *challenges* as much as they discuss philosophical and methodological arguments, present limited case studies and examples of sociologists at work, and practitioner reflections on the difficulties of working in urban education contexts.

The overview by McClafferty, Torres, and Mitchell is a summary of current sociological demographics in the USA having implications for education, critical "theory" perspectives in the field, and quantitative/qualitative methodological debates. It is short on delineating major challenges facing sociologists as they confront the problems of urban education in the 21st century. There is, however, a timely and important discussion of current and changing urban contexts and educational reform.

Part I of this book (Critical Issues) is an odd mixture of critical *theory* perspectives on the sociology of education in the United States (Apple), discussions of a seemingly endless quantitative and qualitative methodological debate in the social sciences, with a proposed "critical theory of methodology" derived from "interpretive structuralism" as a methodological alternative (Morrow), and a reasonable and rather engaging discussion of how sociology might help us make sense of social policy and how sociology as
a field of inquiry might be positioned in future developments in education and policy (Whitty).

Part II of this book (Empirical Perspectives) is again a rather odd aggregation and admixture of research studies reflecting a comparison of Charter Schools in the USA to England’s Grant Maintained Schools, how they came about, their embedded politics and funding, their differences (Wells), the ambiguous role that the private sector can play in school reform (Mickelson), a rather unenlightening “comparative analysis” of school discipline policies and how they are to be understood with variations in school cultures (Fenning, Wilczynski, & Parraga), a description of how a group of university-based sociologists have developed statistical models to assist school districts in understanding changing demographics and student achievement (Dworkin, Toenjes, Purser, & Ayman Sheikh-Hussin), an historical, fluid, literary description of hip hop culture and gangsta rap and how they are to be understood as a reflection of urban culture, challenges to power through a Marxist lense, and the hopelessness in urban culture (with few implications for sociologists and their work) (McLaren), and a high school case study that attempts to show how the frustration, hopelessness, and desperation of the urban poor can be understood and addressed through the application of “critical pedagogy” and alternative perspectives on teaching and learning (Keiser).

Part III of this book (Memoirs of Urban Education Policy Makers) includes a dialogue with prominent, highly experienced higher education and K–12 educators/administrators about their perspectives on historical and predicted issues and problems in the education of the urban poor (Mitchell, Torres, & McClafferty and Handler, Thompson, & Tucker).

This book is a compilation of perspectives on critical theory as a model for sociologists to understand the urban poor (a more appropriate perspective might be critical ideology), yet again another detailed description of the plight of the urban poor (rampant nihilism) and the difficulties of their education, and a few qualitative case studies and interviews that are designed to inform us about sociological “perspectives for the next century.” The book appears to offer little information that is on the cutting edge or that in any seminal way informs either education or urban
sociology as fields of scholarly inquiry. Some of the information is clearly out of date and not well integrated with important literature on schooling. The most salient quote from the book that seems to capture its thematic essence consistent with the literature on school change, reform and the plight of the urban poor is provided by Mitchell, Torres, & McClafferty at the end of Chapter 10 who state:

Much of the cyclical nature of school reform has to do with our need to address, but never to address at a very deep level, the inherent contradictions in capitalist democratic society in which we talk about equality but have social systems that are geared fundamentally around issues of inequality (p.312).

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The telling of history is more than the chronological enumeration of events; it involves the interpretation of these events and the construction of a coherent explanation of why particular events occurred and how they evolved over time. Both books reviewed here successfully transcend the narrative style of many previous histories of the evolution of the social work profession, and offer novel perspectives that make a significant contribution to the literature. Kendall’s contribution lies in documenting and explaining the history of social work in Europe and elsewhere. Leighninger’s contribution has resulted in the compilation of an excellent anthology of excerpts from the writings of some of social work’s founders. Both books are readable, engaging and important!

Katherine Kendall’s contribution to fostering an awareness of international developments in social work and social welfare among social workers in the United States has been widely recognized. She has long been viewed as a leader in international social
work. She has sought to demonstrate to colleagues the importance of understanding international developments and of transcending a preoccupation with domestic concerns. Her legacy finds expression in the ways many more social workers today take it for granted that their daily professional lives are inextricably linked to global events. Her professional commitments and numerous publications have fostered the integration of local, national and international perspectives in the profession.

Kendall’s new book was published in the year she and her many friends celebrated her 90th birthday. The book is not only a remarkable achievement for a 90 year old—it is an major achievement for an author of any age. As noted earlier, it transcends the tendency to offer descriptive narratives and instead, draws on her own perspective to provide many new insights into the evolution of social work in Europe. For example, it is not well known in the United States that the first professional school of social work was, in fact, established in Amsterdam in 1899—several years before similar schools were created in Chicago, London and New York. (The Charity Organization Society in New York had previously operated a summer program but it was not until 1904 that this program evolved into a propriety school). Nor it is widely known that the oldest school of social work in the developing world was established in Santiago in Chile in 1925—many years before social work education in the United States fully took hold.

However, the book contains much more than interesting facts. Kendall’s analysis of the people and forces at work in the evolution of social work is highly original. While the role of Settlements and Charity Organization Society is given appropriate emphasis, she shows how the ideas of John Ruskin influenced the founders of social work both in the COS and Settlements. Ruskin’s anti-modernism offered a interpretation of social need that fostered a combination of romantic, communitarian and religious beliefs which significantly shaped the profession’s meliorative mission and continues to exert influence today. On the other hand, the efforts of the Fabians to link social work with organized political action at the highest level did not endure. Although social workers including Clement Attlee, Jane Addams, Harry Hopkins and others did engage the political process, social work does not influence political decision making to the same extent today. The
recent U.S. elections may offer an opportunity to reinvigorate social work's historic involvement in politics. Not only were several social workers newly elected to Congress but the presence of a greater number of women in the Senate may prove helpful to the profession.

Leighninger's collection of excerpts from the writings of some of the profession's founders is equally interesting. The excerpts, which are brief but pointed, are nicely organized under a series of headings that deal, in turn, with the beginnings of social work training in the 1890s, the creation of the first social work schools around the turn of the century, the relationship between the schools and the emerging profession, and the characteristics of social work education by the time of the first World War. Leighninger is one of only a handful of historians to have documented the efforts of African Americans to promote social work education at the historically black universities. The inclusion of content on this topic is an important and welcome addition to the literature. By letting the founders of social speak to us many decades later, her collection is both poignant and important. Many of the people social work students will hear about in introductory lectures are included. Edith Abbot, Edward Devine, Mary Richmond, Zilpha Smith and yes, the infamous Abraham Flexner, come alive. Like Kendall's book, this excellent collection is essential reading not only for students, educators and practitioners, but for anyone interested in how the social work profession emerged and evolved in the early decades of the 20th century.

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Book Notes


Amazingly comprehensive for such a short history, this book addresses the fundamental concerns of sociological thought from its roots in Greek philosophy to current discourses and debates in the field. The first part of the book reviews selective features of classical sociology. This includes discussions of the problems of industrialization and modernization and how positivism helped sociologists address these issues. Overviews of the works of Karl Marx and Emile Durkheim follow with references to their influences and key ideas on sociological thought. Variants of Marxism that emerged after Marx’s death are also examined.

The second part of the book links classical sociological thought to modern sociology. Beginning with functionalism, it reviews the key features of the discipline in the twentieth century. Included are readable overviews of ideas about symbolic interaction, structuralism, and post-structuralism. The problems of agency and structure which have been debated in the discipline since its origins are also reviewed. Singlewood also discusses the relevance of post-modern thinking to sociology. This discussion leads to a useful examination of the new social movements that currently affect the discipline.

The book’s greatest strength lies in its ability to integrate classical sociological thought into a discussion of contemporary issues in the discipline. The clear writing and breadth of the book will help both beginning and advanced students of sociology gain a greater understanding of theory. For this reason, it deserves to be widely prescribed.


It is only in recent years that the practice of female circumcision in parts of Africa and the Middle East has become generally known and predictably, it has been widely condemned. It has
severe health implications both in terms of its immediate consequences for the young girls who are subjected to the operation, but also in later life when women, and particularly those who have experienced infibulation, often suffer medical complications. Its role in maintaining patriarchal and sexual domination over women has also been stressed, particularly in feminist writing on the subject. There seems to be no ground for justifying a practice that many regard as a barbaric ritual.

Yet, as Ellen Greunbaum's extremely informative and balanced book suggests, the issue is very complicated. Written from an anthropological perspective, the book presents an analysis which draws extensively on the interpretations of the very women who have been subjected to the operation. It reveals the diverse functions which the practice serves and the way it is perceived and interpreted by women themselves. It also draws attention to the hypocritical way Westerners condemn the genital mutilation of girls but have no qualms about the fact that boys are also subjected to genital mutilation not only in Africa but in many other parts of the world, including the United States. However, Greunbaum does not offer an apologetic and instead shows how an appreciation of the cultural, economic, familial and political functions of female circumcision can lead to reforms that will be accepted. Indeed, her book has positive implications for policy and makes important recommendations that can effectively address the challenge of eradicating a deeply entrenched but harmful practice. In addition to its sensitivity, the book's optimism about the prospect of reform is encouraging.


Much has been written over the last decade about globalization and its adverse effects on people's well-being. Much of the literature has focused on the way globalization has undermined the sovereignty of nation states and drawn them into a world capitalist system that, it is claimed, deprives governments of the ability to regulate economic activities to their own national advantage, and that of their citizens.

Writing within this framework, Castles and Davidson focus on the political ramifications of globalization and particularly on
its implications for the notion of citizenship. In modern democracies, citizenship has become institutionalized as a means of ensuring individual rights and of balancing them with community obligations. However, the notion of citizenship is firmly rooted in the political and cultural context of the nation state. Citizenship rights and duties are defined and realized within a bounded national political and social system that is often based in a shared ethnic and cultural identity.

As many more people travel across national boundaries and take up residence in nations states that are not their own, the very essence of the concept of citizenship is being challenged. For this reason, the authors call for new ideas that redefine the notion of citizenship. Many more people now live in societies which deny them citizenship rights. Many others live in more than one society and often move between them and again, many do not have political, social and other citizenship rights in these societies. If democracy is to have meaning in a world that is increasingly shaped by globalization, a new conception of citizenship that accommodates changing demographic and cultural realities will be needed.

The book considers these issues in a readable and informative way and makes a number of interesting suggestions for a reconceptualized concept of citizenship. The authors are particularly committed to the idea that citizenship status needs to be decoupled from ethnic or cultural status. They also consider the prospects of global citizenship. The book has implications for social welfare, and particularly for the way the notion of social citizenship based on a theory of social rights is being undermined within the global capitalist system.


Accounts of the history of social policies and programs are often descriptive providing chronological narratives of their evolution. Indeed, it was not until the 1970s, that the first systematic attempts to use theory to analyze the development of social policy were made. The tendency to apply theory is more widespread today, and social policy scholarship now frequently employs established conceptual approaches to frame the material and
interpret historical events in the light of the analytical insights of theory.

This book augments this tradition by drawing on Michel Foucalt’s theoretical work on the subject of ‘governmentality’ to analyze the way the issue of unemployment has been defined and managed by Western governments over the last hundred years. Walters shows how unemployment has been defined in different ways by the state during this period. Indeed, he contends that the concept of unemployment did not exist until the end of the 19th century when industrialization created pressures for governments to respond to what was increasingly perceived as a problem that not only affected individual workers but undermined family life, the moral order and cherished social institutions. Attempts to deal with unemployment were, therefore, not necessarily motivated by altruism but by many other complex considerations which give expression to the role of government in regulating the welfare of its citizens. In pursuing this task, the problem of unemployment has frequently been redefined. Early definitions that viewed unemployment as a function of disorganized labor markets, or of deficient moral character have given way to new conceptions that emphasize social risk or, increasingly today, of a lack of skills. While these diverse conceptions produce different policy responses, all seek to regulate the problem through state intervention.

However, in offering this analysis, Walters rejects simplistic deterministic accounts which emphasize the role of structural forces in interpreting events. The author rejects these explanations and offers a more complex analysis which draws on the use of a genealogical methodology. This methodology, he contends, provides more powerful insights. Walters has written a sophisticated account not only of the history of unemployment but of the way social problems are defined and handled through practices of governmentality. His book should be widely consulted.


Many books and articles designed to assess the impact and legacy of the Clinton presidency are likely to be published during
the next few years. Indeed, as Steven Schier points out in this recent publication, several books (including his own) on the subject have already appeared. While each will emphasize particular aspects of the Clinton record, his own book emphasizes the way the Clinton administration gave expression to the cultural and political themes of the post-modern age within which, he contends, the administration functioned. As he put it, Bill Clinton's style of leadership "fared well in a culture grounded in ambiguity, confusion and irony (p. 1)." The book thus conforms to a tradition of political science analysis which places more emphasis on the role of institutional factors in determining a political agenda than the personal skills, commitments or intentions of presidential incumbents. While personal characteristics do matter, wider forces are more important in determining the way the presidential record unfolds.

Framed by this theme, the book examines diverse aspects of the Clinton presidency. Its chapters range over topics such as economic policy, race and gender politics, foreign policy, and Clinton's relations with the public. An interesting introductory chapter examines the way Clinton used his personal style to address the forces which impinged on his administration and sought to shape his executive style. Clinton was enormously successful in responding to these challenges often in idiosyncratic and unpredictable ways, and his ability to survive political onslaughts including the offensives associated with the Lewinsky scandal were remarkable. The book contains three chapters dealing with Clinton's relationship both with the Republican and Democratic Parties in Congress, and his ability to negotiate with them.

Although none of the book's chapters are specifically concerned with social policy, material on welfare reform, health care and similar initiatives are briefly addressed in different places. However, it is a pity that the editor did not allocate a separate chapter for a full discussion of social policy issues. Clinton's legacy in managing and directing social policy in the wake of the Reagan revolution deserves much more attention. Hopefully, a book that addresses this topic will soon appear.
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