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ERRATUM:
In the article from December 2011 titled, “Health Services Access for Rural People Living with HIV/AIDS in China: A Critical Evaluation,” authors Wang, Zhang, Xu, & Zhang state that 2.396% of the population of China is currently living with HIV/AIDS. This should be 0.02396%, not 2.396%.

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THE FEMINIZATION OF SOCIAL WELFARE: IMPLICATIONS OF CULTURAL TRADITION VIS-À-VIS MALE VICTIMS OF DOMESTIC VIOLENCE
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As pertains to feminization of social welfare, the inability to acknowledge male victims of domestic violence is attributed less to personal preference and more to cultural traditions of the Western patriarch. Yet, according to scholarly literature, men in the U.S. are equally as likely to be the victims of domestic violence by women as are women by men. Solutions to cultural tradition aimed at eliminating male victims of domestic violence must necessarily begin with acknowledgement of the characteristic warning signs and symptoms. Moving beyond the feminization of social welfare as pertains to domestic violence can be accomplished by the recognition that cultural tradition should not be the sole determinant of services. An effective tool is application of more objective policy models which better locate the role of culture in the perception and attention to all victims in need.

Key words: feminization, social welfare, domestic violence, male victims, cultural tradition, policy

According to Merriam-Webster (1993), social welfare is defined as “organized public or private social services for the assistance of disadvantaged groups” (p. 1115). According to Zastrow (2009), in America the social welfare system operates by way of the “residual” model. In the residual model a stigma is attached to receiving social welfare aid. Those who require assistance are perceived by society as dysfunctional or otherwise inadequate. The underlying cultural traditions associated with the residual model of social welfare discourage
societal provisions for male victims of domestic violence and inhibit the willingness of same to seek social welfare services. Thus, the social welfare system in America at federal, state, and local levels has operated within a cultural tradition which sees women as victims and men as perpetrators of domestic violence (Loiacono, 2010). Commensurate with such traditions, women in need have qualified for various social welfare services less available to men (Mincy, 2006). This began in 1935 when Democrats founded the Social Security Act, which was mainly a means to assist needy elders, but included a provision for women unable to sustain themselves without support of welfare services (Grabham & Smith, 2010). The Social Security Act offers a dramatic illustration by which social welfare disparities between men and women can be exposed and investigated. Aid to Families with Dependent Children (AFDC) and the Maternal and Child Health program benefitted women in need without public opposition because said services reserved for women conformed to cultural tradition, hence feminization (Smith, Brooks-Gunn, Klebanov, & Lee, 2000).

The prestige brought by the federal government in funding social welfare services comes from a culturally-motivated public and political intervention. By its own policies and actions government then influenced the institutions of social welfare to the extent that services now show less consideration to needy men (Jagannathan, Camasso & Sambamoorthi, 2010). This is so despite evidence acknowledging males in need, resulting in the feminization of poverty. Subsequently, while the feminization of poverty did not result in less attention to poor men, the feminization of social welfare has resulted in less attention to male victims of domestic violence.

According to Pearce (1978) and Northrop (1990) the feminization of poverty illustrates an existing bias against women and/or female-headed households. Subsequently there exists a disparity in the levels of poverty between men and women. This feminization of poverty may also account for the increasing impact of sex roles as a determining factor in both perceived rates of poverty and the ability of male victims of domestic violence to access social welfare services.

Because of feminization, the evidence of men victimized by domestic violence has not been sufficiently addressed in
The Feminization of Social Welfare

The feminization of social welfare illustrated by domestic violence as vehicle is a long-standing tradition embedded in the cultural perception of women as care-givers (Wakabayashi & Donato, 2006). In Western patriarchal societies such as the U.S., women as care-givers are assumed subject to the authority of men. In fact, women as care-givers are no more or less significant to care-giver roles than are men to whose authority they are assumed subjected. What's more, those among public discourse (Hines & Douglas, 2010). Efforts on the part of government less inclined to assist male victims of domestic violence are embraced by the most politically conservative members of society (Mayer, 2008). Those who object do so only regarding which programs serve which population and how much they should cost. The feminization of social welfare as a cultural tradition and its implications for male victims of domestic violence are seldom acknowledged.

The intent of this paper is to illustrate vis-a-vis domestic violence the impact of feminization upon the provision of social welfare services as pertains to male victims. While feminization will be addressed in the context of domestic violence, it is suggested that feminization permeates all aspects of the social welfare system because it is commensurate with the cultural traditions of Western civilization (Kimenyi & Mbaku, 1995). Feminization herein is thus defined as a social, institutional and political motivation to sustain objectives, however unintended, counter to assisting males in need (Kelleher, 2010). By addressing feminization of social welfare through domestic violence this paper will expose the disservice characterizations of an otherwise vulnerable population of men who, by cultural tradition, are designated less entitled (Hall & Pizarro, 2010). The vulnerability of these men provides a rationale for the construct of a more scientific and/or technological social welfare paradigm to objectively allocate social welfare resources. The following will facilitate comprehension of the circumstances: (1) the feminization of social welfare; (2) a brief overview of domestic violence; (3) male victims of domestic violence; and (4) solutions to cultural tradition.

The Feminization of Social Welfare

The feminization of social welfare illustrated by domestic violence as a long-standing tradition embedded in the cultural perception of women as care-givers (Wakabayashi & Donato, 2006). In Western patriarchal societies such as the U.S., women as care-givers are assumed subject to the authority of men. In fact, women as care-givers are no more or less significant to care-giver roles than are men to whose authority they are assumed subjected. What's more, those among
decision makers who reinforce feminization in the context of cultural traditions are more often male judges, male politicians, male police officers, and male social workers employed in the social welfare system (Muller, Desmarais, & Hamel, 2009). Thus male social workers who should oppose patriarchy are no less culpable than women in sustaining it. Their inability to acknowledge male victims of domestic violence is attributed less to their personal preference and more to traditions of the Western patriarch. Subsequently, by Western patriarchal tradition, submission is believed of women (i.e., victim) and aggression is believed of men (i.e., perpetrator). Social welfare programs and services are then necessarily feminized, because the benefits of patriarchal chivalry have been the traditional cultural domain of women (Herzog & Oreg, 2008). Yet according to McNeely and Robinson-Simpson (1987), scholarly literature published in respected peer-reviewed journals consistently illustrates that men in the U.S. are equally as likely to be the victims of domestic violence by women as are women by men.

The feminization of social welfare is recapitulated among male social workers who provide services to women clientele. According to Hall (2007), male social workers who do not actively oppose male patriarchy are in fact breeching the NASW Code of Ethics (1999). Hall’s insistence that male social workers actively oppose patriarchy leaves little doubt as to its existence. In Black Males Left Behind (Mincy, 2006), referring to Pouncy’s contention that “opposition comes from advocates for low-income women” (p. xvi), the feminization of social welfare is then institutionally sustained as standard. Evidence exists in gains made by low income women and is suggested in their higher earnings brought by welfare reform efforts. According to Haskins (2001), both employment and earning gains for women during the Clinton Administration were much stronger than for similarly economically situated men.

Voyce (2008) investigated the significance of cultural tradition in male patriarchy relative to domestic violence. Subsequently it was determined that male patriarchy as a cultural tradition is also manifested in affairs of the state relative to its administrative apparatuses of power contributing to feminization. Said manifestation is apparent in both legal and illegal forms of male power. Thus wealth as a male cultural
tradition is sustained as a critical form of governance. Such dynamics operate similarly to sustain the perception of women as exclusive victims of domestic violence. It is, in essence, the means by which the feminization of social welfare is normalized institutionally (Schuh, 2006).

The aforementioned pertaining to the feminization of social welfare is normalized not only by the cultural traditions of its patriarchal institutions but by the associated social welfare scholarship as well. That normalization is evident in the databases where feminization by cultural tradition has dominated scholarly literature (Monteiro, 2000). This otherwise obvious assumption is not the least subject to challenge, as indicated by one of social welfare’s most esteemed sources: the Social Work Abstracts database.

The Social Work Abstracts database contains peer-reviewed papers published for years 1964 to 2010. The following terms alluding to feminization as cultural tradition were searched by the author: men (3,861), women (7,402), mothers (3,680), fathers (1,500), husbands (631), and wives (790). The results indicate that papers published on men were only 52% (52.16) of those published on women. Papers published on fathers were only 41% (40.76) of those published on mothers. Papers published on husbands were only 80% (79.8) of those published on wives. Such disparities reflect cultural traditions which influence social welfare agencies to prioritize services and resources commensurate with the feminization of social welfare, not exclusive of domestic violence.

A Brief Overview of Domestic Violence

A brief overview of domestic violence can also be gleaned from the databases pertaining to papers published. One of the largest data bases is Proquest, which contains scholarly papers written from 1894 to 2010. To assess the issue of domestic violence, the author searched the following terms: male batterer; female batterer; male perpetrator; female perpetrator; male victims; female victims; women victims; men victims; violent men; violent women. The results are presented in table format (see Table 1).
Table 1. Domestic Violence Search in Proquest Database

<table>
<thead>
<tr>
<th>Search Terms</th>
<th>Number of Results</th>
<th>Percentage of Majority Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Batterer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>134</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
<td>5%</td>
</tr>
<tr>
<td>Perpetrator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>710</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>366</td>
<td>52%</td>
</tr>
<tr>
<td>Victim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1,384</td>
<td>49%</td>
</tr>
<tr>
<td>Female</td>
<td>2,803</td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>47</td>
<td>6%</td>
</tr>
<tr>
<td>Women</td>
<td>798</td>
<td></td>
</tr>
<tr>
<td>Violent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>1,129</td>
<td>22%</td>
</tr>
<tr>
<td>Women</td>
<td>252</td>
<td></td>
</tr>
</tbody>
</table>

According to Table 1, papers pertaining to female batterer (7) were 5% of those pertaining to male (134); papers pertaining to female perpetrator (366) were 52% of those pertaining to male (710); papers pertaining to male victim (1,384) were 49% of those pertaining to female (2,803); papers pertaining to men victim (47) were 6% of those pertaining to women victim (798); papers pertaining to violent women (252) were 22% of those pertaining to violent men (1,129).

The Social Work Abstracts is a database aimed specifically at the social work professions. It contains scholarly papers published from 1964 to 2010. To assess the issue of domestic violence, the author searched the following terms: wife victim, husband victim; male batterer; female batterer. The results are similarly presented in Table 2. According to Table 2, papers pertaining to husband victim (28) were 58% of those pertaining to wife victim (48); papers pertaining to female batterer (18) were 51% of those pertaining to male batterer (35).

While most victims of domestic violence are women, those prone to acts of domestic violence cannot be universally
identified as male (Stuart, Meehan, Moore, & et al., 2006). The community appearance, status and demeanor of perpetrators, regardless of sex, make them appear personable and loving to their partner and family members. Their acts of domestic violence may occur in private, concealed from public display. They may act out physical violence against their partner by injuries easily hidden, such as scars not normally visible due to clothing or injuries which do not require medical attention. What qualifies such assaults as domestic violence is that they do not occur by accident. Perpetrators do not act solely out of stress, excessive drinking or drug abuse. Domestic violence is in fact committed for purposes of control by one partner of the other. The ensuing level of violence may escalate until the desired control outcome is reached. Failure to reach such an outcome may conclude in homicide (i.e., murder or otherwise death) (Liem & Roberts, 2009).

Table 2. Domestic Violence Search in Social Work Abstracts Database

<table>
<thead>
<tr>
<th>Search Terms</th>
<th>Number of Results</th>
<th>Percentage of Majority Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Batterer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>18</td>
<td>51%</td>
</tr>
<tr>
<td>Victim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husband</td>
<td>28</td>
<td>58%</td>
</tr>
<tr>
<td>Wife</td>
<td>48</td>
<td></td>
</tr>
</tbody>
</table>

Some of the most thorough investigations of domestic violence have been conducted by scholars in the U.S. The executive of the Family Research Laboratory at the University of New Hampshire, Murray Straus, and a sociologist at the University of Rhode Island, Richard Gelles, are amongst the most noted. For more than twenty years they have tracked domestic violence, compiling what are believed to be the most accurate data available through the National Family Violence Survey (NFVS). It was funded by the National Institute of Mental Health (NIMH). According to what investigators
found, 84% of American families do not engage in domestic violence. Of those 16% who are violent, most engage in some form of slapping, shoving, and grabbing. Approximately 3-4% of about 1.8 million engage in extreme forms of domestic violence including kicking, punching, or using a weapon. Straus and Gelles further contend that 188,000 women a year are subjected to violence severe enough to warrant medical attention. While that number is extreme, it is not in the assumed millions that some have reported (Gelles & Straus, 1988).

Other studies pertaining to domestic violence include that published by O’Leary, Barling, Rosenbaum and Tyree (1989). It involved 272 couples in a longitudinal study of early marriage. Results indicated that 44% of the women compared to 31% of the men were physically aggressive. After 18 months, 36% of the women and 27% of the men reported being physically aggressive. After 30 months of marriage, investigators found no significant differentiations in physical aggression between men and women. However at each interval women were, in fact, more aggressive than the men to whom they were married. These various forms of aggression included pushing, shoving, and slapping. By the use of conditional probability analysis, and given the likelihood of aggression at 30 months and before marriage and at 18 months after marriage, scores were .72 for women and .59 for men.

**Male Victims of Domestic Violence**

In 2009, a male cheerleader at the University of Missouri was brutally attacked by two players on the women’s basketball team. The incident was preceded by the cheerleader’s decision to conclude a team party being held at his residence. He thus requested that guests vacate the premises. However, as reported by the local *Riverfront Times* newspaper, the two noted women players, unprovoked, began a violent assault upon the male cheerleader. They beat and punched him about the facial area until they broke his nose and injured his eye. Party-goers attempted to restrain the assailants but were unable to do so. Both players were suspended from the team and were not prosecuted (Garrison, 2009).

Twelve percent of homicides in the U.S. are committed
by women, and 12% of the serial killers are women (Newton, 2000). They are likely to murder a spouse 19% of the time, a friend or acquaintance 17% of the time, and a boyfriend or girlfriend 10% of the time. What’s more, the rationale for women who kill is money 41% of the time. When an abused woman murders her husband or partner, drugs are commonly involved (Prospero & Kim, 2009).

As party to feminization of social welfare, the government has contradicted itself considering its own research. According to the Justice Department, 41% of spouses murdered were men. Another study conducted by Mann at the Department of Criminal Justice, Indiana University at Bloomington indicates that no more than 59% of women who murdered their husbands claimed self-defense. Of those, about 30% had been previously arrested for violent crimes. Furthermore, according to the Justice Department, of those women who murdered their husbands, 12.9% were acquitted. Of those men who murdered their wives, only 1.4% were acquitted. What’s more, those women found guilty of murdering their husbands received an average sentence of six years, while their male counterparts received 17 years for murdering their wives (Mann, 1990).

Some of the most highly respected among public officials are no less inclined to the feminization of social welfare which views women as victims, such as Donna Shalala, recent Secretary of Health and Human Services. The Secretary reported that 4 million women are “battered” in a given year by their significant male other (Shalala, 1994). She does not report the source of her data but her stated statistics are in conflict with official documentation. According to a 1993 Harris poll, two percent of the 2,500 women interviewed reported being “kicked, bit, hit with a fist or some other object” (Brott, n.d.) If that number is calculated by the approximately 55,000,000 women associated with a significant male other, the result is 1.1 million. Subsequently, there is an excess of 2.9 million reported. The only reasonable explanation might be that women who reported being “pushed, grabbed, or shoved” were considered having been battered (Brott, n.d.). Despite this fact, social welfare professionals (i.e., social workers) as well as the lay public do not accept that women are equally the perpetrators of domestic violence as are men, likely due to cultural
norms (O'Leary et al., 1989). Furthermore, professionals and
the lay public refuse to accept that such men can be the victims
of domestic violence as often as are women. The cultural belief
among Americans is that men, being more aggressive than
women, are prone to violence, despite evidence to the contrary.

Women who commit domestic violence against men en-
counter a double standard when compared to men who
commit domestic violence against women. Much of it is on
display in the literature consisting of investigations exclusive-
ly by various social science scholars. Bohannon, Dossen and
Lindley (1995) collected a sample to assess domestic violence
between husbands and wives. Their results indicate that of
94 military couples, 11% of wives and 7% of husbands were
engaged in behaviors considered physically aggressive, as re-
ported by the wives.

Ellison, Barkowski and Anderson (1999) found an asso-
ciation of religion with incidents of domestic violence. Their
subjects were selected from the first wave of The National
Survey of Families and Households. It included 2,420 women
and 2,242 men. The self-administered survey results suggested
that women were significantly more likely than men to act out
violent behaviors toward their male partners. As per religios-
ity, “regular attendance at religious services is inversely associ-
ated” with domestic violence for both men and women.

Headey, Scott and de Vaus (1999) conducted a study
of domestic violence in Australia. For data they used the
International Social Science Survey/ Australia 1996/97. Their
sample consisted of 1,643 subjects (804 men, 839 women).
Each answered questions pertaining to their experiences with
domestic violence within the last 12 months. Investigators
found that 5.7% of men and 3.7% of women reported being the
victims of domestic assaults. As pertains to physical injuries,
women were found to inflict bodily harm at least as often as
men. Statistically, 1.8% of men and 1.2% of women reported
that the bodily harm they sustained required first-aid. Lastly,
1.5% of men and 1.1% of women reported that their injuries
required treatment administered by a health care professional.

Kessler, Molnar, Feurer and Appelbaum (2001) investi-
gated mental health patterns relative to domestic violence in
the United States. Their sample consisted of 3,537 subjects. Of
these, 1,738 were men and 1,799 were women. These data were extracted from the National Co-morbidity Survey, which is a nationally representative survey conducted between the years of 1990 and 1992. All who qualified were married or cohabitating males and females between the ages of 15-54 years. The findings suggest that “17.4% of women and 18.4% of men reported being the victims of physical violence at the hands of their current spouses and/or partners” (Kessler et al., 2001, p. 491).

McCleod (1984) investigated domestic violence against men. Said investigation was based upon an analysis of official and national victimization data. It consisted of 6,200 cases of spousal abuse in the Detroit area from 1978-1979. Findings indicate that men resorted to weapons 25% of the time. Women, on the other hand, resorted to weapons 86% of the time. As a result, 74% of men incurred injuries and accordingly 84% required medical attention. Subsequently, McCleod determined vis-à-vis empirical data that men are more often injured and are injured more seriously than women.

McNeely, Cook and Torres (2001) set out to determine whether domestic violence is a gender issue or a human issue. They contend, based upon empirical evidence, that domestic violence is in fact a human issue and not due to the commonly held belief that it is a gender issue. The confusion may be a result of men’s “legal and social defenselessness” (p. 2).

Mechem, Shofer, Reinhard, Hornig and Datner (1999) investigated the history of domestic violence involving male patients seen at an urban emergency department. Their sample was compiled during a 13-week period at a Philadelphia emergency clinic. Investigators found that 12.6% of 866 men were domestic violence victims Citing secondary data, investigators acknowledged that 14.4% of women treated in similar emergency departments had been victims. By juxtaposing non-victims, victims were more likely to be single (52%), younger (7.5 years) and identified as African-American (61%). By reference to assaults, 48% of males contend that they had been kicked, bitten, choked or punched by a female partner. Another 37% confided that they had a weapon used against them.

Lastly, Ridley and Feldman (2003) reported on female violence against males in a domestic context. Their sample
consisted of 153 female volunteers. They were administered the *Abusive Behavior Inventory*. Findings were that 67.3% of subjects admitted to at least one event of violent behavior conducted by them personally in the past 12 months. The most common forms of violent behaviors consisted of pushing, shoving, and holding-down (45.1%). The next most common form of violent behavior consisted of slapping, hitting, and biting (41.2%).

While the aforementioned evidence of domestic violence by women aimed at men is dramatic, it is also a factor of entertainment, according to Marcus (2010). The recent television hit series “Jersey Shore” promoted violence against men during one of its highly touted episodes. One of the female characters, named J. Woww, smacked “The Situation." In a later episode, a drunken Angelina struck “Pauly D” in the facial area. What’s more, in response to a previous episode where a male character struck a female character, the administrators of the show featured a public service announcement abhorring domestic violence in response. This show is aired by the MTV cable station.

As a consequence of what it broadcasts, violence against men by women is tolerated while violence against women by men results in a public service announcement. Jersey Shore is not the exception (Marcus, 2010).

Another MTV series which tolerates violence against men is “Teen Mom.” One of the central characters, Amber, on more than one occasion has acted out violence against Gary, who is the father of her child. Another Teen Mom character, Farrah, was reportedly assaulted by her mother Debra. While the assault was not caught on camera, much of the episode focused on Farrah’s follow-up with an attorney to press charges against her mother and her referral for therapy to cope. In response to Farrah being assaulted, MTV broadcast a number for a domestic violence hotline. When women were victims of domestic violence, as was Farrah, the cable station acted. When men, such as Gary, were assaulted by women, the cable station has yet to respond with a public service announcement objecting (Marcus, 2010).

MTV’s reality series have left much of the public confused. It would appear that it has embraced a double standard. That is, domestic violence is permissible as long as it is female to
male. Subsequently, if the Gary character had struck Amber it is likely that the police would have been called and shortly thereafter the station would have aired a PSA against domestic violence. Failure to do so when men are the victims of domestic violence is a disservice to all victims of domestic violence, regardless of sex (Marcus, 2010).

Solutions to Cultural Tradition

By definition culture includes lifestyles, customs, art, religion, language, values and behavior associated with a particular group at a particular point in time (Deal & Kennedy, 1983). Culture enables life by empowering the weak to be collectively strong and thus integrating large numbers of people on the basis of a shared commonality. Culture does not require legal sanction in order to be effective, but more often than not in advanced technological societies, culture influences the structures of litigation.

In actuality culture is a "catch-all" term which appears to exclude very little quality of life matter (Van Wormer, Besthorn & Keefe, 2007). However for comprehending the feminization of social welfare relative to domestic violence, interested parties must consider the associations of culture with patriarchal tradition. Similar to culture, tradition in general includes a set of interrelated phenomena through which reality is created, communicated and by social welfare, administrated. Social welfare relevant phenomena include methods of service, demographics of personnel, perspectives, standards and ways of relating in a cultural context. When such phenomena operate in conjunction, they come to represent a significant aspect of what is assumed in the U.S. to be the most prudent operation of social welfare services, which under the current circumstances enables feminization (Monroe & Tiller, 2001).

The application of tradition gains validation through correlation to several attributes. It gives credibility to the existence of culture for fashioning the delivery of services and its demographic priorities. The traditional social welfare modus operandi emphasizes values and norms of the patriarch, which establishes women as victims of domestic violence and men as perpetrators of same. Without overt formal and/or informal communication, social welfare by cultural
tradition then prioritizes victims of domestic violence according to the standards of feminization. The delivery of services and distribution of social welfare resources become less amenable to scientific facts, which conflict given the existence of male victims (Straus, 2009). Within social welfare institutions, male victims of domestic violence are then located in opposition to similarly victimized women, resulting in unnecessary and disserving tension. Said tension discourages focus on the elimination of domestic violence in toto for focus upon women as the defining and most urgent victims of the problem.

Solutions to cultural tradition aimed at eliminating male victims of domestic violence must necessarily begin with acknowledgement of the characteristic warning signs and symptoms. No partner involved in an intimate relationship, regardless of their sex, should submit themselves to living in fear of their significant other, whether legally joined or not. When the warning signs or violence becomes apparent, victims should not hesitate to terminate the relationship or seek immediate help. According to domesticviolence.org (2010), when attempting to escape the risks of domestic violence, the following are things one needs to think about:

1. Having important phone numbers nearby for you and your children. Numbers to have are the police, hotlines, friends and the local shelter.

2. Friends or neighbors you could tell about the abuse. Ask them to call the police if they hear angry or violent noises. If you have children, teach them how to dial 911. Make up a code word that you can use when you need help.

3. How to get out of your home safely. Practice ways to get out.

4. Safer places in your home where there are exits and no weapons. If you feel abuse is going to happen try to get your abuser to one of these safer places.

5. Any weapons in the house. Think about ways that you could get them out of the house.
6. Even if you do not plan to leave, think of where you could go. Think of how you might leave. Try doing things that get you out of the house—taking out the trash, walking the pet or going to the store. Put together a bag of things you use everyday. Hide it where it is easy for you to get.

7. Going over your safety plan often.

The aforementioned is advised regardless of race, sex, sexual orientation, socio-economic and marital status. Solutions to the cultural traditions of domestic violence must include redefining culture and its appropriate place in the conduct of social services. In the face of two powerful barriers—traditionalism and the status quo—this characterizes the reduced viability of the attempt. Culturally diverse scholars 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 (Hall, 2003). For male victims of domestic violence, this simple proclamation by social welfare personnel would be a revolutionary act in its repudiation of a culturally-imposed limitation upon access to programs and services. Male victims of domestic violence are unique in that their defining difference (sex) is an experience with which the mainstay of social welfare professionals, including both male and female social workers assigned to domestic violence, lack affinity. Since males in need can be identified by their appearance, their access to domestic violence services may be unnecessarily complicated for traditional cultural reasons (Straus, 2009). As a result, to the degree that social welfare and who has access to services is a culturally constructed phenomenon, victimized males in need require advocates in all areas whose sole purpose is problem resolution.

Conclusion

According to Kosberg (2002), men are portrayed in social welfare literature as “gay” or in an otherwise negative context. Women are disproportionately portrayed as victims, powerless, vulnerable and disadvantaged, due to the sexist and racist efforts of men. Such characterizations impose upon the public
perception of male victims of domestic violence, despite scientific evidence to sustain their plight. Therefore, relative to feminization, much of the available literature on domestic violence has justifiably emphasized the needs, problems, and empowerment of women to the exclusion of equally justifiable male victims (Alaggia & Millington, 2008). Such concerns for women are no doubt a legitimate issue. However, the extent of such concern results in the feminization of social welfare, which accommodates an imbalanced frame of reference to a serious social pathology.

"Profession" according to Merriam-Webster (1993) is defined as "a calling requiring specialized knowledge and often long and intensive academic preparation." The feminization of social welfare in the U.S. extends from the traditional cultural norms and preferred values of society (Farber, 1977-1978). Indeed, social welfare personnel, such as social workers, are members of a values profession not irrelevant to cultural traditions in the conduct and delivery of services nationwide. In fact, some have referred to the U.S. as a Christian nation, not irrelevant to the operations of social welfare (Stone, 2008). As an institution, social welfare was in fact subject to the nation's forefathers who understood clearly the potential for abuse when cultural traditions in the form of religion operate in an otherwise multicultural, multiracial society whose fundamental creed is freedom (Lupu, 2010). Thus, by official decree they took action to insure that no one religion, philosophy or other state-sponsored value system would prevail. That belief was sustained by many operatives in the scientific community who felt imposed upon by value systems in the conduct of their work. They preferred separation of culture and services science in an effort to insure attentions to need would prevail, independent of cultural and political influences (i.e., feminization). Unfortunately, such influence has not discouraged the oversight of male victims subjected to domestic violence. The feminization of social welfare thus remains an impediment to the elimination of domestic violence and validation of rigorous scientific discourse.

In the aftermath of their advocacy for male victims of domestic violence in need, both male and female social workers are subjected to unnecessary stress in attempts to maintain coherence and direction (Senge, 1990). Thus, when social welfare
institutions contradict science and cannot reach consensus about the priority of programs and services, neither men nor women victimized by domestic violence can be optimistic about the future. An effective tool is application of more objective policy models which better locate the role of cultural traditions in the perception and attention to all victims in need.

Moving beyond the feminization of social welfare as pertains to domestic violence can be accomplished by the recognition that cultural tradition should not be the sole determinant of services. That is, as an institution, social welfare's attention to those in need must be considered by development of a social welfare technology. While this technology may operate within a cultural context, the resolution of problems must be dictated by scientific objectivity (Wallington & Moore, 2005). Recognized schools of thought suggest that scientific objectivity relative to technological competence means the capacity of social workers within the social welfare system to execute a particular task free of cultural bias (Jones & Alcabes, 1989). This simple definition becomes obsolete when applied in the absence of science, leaving feminization of social welfare to fill the void. Furthermore, as per the feminization of social welfare, technological competence enables services because the variations in tasks are made more consistent and intelligible, commensurate with differing treatment methodologies and demographic categories, including sex (O'Neal, 1999). Whereas decision-making ability, treatment modality, and knowledge base as an extension of culture is important, none of these as a single criterion reign sufficient without the benefits of scientific objectivity. However, considered in conjunction with scientific objectivity, they can potentially comprise social welfare's professional technology.

Cynicism and burnout stem partly from people loyal foremost to culture and tradition (i.e., feminization). It is a common event for those employed in social welfare fields, including social workers, who are often overworked and underpaid (Ng, 2010). Women, in particular, who clearly understand the urgency of domestic violence and who are not influenced by its feminization in their view of male victims, are most at risk for such burnout. Their struggles more often take place within an environment where agencies do not share a common vision about the problems of society. Thus by necessity in resolving
the problem, domestic violence most be moved from a cultural to a social justice context.

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A Social Justice Perspective on Medicare Part D in an Age of Reform: Critical Implications of Trends in Health Care Policy and Advocacy

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This article examines the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) in its current form and explains why a critical perspective is useful when analyzing the policy and reform efforts. Using this approach, we consider the development of the policy and describe ways that gender and racial differences may hinder equal access to medications for some of the most vulnerable older adults. This article explores the implications of gender and racial disparities under the MMA and ramifications of health care reform efforts that could potentially impede, rather than promote, a social justice agenda. Beyond the political advantage of the MMA's current structure, reconsideration should include the potential for disproportionate negative economic and health effects for women and people in historically disadvantaged minority groups.

Key words: Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA); Medicare Part D; critical analysis; health care advocacy; policy practice

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) is the largest benefit expansion in the history of the program. To respond to the need to provide older adults with drug coverage, the MMA added the Part D benefit to Medicare (Madden et al., 2008; Journal of Sociology & Social Welfare, September 2012, Volume XXXIX, Number 3

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Mayes, 2005). While it was politically popular, it appears that Medicare Part D (referred to as “Part D” throughout this article) may not provide a meaningful benefit for the most vulnerable older persons (Bass, 2005). Several groups within the population of older adults face systemic disadvantage because of higher-than-average rates of disability and poverty (Larkin, 2004; Parish & Lutwick, 2005) and chronic lack of insurance (Svihula, 2008). Costs of medical care, even with public subsidies, deplete the resources of poor and near-poor adults, feeding a cycle of economic hardship and worsening health. In this article, we focus on women and racial/ethnic minorities living in or near poverty who have lived with the effects of economic disadvantage resulting from inequitable social policies (Abramovitz, 1996). Gender and racial/ethnic differences associated with economic disadvantage and disproportionate negative health effects due to unequal out-of-pocket cost burden seem to be neglected in Part D; there appears to be little political impetus to reconcile the disparities.

This article discusses a core provision of the MMA, the Part D coverage gap, as it relates to prescription drug coverage and access to medications. The analysis draws on critical race and gender perspectives (Delgado & Stefancic, 2001) and a theory of social justice as applied to the construction and implementation of Part D (Larkin, 2004). We highlight the importance of critically analyzing the impact of disadvantages throughout the life course that can result in economic and health disparities under the benefit. Challenges and benefits of solutions that have been attempted, specifically the Low-Income Subsidy (LIS) Program and potential outcomes of the health care reform (Patient Protection and Affordable Care Act, or PPACA) of 2010, are discussed. Recent moves toward a more progressive premiums or benefits schedule for Part D—like those in other major social support programs (e.g., Social Security)—are a start (Goldman & Joyce, 2008; Mayes, 2005), along with narrowing the coverage gap. We conclude with recommendations for policy reform and practice.

The Medicare Modernization Act and Part D

Core Provision of the MMA: Part D and Economic Disadvantage

Expanded use of the private sector to deliver health care
benefits was a primary tenet of the MMA. Unlike the traditional Medicare program, Congress required that Part D be available to beneficiaries exclusively through private, standalone prescription drug plans that allow insurance providers considerable latitude in designing the benefits plans offered (Hoadley, 2006). The structure of the plans includes prescription drug restrictions, formularies, and cost-sharing requirements that directly affect the price beneficiaries pay for medications. In addition, the MMA prohibits the federal government from negotiating with pharmaceutical companies, a strategy that assists other government health plans, such as the Veterans Administration, to secure lower prices for prescription medications (Geyman, 2006; Slaughter, 2006).

The standard Part D benefit plan requires an annual premium, deductible, and prescription copayments. Congress created the coverage gap, also referred to as the doughnut hole, as a cost-containment measure. Entering the gap means that prescriptions that were previously covered become the sole responsibility of the older adult. Under the 2010 standard benefit, before they reach the gap beneficiaries paid a $310 deductible and 25 percent copay per prescription, until they reach benefit threshold or incur $2,830 in total drug costs (see Figure 1).

Figure 1. Standard Medicare Prescription Drug Benefit in 2010

Up to now, beneficiaries have been responsible for 100 percent of their prescription drug costs while in the doughnut hole. Because of the new health care reform law, the PPACA, beneficiaries in 2010 received a $250 rebate if they entered the coverage gap. In 2011, beneficiaries paid 50 percent of brand name prescriptions that are covered by their particular plan, until they spend $4,550 out-of-pocket. Once beneficiaries reach this limit, they become eligible for "catastrophic coverage," and Medicare and the benefit provider pay for 95 percent of their drug costs for the remainder of the year (Kaiser Family Foundation, 2009a). The cycle renews annually.

The threshold that marks entrance into the coverage gap increases each year as well. The size of the gap in coverage and the rate of increase in other cost-sharing components of Part D are indexed by the increase in the annual cost of the drug benefit rather than the average annual cost of living due to inflation—reflected by the Cost of Living Allowance, or COLA, which helps determine a person's disposable income. The gap increases at a greater rate than beneficiaries' ability to pay, because the cost of medications rises faster than inflation. For example, out-of-pocket costs for prescription medications rose at a rate of nearly ten times the average COLA, which was only 2.85 percent over the same period. Between 2006 and 2010, the amount beneficiaries paid while in the coverage gap rose roughly 26 percent from $2,850 to $3,610 (see Figure 1). However, the cost of living adjustment (COLA) over this same time period increased by only 8.2 percent (U.S. Bureau of Labor Statistics, 2008). By comparison, the COLA increase for Social Security benefits remained consistent with the actual average cost of living adjustment. Thus, the Part D out-of-pocket cost increases are out of proportion with the Part D benefit and Social Security income (Automatic Determinations, 2011). This is significant, as many older adults depend on their Social Security benefits to cover out-of-pocket medical costs.

Svihula (2008) estimated that approximately 26 percent of Medicare Part D enrollees—nearly 7 million beneficiaries—will encounter prescription drug expenses high enough to reach the doughnut hole, and that the overwhelming majority will remain there. Out-of-pocket prescription drug spending typically doubles when a beneficiary enters the coverage gap.
Though catastrophic coverage reinstates insurance for those who emerge from the doughnut hole, only four percent of beneficiaries incur enough out-of-pocket spending to benefit from this provision (see Figure 2) (Hoadley, Hargrave, Cubanski, & Neuman, 2008).

Figure 2. Annual Medicare Prescription Drug Benefit Lifecycle

Theory and Practice: Critical Perspectives, Cumulative Disadvantage, and Social Justice

By applying critical theories of race, gender, and social justice to Medicare policy and prescription drug coverage, we can suggest ways to fill gaps in understanding about economic and health disparities (Larkin, 2004). While there is not a single, unified critical race theory, there are basic tenets comprising critical perspectives: first, discrimination and oppression for minority groups are social norms, rather than exceptions (Delgado & Stefancic, 2001). Second, power hierarchies based on race and other socially-constructed attributes serve a social function, to maintain the hegemony of dominant groups. Third, this function is amplified by the exploitation of differences within groups (e.g., skin color). A fourth principle is that the intersections of race, gender, and class increase the ability of dominant groups to exploit these differences (Hill Collins, 1993; Delgado & Stefancic, 2001). Fifth, critical analysis may be adopted and applied to problems stemming from sexism, classism, and other socially constructed problems (Hill Collins, 1993). Finally, critical race and gender analyses assume that the lived experiences of disadvantaged groups are unique and people in these groups are exclusively
positioned to observe and interpret their needs and solutions (Delgado & Stefancic, 2001; Harding, 1991; Smith, 2004). Our analysis of Part D relies chiefly on the first, second, and fourth tenets to identify areas where pervasive effects of historic and current differential treatment of women and people of color are likely to perpetuate inequality and worse health.

Income Inequalities and Health Disparities

The Part D coverage gap, Congress' main mechanism to control the cost of the prescription drug benefit, does not account for economic disparities or gender-related health differences. While it can be argued that the MMA and Part D were written in gender- and ethnic/racially-neutral language, their potential impact and implications are not neutral. Failure to acknowledge the different experiences of these groups with regard to health and economic status can further perpetuate inequalities (Estes, 2001). Women's likelihood of lower income and higher prevalence of chronic conditions intersect, accelerating depletion of resources and compromising their ability to afford prescription medications, thus deepening the relationship between financial and health disparities. The stated goal of Part D is to promote access to prescription medications through the establishment of a drug benefit (Oliver & Lee, 2009). Yet, disadvantages throughout the life course can increase the need for pharmaceuticals for older women and persons of color and—at the same time—inhibit equal access to this benefit.

The ability to afford pharmaceuticals and maintain adherence to a medication regimen are largely dependent on retirement income and savings. Income in later life is typically based on pre-retirement experiences, and racial/ethnic and gender inequities increase with advancing age (Crystal & Shea, 1990). Wages for females and Blacks and Hispanics have consistently lagged behind those received by White males, and women and minorities are more likely to have been segregated into positions without retirement or pension benefits (Gonyea & Hooyman, 2005). As illustrated in Figure 3, women employed in the paid labor market continue to be compensated less than men for comparable work (Mink, 1998; United States Bureau of Labor Statistics, 2008).
Since Social Security is based on a 40-year work history, older women, Blacks, and Hispanics who received lower wages and/or have fewer years in the labor force will be subject to lower benefits in later life than White males on average (Olson, 1994). Thus, they have less income available to purchase prescribed medications. Income inequalities are even more pronounced for African Americans who experience racial discrimination and disproportionately lack equal educational and economic opportunities throughout the life course (Kail, Quadagno, & Keene, 2009). Furthermore, wealth inequality, even beyond employment income, reduces access to benefits that require significant out-of-pocket spending (Collins, Estes, & Bradsher, 2001). While poverty in old age is twice as likely for women as for men, it is three times higher for Blacks and Hispanics than non-Hispanic Whites (Finkle, Hartmann, & Lee, 2007; Gonyea & Hooyman, 2005; Wright & Devine, 1994).

Economic disadvantage because of lower income is frequently accompanied by a higher prevalence of chronic health conditions; both problems feed each other. Racial and gender inequities in morbidity exist throughout the life course and health trajectories continue to diverge with increasing age (Clark, 1997; Kelley-Moore & Ferraro, 2004). Women are more likely to report functional limitations, a higher number of chronic conditions, and rate their health as poor or fair than
their male counterparts (Murtagh & Hubert, 2004). As the result of increased morbidity, females and African Americans are more reliant on pharmaceuticals (Goulding, 2005). Yet, their ability to afford prescribed medications is more often compromised because of lower SES. Compared to White males, older women and Blacks spend a higher proportion of their income on pharmaceuticals (Rogowski, Lillard, & Kington, 1997; Sambamoorthi, Shea, & Crystal, 2003). This suggests that they will continue to experience a disproportionately heavier financial burden under Part D (Wei, Akincigil, Crystal, & Sambamoorthi, 2006).

Beneficiaries who incur enough spending to reach the coverage gap show lower drug consumption (Pedan, Lu, & Varasten, 2009; Sun & Lee, 2007; Zhang, Donohue, Newhouse, & Lave, 2009) and decreased adherence (Hsu et al., 2008) because of increased out-of-pocket expenditure requirements. Though rationing to save money and partial adherence is far from a healthy solution, individuals can maintain a small degree of control over both financial and health conditions without giving up entirely on either.

In addition, beneficiaries with certain chronic illnesses associated with living in poverty, such as depression and diabetes, have a greater risk of encountering the coverage gap because they spend more on medications. They are, therefore, at greater risk of nonadherence (Hoadley et al., 2008; Stuart, Simoni-Wastila, & Chauncey, 2005). Fifty-one percent of older adults with diabetes who reached the benefit threshold demonstrated a decline in out-of-pocket spending on medications, suggesting that they may have become noncompliant after losing support in the gap (Hoadley et al., 2008). Because older women and Blacks experience higher rates of diabetes (Gellad, Huskamp, Phillips, & Haas, 2006; Schoenborn & Heyman, 2009) and a greater number of depressive symptoms (Skarupski, Mendes de Leon, Barnes, & Evans, 2009), they could face a greater risk of encountering the coverage gap and becoming nonadherent. That is, people may be excluded from benefits while ongoing treatment is needed to sustain life or quality of life. Catastrophic coverage available past the gap—if reached—could come too late.
Solutions at the Intersections of Economics, Politics, and Health Inequities

Because medication costs are a primary barrier to prescription drug access under Part D (Madden et al., 2008), an attempt has been made to provide cost-sharing assistance for older adults with limited means through the Low-Income Subsidy (LIS) Program. The MMA stipulates that individuals whose income and assets are below a specified level or who receive Medicaid benefits are eligible for a subsidy to help cover the cost of medications (Kaiser Family Foundation, 2009b). The LIS replaced previous programs that ran concurrent with Medicaid, called State-supported Pharmaceutical Assistance Programs (SPAPs). Some states continue to utilize SPAPs as supplementary or wraparound coverage for Part D beneficiaries receiving the LIS (National Conference of State Legislatures, 2010).

Subsidies previously available before Part D through the Medicaid and SPAP programs typically paid a greater share of prescription drug costs and contained prescription drug formularies that were less restrictive (Bakk, Woodward, & Dunkle, 2012). Beneficiaries utilizing the LIS program have had problems accessing medications (Kaiser Family Foundation, 2008) because of program complexity, limited drug plan availability, cost-sharing requirements, and formulary restrictions (Bakk, Woodward, & Dunkle, 2012; Donohue & Frank, 2007; Morden & Garrison, 2006; West et al., 2007). For persons who qualify for the LIS, premium and cost-sharing assistance can be considerable (Kaiser Family Foundation, 2009b). Yet, a substantial number of Part D beneficiaries with incomes between 100 and 200 percent of the federal poverty line are not eligible because their income or assets exceed program guidelines. An estimated 2.37 million low-income Medicare beneficiaries do not pass the asset test. They report continuing to cut back their spending on basic needs and have more problems with medication nonadherence (Briesacher et al., 2010). Nearly half of those failing the test are widows, and almost all are older women living alone (Rice & Desmond, 2005).

Thus, the viability of the LIS as a means of providing benefits to at-risk older adults is questionable. Research pertaining
to the efficacy of the LIS as a means of providing assistance to women and minorities is also somewhat limited. People in these groups are more likely to qualify for LIS assistance (Rice & Desmond, 2005), but racial/ethnic and gender comparisons of actual enrollees and experiences with utilization of the subsidy are unavailable. More research is needed in this area. It is critical that this impact be monitored because older Blacks and Latinos face greater health risks associated with restrictions in coverage and increased cost-sharing requirements.

The Patient Protection and Affordable Care Act (PPACA) signed into law on March 23, 2010 will gradually reduce the beneficiary cost-sharing requirements in the coverage gap from 100 percent to 25 percent by 2020 (Kaiser Family Foundation, 2009a, 2010), significantly decreasing the doughnut hole. The need to reduce or eliminate the Part D coverage gap has been recognized (Kaiser Family Foundation, 2010), and the PPACA is an important step toward reconciling both financial and health disparities. Some key provisions are expected to help women and people of color. For example, an expansion of benefits that cover long-term care proposed in the law should have a positive effect on women who live longer, especially those living with serious chronic conditions. The law also provides up to 50 percent for some brand name prescription medications in the doughnut hole. By 2020, the discount will increase to 75 percent. This is significant, but perhaps a bit misleading because “phasing out” the gap (Kaiser Family Foundation, 2011) could be construed as eliminating copays altogether. Phasing out the gap simply brings the benefit in line with the coverage before the gap. This will help those who would be devastated when they suddenly enter the doughnut hole, but it still does not address those problems faced by near-poor older adults who can barely afford any copayments (Bakk, Woodward, & McGuire, 2012). It also does not address income and assets limits provided for the “poorest poor.”

As Families USA and other advocates for the reform point out, one very important advancement in the PPACA is that it looks to improve the economic and social situations for future generations. The PPACA specifically targets workforce diversity in order to alleviate some of the historic disparities in income and wealth that lead to worsening health because of
inability to pay. Such improvements could also address physical stress effects of cumulative disadvantage and discrimination on women and people of color (Health Reform Central, n.d.).

However, there are reasons to be cautious. It has also been suggested that insurers could react to these provisions by increasing Part D premiums to manage the change (Davidoff et al., 2010). Because the cost of prescription drugs continues to increase faster than inflation (Kaiser Family Foundation, 2009a), medication costs may still pose significant difficulties for economically vulnerable populations, especially those who exceed the LIS income/asset thresholds, because cost-sharing is still required. The second caveat is that while the law in its final form calls for a significant reduction in cost-sharing (to 25 percent), the remaining costs will still be out of reach for many Part D beneficiaries (Ettner et al., 2010). Failing to completely close the coverage gap will do little to ease economic burdens that lead to older adults rationing their own medications. Finally, threats to repeal the law are still in the air. While a full repeal is extremely unlikely, as the Senate has not passed the bill and President Obama has promised to veto it, some parts of the bill may be in danger. If reforms to Part D provisions that assist the worst off beneficiaries, such as narrowing the coverage gap, are not maintained, the most vulnerable adults will face even greater economic hardship and more serious health outcomes.

Recommendations

Three main recommendations emerge. First, because prescription drug needs and the ability to purchase prescribed medications vary depending on gender and racial/ethnic affiliation, the law should be written with greater flexibility to better account for multiple, co-occurring, and stress-related illnesses that are often associated with cumulative disadvantage earlier in life. Second, lower lifetime earnings should be taken into account when determining benefit levels. Social Security benefit rates may be a good indicator of the appropriate subsidy for beneficiaries, as they have been shown to be functional over time and are directly connected
to low-income older adults' ability to afford their medications. Similarly, indexing the Part D benefit to inflation or the cost of living, rather than drug costs, may improve the law's sensitivity to beneficiaries' actual needs. Because the MMA imposes a disproportionate and inequitable share of cost-sharing requirements on women and persons of color, ensuring that the adjustments to the coverage gap are realized and maintained in health care reform can reduce the risk of nonadherence due to cost, as well as consequent adverse health outcomes that magnify and perpetuate inequalities. A secondary benefit of such a change is that all low-income beneficiaries who may have been affected by unfair treatment in the workplace or throughout the lifespan (e.g., people in unsafe jobs that cause lasting health problems) will also benefit from such policy reforms.

Conclusion

The MMA, with truly substantial modifications, can recognize economic disadvantage that older women and racial minorities face as the result of inequalities experienced throughout the life course (Shuey & Willson, 2008). Such changes acknowledge the link between Medicare and other safety net programs, like Social Security. These recommendations do not necessitate lessening the influence of private insurers, but rather shifting the idea that health care is a right for beneficiaries (Larkin, 2004).

The synthesis of the critical race and gender, cumulative disadvantage, and social justice frameworks used in this analysis uncovers the potentially serious effects of differential life experiences and indicates potential pathways to equitable access to prescription medications. The results of this analysis of political and economic factors on the health and well-being of older adults can be used to advocate for socially just solutions and policy changes. Service providers can take the standpoints of older adults who are living with the effects of lifelong disadvantage into account when working with Medicare beneficiaries and take action to promote systems change as a primary intervention (Sosulski, 2009).

Advocates for older adults will need to be vigilant in order to monitor the progress of Medicare policy and Part D
benefits, in particular. Social service providers and policymakers can advocate for greater social justice by recognizing gaps in the law that allow the most vulnerable groups to suffer from economic uncertainty and consequent health crises. More research, policy analysis, and policy development are needed to ensure that issues of gender and race are fully considered in this age of reform in order to create changes that enhance older adults' health and well-being.

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Competency and Voters with Psychiatric Disabilities: Considerations for Social Workers

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The ability of those with psychiatric disabilities to vote is an important activity impacted by competency issues and potentially overlooked by social workers. The purpose of this article is to assist social workers in making informed decisions about preserving and supporting voter participation among those with psychiatric disabilities. Common issues regarding the voting rights of individuals with psychiatric disabilities within the legal system and other systems of interest to social workers are explored.

Key words: voter competency, psychiatric disability, social work

Voting is defined by, and in turn defines, the democratic process. The Supreme Court deemed voting a “fundamental right” and declared, “no right is more precious” (Harper v. Virginia, 1966; Wesberry v. Sanders, 1964). To exercise one’s right to vote is the manifestation of personal power in the selection of leadership that will represent the values and needs of the individual. The National Association of Social Workers expresses these sentiments by speaking to the right itself, “voting is a basic right, and citizens should be assisted in all possible ways to exercise that right; any action that denies access or discourages any citizen from voting should be prohibited” and by speaking to the responsibilities of the profession … social workers are encouraged to help educate clients to be informed voters and to mobilize them to vote in elections” (2006, p. 377). Social workers can be instrumental in furthering voter participation and eliminating the barriers that affect it. They act both as agents for empowerment of those with
psychiatric disabilities, helping them move toward normalized and productive community participation and as overseers of the rights for these individuals to take action on their own behalves (Coppock & Dunn, 2009). However, in order to do so, social workers must familiarize themselves with obstacles to voting that lie both inside and outside of the legal system.

Individuals with psychiatric disabilities commonly face voting disenfranchisement because of concerns about their competence to vote (Schur, Adya, & Kruse, 2008). The legal disenfranchisement of those with psychiatric disabilities is achieved, however innocently, through the appointment of a guardian, which results in the person's loss of legal rights (Schriner, Ochs, & Shields, 1997). As informants about consumer functioning in the guardianship process, social workers are often instrumental in determining the outcome of guardianship proceedings to include the preservation of voting rights. The social work role in addressing voter participation also rests in the need for social workers to confront their own perceptions of voter competence. Are these perceptions based on an accurate definition and assessment of voter competency?

The purpose of this article is to assist social workers in making informed decisions about preserving and supporting voter participation among those with psychiatric disabilities. Framed by a socio-legal perspective, contemporary law regarding voting rights and guardianship, a legal definition of competency and a proposed assessment for voter competency are presented. This article then proceeds to examine barriers to voting that occur outside of the legal system and how social workers can advocate in these situations.

At the outset, it is important to note that the literature in the area of voter rights and voter competence primarily addresses cognitive impairments as the disability of concern. Legal writings related to psychiatric disabilities and voting rights are sparse. There are important differences in functional impairments between those with cognitive disabilities and those with psychiatric disabilities. However, the legal system perceives these functional disabilities as similar, thus making the application of this literature to those with psychiatric disabilities credible.
Competence, Voting Rights & Legal Guardianship

Throughout American history the suffrage struggles of disenfranchised groups, women, persons of color, and most recently, those with disabilities, reflect the importance and power of voting. Withholding the right to vote from certain categories of citizens has been justified as necessary to "maintain the intelligence and integrity of the electorate" (Hurme & Appelbaum, 2007, p. 932). Past suffrage battles were waged to fight the assumption that categorization by color, gender or disability posed an inherent threat to a credible electorate.

The victory for voting rights is reflected in the fifteenth and nineteenth amendments of the United States Constitution, the supreme law of the land and several Acts of Congress. The Fifteenth Amendment reads, "the right of citizens of the United States to vote shall not be denied by the United States or by any State on account of race, color, or previous condition of servitude" (Constitutional Amendment XV, section 1). The Nineteenth Amendment provides the same protections for women, ensuring that women have the right to vote (Constitutional Amendment XIX).

Further protections of voting rights were provided by the United States Congress with the passing of the Voting Rights Act of 1964, the Americans with Disabilities Act of 1990 (ADA), and the National Voter Registration Act of 1993 (Keyssar, 2000; Monk, 2003; Schriner, Ochs, & Shields, 1997). The Voting Rights Act of 1964 supplemented the Fifteenth Amendment's protection of racial minorities by prohibiting the practice of requiring "otherwise qualified voters to pass literacy tests in order to register to vote" (U.S. Department of Justice, 1965). Voter protection was extended to those with disabilities through The Americans with Disabilities Act by requiring that polling places be physically accessible to people with disabilities when federal elections occur (U.S. Department of Justice, 1984). Individuals with disabilities received additional protection from the National Voter Registration Act, which requires voter registration opportunities to be in place in all offices that provide public assistance and within state funded programs that provide services to individuals with disabilities (U.S. Department of Justice, 1965).
Regardless of the progress that has been made in the protection of voting rights, those with developmental disabilities, cognitive impairments, and psychiatric disabilities face voting disenfranchisement based on concerns about their competence to vote, or lack thereof. The states rule in this regard; the federal laws, which address voting rights, do not preempt the states’ authority to disqualify voters based on their competency, or lack thereof.

Voting Rights & Guardianship Reforms

Competency is an issue at the center of all guardianship laws, which are generally constructed and enforced by the separate states. Reforms in guardianship laws have begun to address the right to vote. One contributor to this wave of reform is found in the 2001 Maine case of Doe v. Rowe. In this case, the plaintiffs, three women with psychiatric disabilities who were denied the right to vote, claimed that, “Maine’s disenfranchisement of those under guardianship by reason of mental illness failed to provide adequate procedural due process” (Doe and the Disability Rights Center of Maine v. Rowe, 2001). The court that placed the women under guardianship did not specifically consider the right to vote as a distinct aspect of its decision and failed to notify each woman that her right to vote would be automatically suspended when the guardianship order was given. One of the women obtained a modification to her guardianship order and subsequently voted in the 2000 state and federal elections. The other women’s orders were not modified and they sued the state, asserting that the state’s guardianship law amounted to a constitutional disenfranchisement in violation of the 14th Amendment of the U.S. Constitution (Doe and the Disability Rights Center of Maine v. Rowe, 2001).

The 14th Amendment grants citizens “equal protection under the law” (U.S. Constitutional Amendment XIV). Within this amendment are The Due Process Clause and Equal Protection Clause, both of which having bearing on voting rights. The Due Process clause prohibits the states from “depriving any person of life, liberty, or property without due process of law” (U.S. Constitutional Amendment XIV) and requires that “the content of the law, not just the procedures,
must be fair" (Substantive Due Process) (Monk, 2003, p. 215) and asserts that the government cannot, "deny a citizen a benefit without notice and a hearing" (Procedural Due Process) (Monk, 2003, p. 171). Further, the Equal Protection Clause prohibits unreasonable discrimination; if the effects of a law are that similarly situated people are treated differently, the state must demonstrate a legitimate reason for the differential treatment (Monk, 2003).

In the case of Doe v. Rowe, the court found that the court’s ruling, which resulted in the women being denied the right to vote, violated the due process provisions of the 14th Amendment because “the practice of probate courts failed to ensure uniformly adequate notice regarding the potential disenfranchise ment effect of being placed under guardianship” (Doe and the Disability Rights Center of Maine v. Rowe, 2001). This is clearly a procedural due process argument. In the same case, substantive due process issues were addressed when the court found that “the Equal Protection Clause was violated because guardianship for reasons of mental illness was an inadequate proxy for the capacity to vote” (Doe and the Disability Rights Center of Maine v. Rowe, 2001). In other words, just because one is subject to a guardianship order does not mean that her competence to vote has been disproved.

In the context of overall guardianship reform, Doe v. Rowe gave legal teeth to the right of individuals to have their voting rights specifically addressed during guardianship proceedings and to be informed of the outcome. As a result, 18 states now specifically provide for judicial determination of the capacity of the individual to vote. In seven states, when deemed to be incompetent, the individual still continues to lose his or her right to vote without having the opportunity for the specific determination of voting capacity (Hurme & Appelbaum, 2007). An alternative approach to resolving this competency-voting rights issue is the automatic retention of voting rights unless the right is specifically challenged, a seemingly just approach (Sabatino & Spurgeon, 2007). A number of states have incorporated this alternative by amending their laws: Alaska, Arkansas, California, Connecticut, the District of Columbia, Georgia, Iowa, Kentucky, Minnesota, New Mexico, North Dakota, Ohio, Oklahoma, Oregon, South Dakota, Tennessee,
Of course, it may well be that the most just approach is that of a voter qualification process that does not take into consideration psychiatric disability or guardianship. The laws of Idaho, Illinois, Indiana, Colorado, Kansas, Michigan, New Hampshire, North Carolina, and Pennsylvania contain no statutes that allow the disqualification of voters due to psychiatric disability or guardianship (Hurme & Appelbaum, 2007).

Including a separate adjudication of one’s capacity to vote within limited guardianship proceedings is a significant advancement in protecting the rights of those with psychiatric disabilities, but still one which is bittersweet. While decisions are made about limiting the rights of the individual due to incompetence, the preservation of voting rights is explicitly being addressed, the finding of incompetence means that certain other rights are limited. And, the determination of voting capacity within a limited guardianship is not a foolproof guarantee against voter disenfranchisement. In Missouri Protection and Advocacy Services v. State of Missouri (2007), a claim was made against the state of Missouri for categorically barring the voter, Mr. Prye, from exercising his right to vote, even though the probate judge had expressly found him competent to vote and did not limit his right to vote at the time of his guardianship proceeding. On appeal, the Court affirmed the district court’s decision for the plaintiffs, finding “while Missouri law generally bans voting by citizens who are incapacitated, that ban is not absolute because probate courts have explicitly preserved the voting rights of some individuals when appointing guardians for them” (Missouri Protection v. Missouri, 2007, 1078, 1081).

Categorical Versus Functional Determination of Voter Competency

The Maine and Missouri decisions reviewed above highlight the dangers of state laws that rely on categorical rather than functional determinations of voter capacity. If voting capacity is treated as something that falls within the range of human functions for which guardianship might be required, then the right to vote is subject to a general, rather than
specific or functional, determination. Still, progress has been made since changes in many state laws have mandated the specific determination of voter competency. This represents a victory for the rights of those with psychiatric disabilities while at the same time raising new challenges. Categorical suspension of voter rights did not require that courts specify a definition of and criteria for voter competency; consideration of individual functioning requires that these specificities be determined.

**Legal Standards for Determining Voter Competency**

The express rationale for the disenfranchisement of certain groups of voters has historically been the same: the need to maintain an intelligent electorate. An intelligent electorate has been viewed as essential to the well-being of democracy throughout U.S. history and has served as the rationale for limiting suffrage based on specific demographic criteria, such as gender, race and socio-economic status. The white, male property owner was presumed to have the necessary intelligence to protect the validity of our political system. Thus, as the thinking went, to have only the most “qualified” individuals participate in the democratic process would result in intelligent and productive selections for the leadership of our society (Keyssar, 2000).

The criteria used to determine one’s capacity to participate in an intelligent electorate have all been deemed unconstitutional when challenged in the courts—land ownership, civics tests, and intelligence tests have all been eliminated (Schriner, Ochs, & Shields, 1997). The last remaining means of legally preventing a citizen from voting is the determination of one’s mental incompetency to do so. Of course the state has a vested interest in protecting the integrity of the voting process (Hurme & Appelbaum, 2007). If the voting public were to perceive that incompetent individuals routinely cast ballots, the credibility with which the competent voter views the process of selecting leaders and issues for their support might be diminished. Competent adults may wonder if the electoral process is that important if anyone, including those perceived as incompetent, are allowed to participate in it (Hurme & Appelbaum, 2007).
Current Competency Standards

The avenue for protecting the integrity of the process while allowing all capable individuals the opportunity to vote lies in the establishment of clear criteria for determining voting capacity. This complex and difficult task requires that there be agreement on criteria by each state for each state. As a remedy for this complexity, a federal competency standard for all elections has been proposed, although the specific competency criteria to be used have yet to be determined. But the proponents of federalism argue that states should have the ability to determine their own competency standards (Karlan, 2007).

As a result of these tensions, a compromise proposal was offered by a group of policy scholars who suggested that universal standards for federal elections be enacted and then the states be allowed to devise and maintain their own standards for state and local elections. Not surprisingly, the logistical complications of trying to maintain and enforce two sets of competency standards were thought to be unrealistic and the proposal was dropped (Karlan, 2007). In the end, the devising of standards for determining voter competence has remained the responsibility of each individual state.

Few state laws provide clear and specific criteria for who has and does not have the capacity to vote (Hurme & Appelbaum, 2007). Only four states give specific direction to their judges as to what should be considered when determining voter competency. In Delaware, the direction provided to judges does not include clear criteria for determining competency; instead, the direction sets out the standard of proof required to prove incompetence. That standard calls for clear and convincing evidence of "severe cognitive impairment, which precludes exercise of basic voting judgment" (Del. Code Ann. Tit. 15, secs. 1701 as cited in Hurme & Appelbaum, 2007). Iowa courts may find a voter to be incompetent only when "the individual lacks sufficient mental capacity to comprehend and exercise the right to vote" (Iowa Code Ann. secs. 633.556[1] as cited in Hurme & Appelbaum, 2007). In Washington state, the law provides criteria for voter competency requiring that courts determine "that the person is incompetent for purposes of rationally exercising the franchise in that the individual lacks the capacity to understand the nature and effect of voting such

The above standards represent earnest efforts toward establishing fair criteria in assessing voter competence, however all but one standard remains difficult to apply when making a competency and voting rights determination. Washington state criteria call for the determination of the person’s ability to make decisions and his or her awareness of the effect and the nature of voting. These more specific criteria imply an actual assessment of the voter’s understanding of the process. As such, it avoids some of the limits found in other proposed criteria. For example, another proposed set of criteria called for an assessment of the level of a person’s knowledge of the issues and the candidates listed on a given ballot. Aside from the very real and common problem of perfectly competent voters walking into the booth on election day only to find a name or a referendum about which they know or have heard nothing, two additional and related problems exist. First, it is difficult to determine what amount or level of knowledge regarding candidates and election issues is required to cast an intelligent ballot (Schriner, Ochs, & Shields, 1997). Second, if these criteria for voting capacity could not be met by many in the electorate because most voters only possess a superficial knowledge of major ballot issues and candidates (Watkins, 2007; Schriner, Ochs, & Shields, 1997), would it not be a violation of the 14th Amendment to exclude one group of people simply because of their disability while allowing another group of individuals with the same level of voter incompetence to cast its vote? The Washington state criteria that relate to decision-making ability, an understanding of the process and the effect of voting were adopted by the Maine Federal District Court in Doe v. Rowe as the functional standards for determining voter competency (Hurme & Appelbaum, 2007). These criteria not only lend themselves to assessment, but acceptable means of accomplishing this assessment already exist.
Proposed Competency Standards

The assessment of competency to make decisions on one’s own behalf is regularly required for medical consent. Research has produced a number of possible standards to use in this assessment. In recent years, the courts have recognized a limited number of standards to determine decision-making capacity. Four standards are found in the law, each addressing a different aspect of decision-making ability: (1) to express a choice; (2) to understand information relevant to the decision about treatment; (3) to appreciate the significance for one’s own situation of the information disclosed about the illness and possible treatments; and (4) to manipulate the information rationally (or reason about it) in a manner that allows one to make comparisons and weigh options (Grisson & Appelbaum, 1995). These four standards reflect a rigorous set of requirements for decision-making capacity.

Based on the potential for harm if an individual makes an erroneous decision about medical treatment, this rigor is justified. But when considering these standards in the context of voting, the need for this level of rigor falters. In reality, the potential for harm done to the individual or society is minimal if the individual’s vote is contrary to how she would have voted if not impaired. Hurme and Appelbaum (2007) posit that due to the lesser potential for harm, the reasoning and appreciation standards found in the medical consent criteria provide unnecessary rigor for voting competency.

Two of the standards, the ability to make a choice and to understand information relevant to the decision are similar to the criteria found in the Washington/Doe standard. These two criteria are believed to provide a level of rigor in keeping with the gravity of decisions made by voters. Thus, the use of an adapted version of established decision-making criteria seems sensible. The perspective of voting as a decision-making process and the realistic assessment of the substantive requirements of the decision is more accurate, realistic, and inclusive. The perspective of voting as an intellectual exercise that must be performed by individuals well-versed in the specific issues and platforms of each candidate is an ideal still used to distinguish competent and incompetent voters. This is neither realistic, reflective of the typical voter, nor something that reflects the
legitimacy of the individual vote. Having an understanding of the office to be held by the candidate and the general duties of that office reflect an informed decision and require a realistic level of voter knowledge. The rigorous requirement that the voter have an in-depth knowledge of issues and of candidates has been used historically to disenfranchise the voter.

Other standards have been proposed that provide guidance to the courts in determining one's competency to vote. The American Bar Association posits that,

any person who is able to provide the information, whether orally, in writing, through an interpreter or interpretive device or otherwise, which is reasonably required of all persons seeking to register to vote and allowed to cast a ballot in any election held in the election precinct where the voter is registered, shall be considered a qualified voter of this state...” (American Bar Association, as cited in Schriner, Ochs, & Shields, 2000, p. 451)

This standard has been adopted by the state of California to determine voter competency (Schriner, Ochs, & Shields, 2000). It represents a threshold of capacity that is somewhat lower than that of the Washington/Doe standard. This standard does not require the cognitive machinations of decision-making and awareness of effects but only the ability to communicate minimal demographic information. It would allow more individuals to be determined competent to vote, as it would not take into account one's decision-making ability, and that ability that may vary depending on time, place and situation. The question remains however, whether this standard applies the appropriate level of rigor required to uphold the legitimacy of the election process. Perhaps not. The ability to make a decision is inherent in the ability to cast a vote. If one is not able to make a decision, then he or she will not be able to vote without another making the decision for him or her. That kind of scheme does not lend itself to a credible election process.

Therein lies another level of complexity in determining competency standards, balancing the needs of the electorate with standards of competency that allow the most
competent individuals to vote. Each state is left to decide how to find this balance. Unfortunately, many still have not begun to examine specific, applicable standards for determining voter competence. They continue to rely on the opinions of professionals, including social workers, who make voter competency determinations based on the individual’s overall ability to care for themselves and manage their affairs (Karwalish et al., 2008).

**Barriers to Voting Outside of the Legal System**

The determination of voter capacity has been appropriately maintained in the legal system. The obvious barriers to voting faced by citizens who have psychiatric disabilities and the progress toward their resolution have been discussed thus far. However, in reality, individuals outside of the legal system present additional barriers to voting. This occurs when professionals, caretakers, and others outside of the judicial setting make judgments, typically outside of the law, about who is competent to vote. One study of three long-term care facilities found that two of the three facilities assessed voter capacity and the assessments were performed exclusively by individual staff members in a non-systematic manner. Each staff created his or her own individual standards for voter competency without the benefit of training on the election laws of their state (Karlawish et al., 2008). Social workers are among the most common service providers of psychiatric services and so are likely to participate in and perhaps even perform this type of uninformed assessment.

Of particular concern is the body of evidence that suggests that election officials make independent, ad hoc decisions regarding voter competency. Individuals who present to register to vote or cast a ballot may be denied on the basis of their appearance, behavior, or the personal knowledge of the election official about the individual’s diagnosis (Karlan, 2007).

The illegality of this behavior was determined in 1976 when an individual with mental retardation who was not permitted to register to vote by election officials brought a case. In this case, Carroll v. Cobb, the court ruled that election officials were not permitted to assess individuals for competency to vote (Carroll v. Cobb, 1976). While the court long ago determined that determinations by election officials are illegal,
they do continue. The Public Advocate in New Jersey took an aggressive and thorough approach to the problem. Prior to the 2006 election, Ronald Chen sent a letter to each disabled individual in the state that laid out their rights to vote, the voting laws, voting accommodations under the ADA, and resources for redress if they experienced difficulties registering or at the polls. With emphasis, Mr. Chen encouraged the recipients to take the letter with them to the polls "in case any questions arise while you are there" (New Jersey Department of the Public Advocate, 2006). This effort represents a proactive and dedicated response to the voting needs of the disabled, including those with psychiatric disabilities, and a useful source of education for election officials. Social workers also have an opportunity to support voter participation through advocacy efforts with election officials. This can occur by accompanying consumers throughout the voting process (registration, polls) and/or by contacting election officials as an agency to ensure that proper voting laws will be followed.

Conclusion

The voting rights of those with psychiatric disabilities under guardianship, the standards by which voter competency may be established, and other barriers to voting have been explored. However, the corollary of the above issues is the voter participation of those with psychiatric disabilities who do not have guardians and barriers to voting that they face. Social workers are in a unique position to address the barriers to voter participation and the competency issues confronting this population. The next step in addressing these issues likely requires that we as a profession examine how supporting the voting rights of those with psychiatric disabilities can become a greater priority.

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References


Across the United States homeless persons, prostitutes, and drug and alcohol users are subject to policies that severely limit their freedom of movement. These new policies create spatial exclusion zones that deny these groups the right to inhabit or traverse large areas of their cities, particularly in the downtown cores, where treatment centers, shelters, food banks, soup kitchens, government services, and other social services are typically concentrated. In this paper, I examine these new spatial exclusionary policies (with a focus on Washington State's policies), present a brief historical account of socio-spatial practices, contextualize the current spatial laws, and end with the implications of current exclusionary laws for social work practice, policy, and research.

Key words: spatial policies, exclusion zones, human rights, social justice, space, marginalization, homelessness, prostitution, drug use, urban

Across the United States homeless persons, prostitutes, and drug and alcohol users are subject to policies that severely limit their freedom of movement. On April 13, 2011, in Minneapolis, for example, James Solomon was given a court probation order restricting him from approximately 90 downtown blocks for one year. His offense: loitering with an open bottle (Minneapolis Police Restriction Order, 2011). In Miami, on March 25, 2011, Tenisha Shepard received a six-month spatial probation for prostitution, banning her from over 150 blocks. If she is found in this area she can be arrested and jailed (Goyette, 2011). Many of these new policies create spatial exclusion zones covering large areas of U.S. cities (Beckett & Herbert, Journal of Sociology & Social Welfare, September 2012, Volume XXXIX, Number 3

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Populations convicted of "social crimes" (e.g., sleeping in parks/parking lots/public spaces after hours, prostitution, drug use/buying illegal substances, drinking in public) are the focus of these spatial restrictions. Most of these probationary restriction zones are in downtown cores. Treatment centers, shelters, food banks, soup kitchens, government services, and other social services are typically concentrated in these areas, and the inhabitants denied access to these zones are those most in need of these services.

Despite the growing pervasiveness of these "no go" policies and practices, and their obvious implications for social work practice with vulnerable and underserved populations, they are receiving almost no attention in the social work literature. This paper seeks to address this gap, arguing that social workers not only need to be well informed about the current proliferation of exclusionary spatial policies, but also, in general, would benefit from critical awareness of the links between space, power, and social control.

Although the primary focus of the paper is on contemporary forms of spatial control, the use of spatial mechanisms to control and marginalize unwelcome groups of people has a long history. To situate current policies, I first present a brief history of socio-spatial exclusion in the United States from colonial times to the re-emergence of exclusionary spatial practices, in new guises, in the 1980s (with their ubiquitous use in Washington State serving as one example). The body of the paper then describes and contextualizes current laws and policies. The paper concludes with a discussion of implications for social work practice, policy, and research.

Historical Spatial Exclusion

Criminalizing homelessness has a long history in the United States—one which often resulted in forms of incarceration in workhouses or poorhouses, if not prison. The colonists brought vagrancy (the status of possessing no permanent home) laws with them that dated back to the Elizabethan Poor Laws of the 16th century (Amster, 2003). These laws subjected vagrants to physical punishment including beatings, scouring, and pillorying as well as a "[two year] enslavement penalty..."

By the 1700s and 1800s, vagrancy laws were also being used to control criminals and those deemed nuisances (Chambliss, 1964). In 1837, the United States Supreme Court made its opinion of vagrants clear in its decision on City of New York v. Miln:

We think it as competent and as necessary for a state to provide precautionary measures against the moral pestilence of paupers, vagabonds, and possibly convicts; as it is to guard against the physical pestilence, which may arise from unsound and infectious articles imported, or from a ship, the crew of which may be labouring under an infectious disease. (36 US (11 Pet) 102, 142-43 (1837) in Douglas, 1960, p. 2)

The use of vagrancy laws to address a wide range of “social crimes” persisted into the 1960s. In California, for example, during the Great Depression, vagrancy laws were used to stop the influx of immigrants from other states (Chambliss, 1964) and for other purposes: for example, against waterfront strikers in 1935 (Douglas, 1960) and to silence criticism of the police in 1953 (Douglas, 1960). In 1960 in Washington, DC, a law defined vagrants as anyone identified as a “pickpocket, thief, burglar, confidence operator, or felon”; persons leading “immoral or profligate life”; persons involved with houses of “ill-fame” or “gambling establishments”; persons “wandering abroad”; persons “begging”; and persons on the streets at “late or unusual hours of the night” (D.C. Code Ann. 22-3302 [supp. VIII 1960] in Douglas, 1960, p. 6).

As political movements around civil rights increased in the 1960s, vagrancy laws were increasingly criticized by legal scholars for their vagueness. In 1972 the U.S. Supreme Court declared vagrancy laws to be unconstitutional (Papachristou v. City of Jacksonville, 405 U.S. 156 [1973] in Ades, 1989). In response, states began using loitering (standing idly doing nothing) laws as they had been using vagrancy laws. Ten years later, in 1983, the Supreme Court declared loitering laws unconstitutional due to ambiguity (Kolender v. Lawson, 461 U.S.
leaving states without the use of vagrancy or loitering laws. At the same time, states were faced in the 1980s with a spike in the number of homeless people due to multiple factors: economic restructuring that sent well-paying manufacturing jobs overseas while promoting low-wage service industry jobs and unemployment; an increase in inflation with a decline in real incomes for middle- to low-income wage workers; the destruction of low-income housing through the revitalization and gentrification of downtown areas; rises in property values (resulting in higher rents in cities); and the reduction of federal funds for General Assistance Benefits, AFDC benefits, and Food Stamps (Ades, 1989; Burt, 1992; Shlay & Rossi, 1992; Wolch & Dear, 1993; Wright & Lam 1987; Wright, Rubin, & Devine, 1998). Burt’s study in 1991 showed that the number of shelter beds tripled from 1981 to 1989. Another study reported homelessness almost doubling from 1987 to 1996 (Burt, Aron, Lee, & Valente, 2001).

Cities responded to the homelessness crisis of the 1980s and '90s with a host of new anti-homeless city ordinances, mostly focused on sleeping or sitting in public spaces and pan-handling. No-camping ordinances spread across the United States until almost every large city had one (Saelinger, 2006). The National Law Center on Homelessness & Poverty and the National Coalition for the Homeless (2009) examined 235 cities and found that 47% of them had bans on camping either in particular public places or city-wide. Over the same period, an acute shortage of shelter beds arose (United States Conference of Mayors, 2010). Along with increases in anti-homeless ordinances in the late 1990s and early 2000s, were increases in the number of hate crimes in the form of blatant verbal and physical attacks against the homeless (Wachholz, 2005). In the 1990s, policies to remove groups of unwanted people from particular spaces took a new turn: the creation of zones of exclusion (Beckett & Herbert, 2010).

Zones of Exclusion

Beginning in the 1990s and proliferating in the 2000s, the United States and other industrialized nations enacted spatial policies designed to keep “undesirable” populations from
particular city spaces. Under these policies, homeless people, prostitutes, and drug users are literally banned for lengths of time (often up to two years) from city cores. These new spatial laws do not exist to keep someone from committing a crime (those laws already exist); they ban groups of people from a space because they at one time committed a crime in that space. As Flanagan (2003) notes "...the excluded individual need not engage in criminal activity, nor even be suspected of it. Rather, it is the individual’s mere presence in a particular area that offends" (p. 329). In essence, the spatial exclusion laws target people for who they are, not what they are doing.

Though this study focuses on the United States, there are many European cities that have adopted spatial policies to control the same populations. Both Europe and the United States have spatial ordinances regulating prostitution. The Danish government created “green-light” spaces for prostitution and in the process declared its city centers as exclusionary zones for prostitution (Hubbard, 2004). As of 2007 in Germany, cities had enacted spatial prostitution bans in 17 areas, which included center city spaces. Other “undesirables” are also excluded from the center of German cities (Belina, 2007). Anti-social behavior ordinances were first enacted in the United Kingdom in 1998 under the Crime and Disorder Act (Statewatch, 2010) to ban people from specific acts and from certain spaces of the city (Flint & Nixon, 2006).

In the United States, spatial exclusion orders are usually attached to a probation agreement for two reasons: first because spatial exclusionary orders not attached to probations were often rejected by courts as too broad and too restrictive (this was true in court cases in Fresno, 1979, New York City, 2000, and Cincinnati, 2002) (Hill, 2005) and second because the connotation of probation has dramatically changed over forty years. Probation was previously thought of as a less punitive sentence than jail, imposed by judges on case-by-case basis and reserved for offenders who were considered more tractable to rehabilitation (McAnany, 1995). In the 1980s punishment became more emphasized over rehabilitation through stricter sentencing and ever-increasing imprisonment (McAnany, 1995), and probation became a spatial fix to rid city streets of undesirables. Furthermore, Snider (1998) noted that almost anything can be attached to a probation or parole restriction:
Most jurisdictions have held that any condition, so long as it is not illegal, immoral, or impossible to perform, may be attached to a parole or a pardon. Banishment as a condition of a parole or pardon has been upheld... even in cases where the state constitution contained a provision outlawing banishment. (p. 471)

Because, judges, police, and lawyers know that those convicted of spatial crimes (the homeless, prostitutes, and drug users) rarely have the time, money, or energy to refuse parole or probation, spatial restrictions typically are not fought in court (Snider, 1998). Spatial probations are being used with a variety of existing city laws, ordinances, and orders, including Park Exclusion and Trespass Orders, Prostitution Laws and Drug Laws.

Spatial Exclusions Probations Attached to Park Exclusion and Trespass Orders

Washington State provides useful examples of these types of orders. The cities of Everett, Monroe, Seattle, Tenino, and Vancouver have Park Exclusion Orders in their municipal codes. Below is an example of a Park Exclusion Order, SMC 18.12.278, Seattle's Park Exclusion Code:

A. The Superintendent may, by delivering an exclusion notice in person to the offender, exclude from a City park zone or zones, anyone who within a City park: ...

The offender need not be charged, tried, or convicted of any crime or infraction in order for an exclusion notice to be issued or effective. The exclusion may be based upon observation by the Superintendent or upon the sort of civilian reports that would ordinarily be relied upon by police officers in the determination of probable cause. (Seattle Municipal Code, 1997-2011)

Since free food services are often provided in downtown parks, those excluded speak over and over again about the impact of being deprived of the right to go to parks (Beckett & Herbert, 2010):
But if somebody's feeding at the park, uh, I can't go to the park and partake of the meal being offered? That's bullshit.

Now you're going to arrest me for, for going where you put the services for me to get? You know, that doesn't make sense! It's crazy.

Those places that they're telling them that they cannot be, they're not moving. But they're asking the people to move ... and I know if I can get in there and around the police I can eat. I'm going to do it, you know, and at all cost. (pp. 135-136)

The number and types of spaces of exclusion are proliferating. Some cities are banning people from businesses (or combined businesses, so for example, being banned from a McDonalds might, under the parole requirements, mean banishment from twenty-five to thirty different types of businesses in the city) and from parking lots (Seattle has a trespass program where being banned from one parking lot bans the
person from 320 other downtown core parking lots) (Beckett & Herbert, 2008). (See a Trespass Program Sign in Figure 1).

An interview with a homeless individual in Seattle under spatial restriction orders due to trespass probation speaks to the scope of these restrictions:

I mean, they [downtown parking lots] are everywhere. And I'm not just talking about the ones on the surface... there's the underground ones; they're on almost every corner that you take shortcuts through, like we just did. You know, and my feet aren't so good, so I take shortcuts... It's too much.

On the back of the card, you know on the back of the card, it says when you sign the card, you trespassed from all these places on the back of the card. That's everywhere! You can't go to Sorry's, you can't go to Feathers, you can't go to Rainier Beach, you can't go to Bank of America, you can't go to the Moore place, you can't go to Safeway, you can't go nowhere! (Beckett & Herbert, 2010, pp. 130-131)

Some cities are banning people from a variety of public spaces, such as alleys, bus stops, buses themselves, churches, libraries, hospitals, university and college campuses, apartment buildings, public housing complexes, and social service agencies (Beckett & Herbert, 2010).

A service provider for the homeless stated that most of the employees at her agency were accustomed to having one or more of the people they are serving subjected, at any given time, to a spatial exclusion order. The service provider said that many of the agency's clients get exclusion orders at downtown parks, bus stops, and tunnels (personal communication, March 28, 2011).

Stay Out of Prostitution Area Orders

In the United States, spatial parole policies create banned zones for prostitutes, like the SOAP Orders. Cities in California, Florida, Louisiana, Missouri, Nevada, Oregon, and Washington have all enacted forms of SOAP ordinances (See a SOAP Sign in Figure 2).
Judges and correction officers are using probation restrictions attached to orders against convicted prostitutes to ban those considered unwholesome from certain spaces in the city, and in some cases from entire downtown areas (Beckett & Herbert, 2010). Portland, Oregon, enacted a SOAP Ordinance in 1995. Though the Ordinance was repealed in an Oregon court on the grounds that people can’t be arrested twice for the same violation (double jeopardy), the Oregon State Supreme Court upheld the Ordinance on the basis that the violation was of the probation restriction, not a re-arrest for prostitution.
Whether intentional or not, the acronym SOAP, signifying the need to rid public spaces of the "unclean," conveys lawmakers' conception of prostitutes. By creating space in which prostitutes are not allowed, the law is saying that any prostitute in that space is seen by the law as acting as a prostitute, no matter the activity in which he or she is engaged. In this regard, Sanchez (2004) writes that such a law:

...reifies the prostitute identity on women and men who have once engaged in street prostitution, assuming that street work is a permanent and full-time occupation, and arresting women and men for their mere existence in public space. But this neglects to consider that many, if not most, street workers move in and out of prostitution, sometimes by the week, and it deprives them of the opportunity to shift their energies onto other work, family, and activities. Moreover, it ignores the fact that sex workers use the five major city streets of the zone for all of the same purposes that others do: to buy groceries, catch the bus, walk to the park, care for children, and so forth. (pp. 869-870)

Since 2003, Seattle has implemented five SOAP areas, comprising a total of 3.2 square miles, which is almost the entire downtown core (Hill, 2005). These SOAP orders are affecting arrests for prostitution; for example, from 1996 to 2002 prostitution arrests increased from 97 to 403 (Hill, 2005). One woman under a SOAP order, who was interviewed by Beckett & Herbert (2010), said:

I told you about that experience when the bus door opened, the police officer seen me on the bus ... I was traveling through, going to where I lived right on Pacific Highway, out there by Larry's Market. I stayed in a trailer park over there ... I mean, once I got off the bus he was right behind the bus there and stopped me. And took me right back to jail ... Cuz I had just got out of jail that day for a SOAP violation, being in a SOAP zone, which is where I was living. And, when I got out, and walked out of the bus, here he is ... I have enough time to get out of that jail, walk into the store, get on the
bus and go uptown ... get off the bus, and don’t even make it across the street, and I’m gone, back to jail. He just drove me back to Tukwila. Just drove me right back down to the jail house. (pp. 123-124)

Stay Out of Drug Area Orders

Another common banishment zone is associated with SODA parole attachments. Forms of SODA ordinances have cropped up in cities in California, Florida, Hawaii, Nevada, Ohio, Oregon, Virginia, and Washington. Below is an example of a SODA Order:

10.13.025 Stay Out of Drug Areas Orders Everett, WA, SODA Ordinance. Any order issued pursuant to this chapter that specifically orders as a condition of pretrial release and/or deferral or suspension of sentence that the defendant stay out of areas with a high level of illegal drug trafficking shall be hereinafter referred to as a “SODA” (“Stay Out of Drug Areas”) order.

B. SODA orders may be issued to anyone charged with or convicted of possession of drug paraphernalia, manufacture/delivery of drug paraphernalia, delivery of drug paraphernalia to a minor, selling/giving drug paraphernalia to another person, possession of marijuana, or any of the aforementioned crimes that occur within a drug-free zone.


A number of cities with SODA parole policies have been accused of using them to keep African Americans out of downtown cores (England, 2008). Certainly African Americans appear to be overrepresented among those receiving SODA paroles. For example, in Portland, Oregon, between June 1 and October 31, 2006, 58% of whites arrested for drug possession were given SODAs compared with 100% of blacks (Moore & Davis, 2007).

SODA orders also exist in Seattle (since 1991); here too African Americans are overrepresented among arrestees. England states:
During the first three months of SODA’s original implementation, over 50% of those arrested for drug loitering were African Americans. Less than one-third of those arrested led to actual charges, lending credence to the charge by some that the law was primarily implemented as a device to remove Black males from downtown streets. (England, 2008, p. 198)

This overrepresentation of African Americans receiving SODA orders is not surprising, given the findings of a study by Beckett (2008) for the ACLU and the Defender Association that demonstrated that African Americans are disproportionately arrested for drugs in Seattle. Though African Americans comprise only 7.9% of Seattle’s population (2006), and through numerous different measurements represent well under one-half of Seattle drug users, they are over-represented in arrests for drugs, because the Seattle Police have focused on arresting crack cocaine users in the downtown area of Seattle, the majority of whom are African Americans (Beckett, 2008).

SODA laws have other impacts on vulnerable and marginalized populations. The spaces being demarcated are also often the spaces where those being restricted live or where their social networks are located. Beckett and Herbert (2010) wrote of the hardships imposed upon those denied the right to traverse the city. A Seattle woman kept from visiting her mother due to spatial banishment explained:

The judge was like, “No way. I don’t care if that’s your mother or not, there’s no way. That’s a drug area, that’s around the area you got caught in, so we don’t want you in there.” I’m like, “That’s my mom, I mean, either you’re gonna have to just keep taking me to jail and give me SODA violations, because I’m not gonna stop seeing my mom.” (Beckett & Herbert, 2010, p. 4)

In King County, Washington, thirty-one SODA zones currently exist; these include the majority of Seattle’s downtown core. The magnitude of the SODA zones is felt by many SODA parolees:
There's too many, they have way too many. Everywhere! Have you ever seen the SODAs? They're crazy! You may as well just say, well, I'm not supposed to go out today!

Pretty soon, there's nowhere for you to go but in your house because the SODA zones are all over Seattle ... They say these are the areas where the drugs are sold. Drugs are sold almost everywhere. (Beckett & Herbert, 2010, p. 130)

If a person violates a SODA order they face a longer jail term and a longer probation. A service provider noted that the Drug Court is diligently enforcing SODAs:

Many in this group, when faced with an exclusion order, come to it by way of Mental Health [or] Drug Court, which includes lots of formal Department Of Corrections supervision. Our sense is that our severely mentally-ill clients don't see the spatial orders strongly enforced by their DOC supervisors, who understand the client's limitations to following them. Those clients in Drug Court, however, see their SODAs enforced closely and most of them say they benefit from that, seeing it as supportive structure. (personal communication, March 28, 2011)

Not surprisingly, Herbert and Beckett (2011) found that only one-third of people with exclusion orders whom they interviewed said that they "mostly complied" with the banishment. Keeping people out of the spaces where they grew up, obtain services, their relatives live, and they are acclimated to is not an easy proposition. We are all tied to spaces: as Jackson (1994) insists in his book, *A Sense of Place, A Sense of Time*, the essence of a sense of place is when we think of it as home.

But you got to realize, too, this is the only place I know... good or bad, good or bad. It's the only place I know. I can get food, get housing, take a shower, brush my teeth, this place it provides for me, you know what I'm sayin', it provides for me, and then, even if I'm doing wrong, it still provides. Cuz if I mess up on my money, I can still go up to the park to eat. You know what I'm
sayin'. So, you have to know that some people live here. This is home for us. (Beckett & Herbert, 2010, p. 115)

Neoliberal policies reduce funding for social services while creating harsher restrictions on receiving services. Providers find themselves between a rock and a hard place. Yet there is a vast difference between struggling to make do with funding shortages and supporting neoliberal policies. British researchers Sarah Johnson and Suzanne Fitzpatrick have written numerous articles suggesting that spatial restrictions are helpful for the needy. In a 2008 article they quote drug users saying:

"...this ASBO, in a kind of weird way, has done me a favour because I've faced my demons..." and [Interviewer]: "Where would you be now, do you think, if you hadn't had your ABSO?" [Street user]: "Dead or in jail on a life sentence or something." (Johnson & Fitzpatrick, p. 198)

Another service provider notes, "Some clients tell us they value the orders because they help them stay out of areas of drug dealing and in compliance with Department of Correction Supervision" (personal communication, March 28, 2011). However, Beckett and Herbert (2010) found that only 12% of those they interviewed in Seattle said they obtained some positive outcomes from their exclusion orders, whereas the majority of respondents focused on negative consequences.

Contextualizing Zones of Exclusion

Much of the contemporary rationale for spatial exclusion policies is economic. For many years, through referendums and requests for city improvement funding, cities have been suggesting to their inhabitants the need to clean up waterfronts, parks, and downtown areas so they can attract corporate investment and people for shopping, housing, and cultural events (Lefebvre, 1996). Under the facade of urban renewal/ redevelopment, corporations have obtained public space in de-industrialized cities' cores for close to no cost (Herbert & Brown, 2006; Hubbard, 2004; Mitchell, 1997; Smith, 1996). Corporations have profited while contributing to social and economic disparities by destroying low-income housing,
raising rents to prohibitive levels for the poor, not creating sufficient living-wage jobs, thus throwing large numbers of people into homelessness (Katz, 2001; Mitchell, 1997). Moreover, the old deindustrialized cores were the spaces that cities had pushed their most marginalized groups into, and now these marginalized people hinder redevelopment (Herbert & Brown, 2006; Hubbard, 2004; Mitchell, 1997; Smith, 1996). All of these practices are occurring in U.S. cities today; they continue to be framed for the public as acceptable practices in order to maintain order, civility, and safety.

Exclusion of homeless populations from the public sphere, for example, is linked by governments to “the broken window” argument (Wilson & Kelling, 1982), used by Mayor Guiliani in New York City (Mitchell & Beckett, 2008). This argument posits that a broken window invites crime and disorder. Similarly, the mere presence of a homeless person is seen as inviting crime and disorder. Since the early 1990s, some police, lawyers, and public servants have been calling for new laws to limit access to public spaces, because panhandlers, park-campers, and homeless people make these spaces unsafe and uncivil (Ellickson, 1996; Siegel, 1992; Teir, 1993). Teir (1993) makes this argument by suggesting it is a middle approach between the civil-libertarian method of allowing all people access to the city and the old-English/Scottish style of beating and maiming the homeless person:

Legislation aimed at unwelcome panhandling is a key element in returning safety and civility to urban streets. Other measures being tried with success, but also being routinely challenged by radical individualists, include anti-drug loitering ordinances, regulations of the locale of public sleeping, asset seizures for drug and prostitution customers, and limitations on the public consumption of alcohol. All of these efforts have in common an effort to strengthen communities and make the streets safe so that community life can flourish. (p. 291)

In 1992, George Kelling encouraged the police to quell the public’s “fear of disorder” by cracking down on “petty crime and inappropriate behavior such as public drunkenness, pan-handling, and loitering.” The following year, in 1993, Kelling
stated, "...the signs of disorder—panhandling, street prostitution, graffiti—help create the spiral of urban decline, as fearful citizens retreat into their homes, ceding the streets to criminals. Halting this spiral requires a strong set of laws against disorderly behavior..." (¶10). The problem of urban decline, according to Kelling, is the panhandler, the loiterer, the homeless, the drug-user, and the prostitute inhabiting public spaces, with no consideration of the reasons why they are inhabiting these spaces (sky-rocking housing costs and unemployment). In the early 1990s, new laws were created to rid city cores of the marginalized people living on the streets, and this was accomplished using a construct of disorder, incivility, and endangerment as the rationale for such laws.

Such arguments ignore the socioeconomic and sociopolitical processes that in the preceding decades resulted in the ghettosization of deinstitutionalized, mentally-ill patients (Dear & Moos, 1986; Moos & Dear, 1986), the homeless, prostitutes, and drug users in the inner cities. The decades after World War II saw the exodus of the middle class from urban spaces to suburbia. In the 1960s and 1970s, the destruction of single-room occupancy (SRO) housing (without building alternatives), and in the 1980s the discontinued funding of developers for the building of low-income housing (ending tax breaks) and the cutting of social services pushed hundreds of thousands of people into the streets, creating a huge homeless crisis in the United States (Burt, 1992; Rossi, 1989; Shlay & Rossi, 1992; Wolch & Dear, 1993; Wright & Lam, 1987; Wright, Rubin, & Devine, 1998). As Moos and Dear (1986) discussed, the transfer of federal funding to the state level created budgetary constrictions for social service delivery. Due to lack of client transportation and the costs of a facility and wages for service providers, social services were forced into specific central locations in the urban cores (Dear & Moos, 1986). The location of these services, in turn, encouraged the movement of the homeless, drug users, and prostitutes to the cores of the cities, helping create these urban ghettos (Dear & Moos, 1986). Certainly the homeless, drug users, and prostitutes had no say in the policies that moved them into these urban cores, just as they are not having any say in the current policies that are moving them out of these cores.
Lefebvre’s discourse on space and “the right to the city” (1991, 1996) provides a useful analytic lens here. Lefebvre (1991) argued that social relations “project themselves into a space, becoming inscribed there, and in the process producing that space itself” (p. 129). Space thus reveals how, what, and where power is at play. Spatial exclusion policies reveal the city government’s perceived right to deny certain people the right to a space open to everyone else in the city, but also to designate who the public comprises. These new spatial policies give city governments the power to control who has the right to the city spaces, thus implicitly deciding who is not given the rights of a public citizen.

Implications for Social Work and Social Services

Over the last thirty years, these new and more punitive spatial policies have been formulated by city governments to push “undesirable” populations out of city cores. These spatial probationary restrictions surely just move these unwanted people and their behavior to other spaces, while denying them the right to enter spaces where they must go to survive: food banks, food kitchens, substance abuse centers, mental health clinics, hospitals, courthouses, libraries, and transportation services. The production of public spaces for only a particular sphere of the public and not for others is, in a sense, offering the right to the city to the chosen. The whole construct fits within current neoliberal ideology, which defines a citizen as one who buys products (Brown, 2003); all others do not belong.

In addition to the general construct of “the chosen,” concerns around social justice and the targeting of people of color and women, as well as class issues, need be considered. Feminists and critical race scholars describe how full social citizenship has been bestowed by those in power only on those who share the same identity, i.e., male and white (Benhabib, 1992; Fraser, 1989; Haney-Lopez, 1996). Exclusionary practices throughout U.S. history are linked to race and gender. The full rights of citizenship have been granted to people who conform to the accepted social standards of society (Carr, Brown, & Herbert, 2009). Prostitutes, drug users, and the homeless are populations outside of normative societal standards.
Social work practitioners and researchers need to examine the effects of spatial policies on those being excluded, as well as on the agencies that may find themselves in city spaces bereft of clients. Social welfare scholars should explore how providers perceive the positive and negative outcomes of spatial bans. If we accept that some individuals benefit from spatial exclusion orders, we need to determine who is helped and who is not, and why, to inform better practices.

At the policy level, researchers should undertake comparative studies of cities with and without exclusionary spatial probation restrictions to discover whether cities with these policies have different rates of homelessness, prostitution, and drug abuse. In addition, researchers need to evaluate whether these policies work. Do they prevent re-offending or do they push the problem elsewhere?

Finally, social work researchers are well placed to examine how power is played out in space. With neoliberal-based cuts to social services, as well as policies that shift national distribution of aid for the poor to the state level, welfare benefits dry up in economically distressed periods, widening inequality and creating more unsheltered homeless people. The new economic transformation of society as a whole has resulted in new spatial regulations on local levels. This paper represents a starting point for policy makers, researchers, and practitioners to consider the effects of spatial policies on the marginalized populations that we all serve.

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References


Zones of Exclusion


Long Term Care Insurance
Beyond the CLASS Program

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The Community Living Assistance and Supports (CLASS) program, created under the Patient Protection and Affordable Care Act, established a federally-administered, voluntary insurance program that allows for working adults to purchase insurance to cover the cost of long term support services. The CLASS program is the first step towards moving away from a welfare-based system, improving consumer choice, and creating a stable funding source for long term care needs. Enrollees in the CLASS program who meet benefit eligibility requirements and need care assistance will receive a cash benefit to pay for supportive services such as home health care, adult day services, assisted living, nursing home care, housing modification, assistive technologies, and transportation assistance. The authors apply David Gil’s (1992) model of social policy analysis to assess the effectiveness of this policy alternative to aid in the development of a viable national long term health care solution for the anticipated ongoing health and support service needs of the older adult population.

Key words: CLASS program, Gil model of analysis, long term care, older adults, equality

As the baby boomers age, the need for long term services and supports for individuals living in the community will increase dramatically. Today, approximately 10 million Americans need long term care (LTC) services to assist with
carrying out activities of daily living, and this number is expected to increase to 15 million by 2020 (National Council on Aging, 2010). Issues of LTC are gaining more attention due to the rapid aging of the population taking place in the United States as well as many other developed countries as a result of low fertility rates and increased longevity. Along with increases in the average lifespan, old age is often accompanied by chronic illness that may cause physical or cognitive frailty for an extended period of time. Approximately 80% of adults 65 and above in the United States have one or more chronic illnesses (National Center for Chronic Disease Prevention and Promotion, 2004). Nearly two-thirds of the current health care expenditures for the overall population are devoted to treating chronic illnesses; however this proportion could reach as high as 95% for older adults (Hoffman, Rice, & Sung, 1996). The lifetime probability of an American either becoming physically disabled in at least two activities of daily living (e.g., bathing, dressing, transferring, or eating) or becoming cognitively impaired is 68% for people 65 years and above (AARP, 2003).

The United States heavily relies upon unpaid family member caregivers and the welfare-based Medicaid program to provide a safety net of LTC services for older adults. Families are the primary informal providers of eldercare, and their unpaid caregiving contributions are estimated at $350 billion per year (Houser & Gibson, 2008). The bulk of LTC expenditures for formal services in 2005 were funded through Medicaid (49%) and Medicare (20%), with the remaining amount paid through out-of-pocket expenses (18%), private insurance (7%) and other means (6%) (AAHSA, 2009a). In order to qualify for the means-tested Medicaid program, individuals must either be poor or become impoverished through spending down assets. As a social insurance program, Medicare offers time-limited benefits that cover short-term nursing home or home care services. Private LTC insurance is often too costly for most Americans, and the option of taking out a policy is dependent upon the individual’s current health status and absence of pre-existing conditions. Without substantial financial resources or informal help from a spouse or other family caregivers, older people with chronic and debilitating health conditions are vulnerable.
While many older people will need some LTC services, the majority cannot afford to pay for these services out-of-pocket over an extended period of time. For the lower and middle classes, the costs for nursing home care or in-home care are too high in comparison to available personal resources (Administration on Aging, 2010). In 2011, annual nursing home care costs are estimated to average $77,745 for a private room and $39,132 for assisted living (Genworth Financial, 2011). Average costs for LTC services in 2009 were: $198/day for a semi-private room in a nursing home; $219/day for a private room in a nursing home; $3,131/month for assisted living; $21/hour for a home health aide; and $67/day for adult day services (MetLife Mature Market Institute, 2009). The recent economic downturn and the collapse of the housing market significantly decreased the net worth of baby boomers. The median household wealth for a person between 45 and 54 years old fell by 45% between 2004 and 2009 ($94,200 in 2009) and the median household wealth for a person between 55 and 64 years old fell 50% ($159,800 in 2009) (Rosnick & Baker, 2009). A full 42 percent of Americans 45 years and older have saved less than $25,000 for retirement (Helman, Copeland, & VanDerhei, 2010). Further, the availability of personal financial resources has serious implications for service gaps. A study among adults over 50 years old with a disability found that financial barriers were the most important predictor of unmet LTC needs (Gibson & Verma, 2006).

In an initial effort to encourage individuals to plan ahead for potential LTC expenses, the government has provided federal and state tax advantages to incentivize the purchase of private LTC insurance. The Internal Revenue Service allows a tax deduction for private LTC insurance premiums, on a graduated basis according to age. In 2008, a person at age 55 could claim a maximum tax deduction of $1,190, and the amount would increase to $3,980 at age 70 or above (IRS Bulletin, 2008, p. 1113). Tax deductions or credits from state income taxes are allowed for either a partial or full amount paid on policy premiums in a number of states including Ohio. However, most policyholders of private LTC insurance do not receive federal tax subsidies because they do not meet criteria for itemizing deductions, having a tax liability, or having medical expenses
that exceed 7.5% of adjusted gross income (Baer & O’Brien, 2009). Since 2003, individuals could pay for LTC insurance through tax-free health savings accounts, yet only 8 percent of adults 50 years old or above reported holding a LTC insurance policy (Feder, Komisar, & Friedland, 2007).

The Community Living Assistance Services and Supports (CLASS) Program

As part of the Obama administration’s Patient Protection and Affordable Care Act of 2010 (PPACA, P.L. 111-148), the Community Living Assistance Services and Supports (CLASS) Act was enacted on March 23, 2010 (H.R. 3590-111th Congress). The CLASS program forges the creation of a new federally-administered voluntary insurance program that allows working adults to contribute premium payments towards future long-term services in exchange for a cash benefit provided to enrollees if such supports are needed. The Secretary of the Health and Human Services will announce the details of the benefit by October 1, 2012 and it is anticipated that working adults 18 years and above will be eligible to enroll in the CLASS program shortly thereafter (Administration on Aging, 2011). The CLASS program will provide a cash benefit for support services in the community or residential settings, advocacy services, and advice and assistance counseling to eligible enrollees (O’Shaughnessy, 2010). In comparison to private LTC insurance companies, the CLASS program will not exclude enrollment based on pre-existing medical conditions, the cash benefit is provided directly to enrollees rather than contracted to an agency, and there are no lifetime benefit limitations.

To receive the CLASS program benefits, enrollees must initially contribute monthly premiums for at least five years to be vested, earn enough to be credited for one quarter of Social Security coverage (e.g., approximately $1,120 in 2010) during at least three of the first five years, and qualify for the benefit through a measure of functional or cognitive limitations that demonstrate a need for assistance with two or more activities of daily living (Administration on Aging, 2011). Employers can decide whether to offer the CLASS program to employees, and self-employed individuals may also enroll. Depending on the degree of need, anticipated benefits are estimated to provide
an average cash benefit of at least $50 per day per enrollee, and payments can rollover from month to month.

This cash benefit may be used for a variety of community-based or residential care services, including home health care, adult day services, assisted living, nursing home care, housing modification, assistive technologies, and transportation assistance. Access to supportive services can allow older people to remain living in the community as well as provide respite to informal caregivers. Since the vast majority (86%) of older adults who need LTC services are living in community settings rather than institutions (Henry J. Kaiser Family Foundation, 2009), the CLASS program will enable greater access to LTC services while remaining at home. Plus, those who enroll in the CLASS program will also remain eligible for Medicaid (Administration on Aging, 2011). At the earliest, benefits may be available to enrollees in 2017, after the five year vesting period has been fulfilled.

In this insurance model, the fiscal solvency of the CLASS program balances premium income from voluntary worker enrollment and investment income with spending for direct benefits. The Congressional Budget Office (2009) has estimated that the CLASS program will reduce deficits by $72 billion over 2010-2019. With affordable premiums, estimated from $85 to $100 per month, the CLASS program is considerably less expensive than the amount older adults were willing to pay for LTC insurance in 2005 (America’s Health Insurance Plans, 2007). Like private LTC insurance, younger enrollees will pay less than older enrollees, but unique to the CLASS program, lower income individuals can participate through a sliding scale fee for premium costs. For example, CLASS program enrollees below the poverty level and full-time students age 18 to 21 will pay no more than $5 per month (AAHSA, 2009b).

Aspects of the CLASS program may be modified in response to concerns about the program’s financial solvency over a 75 year period. Various strategies to ensure fiscal solvency have been proposed, including: (1) increasing enrollment to diversify risk (e.g., through providing attractive incentives for employers to participate); (2) building in allowances for increasing premium payments if necessary; and (3) setting more strict eligibility criteria through income or employment requirements (Kenen, 2011). As policymakers struggle with
decisions about how to create and support a sustainable health-care system that includes long term care, insurance coverage is an attractive strategy to reduce health care spending and the federal deficit. The authors contend that the most effective strategy to improve individual care options, the quality of care available, and to reduce health care spending is through expanding the coverage of the CLASS program to establish a universal federal program of LTC insurance.

The Gil Framework of Analysis and Development of Social Policies

This prospective social policy analysis of the CLASS program is based on David Gil's (1992) framework for social policy analysis. Gil's approach enables "governmental and other formal and informal societal units to engage in analysis and development of social policies in a more effective manner than is possible at present, and to design more comprehensive and internally less-inconsistent systems of social policies" (Gil, 1992, p. xviii). Philosophically, the Gil model acknowledges that social policies are both potential causes and potential solutions of social problems, and both of which cannot be separated from economics. The three main objectives of this analysis include: (1) to gain an understanding of how issues related to the financing of LTC affect individuals, service providers, and the welfare state; (2) to identify the expected outcomes through discerning the chain of effects expected to result from the policy's implementation; and (3) to provide recommendations for the development of alternative policies. To date, the authors are not aware of any other policy analysis of this topic using the Gil model.

The Gil framework contains five elements that apply to the evaluation and development of a social policy (Gil, 1992, pp. 71-74). The first element identifies the two primary issues that are intended to be dealt with by the CLASS program, including: (1) improving the access and affordability of LTC insurance; and (2) increasing the expectation of personal responsibility among working adults to plan for their potential future care needs. The second element of the model identifies the effects of this policy as applied to the value of personal responsibility among the target segment of working adults. The third element
includes the implications for groups within society who are at risk of exclusion from CLASS program provisions, such as women, the non-working disabled, racial minorities, and the unemployed. The fourth element of the model identifies the interactions of the policy on different social forces which affect its evolution. This involves examining demographic, economic, and sociopolitical issues in the LTC system, as well as a brief comparison of the United States to Germany’s national LTC insurance program. Finally, the fifth element includes policy recommendations for the LTC system, including the expansion of the CLASS program to achieve greater equity.

Current Issues with the Financing of LTC

Individuals

From the perspective of the individual, the CLASS program improves three of the main issues with private LTC insurance by enhancing the affordability, access, and understanding of LTC services and funding for Americans. First, private LTC insurance is not an affordable option for most Americans. A recent study identified common concerns about purchasing private LTC insurance, including: (1) cost; (2) skepticism about the viability and integrity of private insurance companies; and (3) insufficient information from unbiased sources (Curry, Robison, Shugrue, Keenan, & Kapp, 2009). The Health and Retirement Study (2006) conducted by the University of Michigan found that the average annual LTC premium for individuals under 65 was $1,337 and the average cost for those over 65 was $2,862 in 2006. However, the cost of LTC insurance varies considerably based on the age at which the policy is taken out. In 2008, if a policy was purchased at age 40, the average cost was $1,512 as compared to the cost of $4,515 for purchasing the same policy at age 70 (Henry J. Kaiser Family Foundation, 2009). While initially a younger person may be able to afford premium payments, the rapidly increasing annual cost may become unaffordable in late life. In response to criticism from dramatically rising premium rates among existing policyholders, legislation in 36 states has been enacted to help protect consumers from excessive rate increases (Baer & O’Brien, 2009). Other options to reduce the cost of existing premiums include altering policies to limit care options and
removing provisions that allow for benefits to keep pace with inflation.

As a financial product, private LTC insurance is designed to meet the basic and perceived needs of affluent middle-aged and older people. On average, the purchaser of private LTC insurance is a married, college-educated, 61 year-old with an income of over $75,000 per year and $100,000 in liquid assets who is interested in protecting assets, preserving financial independence, avoiding depending on family members for care, and ensuring the affordability of flexible care options through inflation protection (America's Health Insurance Plans, 2007). A financial planning article from AARP suggested that unmarried individuals with $1 million or more in investments, or a couple with more than $1.5 million, may want to consider purchasing a LTC insurance policy (Pond, 2009).

The CLASS program prohibits the exclusion of enrollees due to health status. In order to maximize profitability and diversify risk, private insurance companies prevent enrollment of high risk individuals through routine screening for pre-existing or chronic health conditions. In fact, private LTC insurance companies excluded 15-40% of the population based on pre-existing health conditions (AAHSA, 2009b).

The accessibility and affordability of long term care insurance secured through the CLASS program will provide working adults with the option to plan for potential needs and access higher quality services. A recent survey indicated that 59% of Americans over 45 incorrectly believe that Medicare will pay for extended nursing home stays, and close to 20% of Americans “don’t know” what funds will cover their LTC costs (AAHSA, 2009a). Another public opinion survey by Met Life Mature Market Institute (2009) found that most Americans understand what LTC is and how much it costs, but many: (1) underestimate how many people need LTC services; (2) do not understand who pays for long term care; and (3) are not planning for their own future expenses (p. 5).

**Service Providers**

Organizations that provide services to older adults often rely upon Medicaid reimbursement, although disparities between the Medicaid reimbursement and the total cost of care
are common. All states are required to balance their budgets, and the most frequently used strategy to control Medicaid spending for older adults has been to reduce provider payments (Smith et al., 2006). The resulting funding gap may require scaling back services to provide only the basics, or on the other hand, restricting services for those who can pay privately. Nursing homes primarily funded by Medicaid provide lower quality care (Cohen & Dubay, 1990; Cohen & Spector, 1996; Grabowski, 2001; Moses, 1994), and have lower staffing levels (see Castle, 2008 for a review). Another trend in LTC financing is a shift in Medicaid spending away from institutional care towards an increased emphasis on home and community-based services (Burwell, Sredl, & Eiken, 2008). Still, over three-quarters of nursing home residents rely on Medicaid to cover their care needs (CDC/National Center for Health Statistics, 2009).

**Government**

The projected long term health care needs of older people have substantial financial implications for government programs. Estimates project that the need for LTC is expected to more than double in the next 30 years (AAHSA, 2009b). Although the Medicaid program provides an important public safety net, the eligibility requirements and benefits vary from state to state (Feder et al., 2007). “Many states are finding it difficult to maintain Medicaid services in the face of continuing tax and revenue shortfalls, and budgetary pressures are likely to intensify as the population ages” (Kenen, 2011, p. 2). According to the CBO (2008), federal spending on Medicare and Medicaid will increase from around 4 percent of the GDP in 2009, to 6 percent in 2019, to a projected 12 percent by 2050 (p. 9). Increased expenses are related to the increased cost of health care and the growth of the aging population, which taken together will “pose a serious threat to the future fiscal condition of the United States” (CBO, 2008, p. 9). The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (2010) estimate that the Medicare trust will be exhausted in 2024. The Medicare program is funded through payroll taxes and beneficiary contributions and pays for intermittent care, such as
short-term nursing home care stays to recover from surgery and limited home health care benefits (U.S. Department of Health and Human Services, 2009).

Overall, the CLASS program is an attractive strategy to offset some of the reliance of individuals upon government assistance for long-term health care needs. As a self-sustaining program, economists expect the CLASS program to reduce deficits in other health care entitlement programs for older adults. Also, private LTC insurance companies can increase their market share through selling additional supplemental insurance products to enhance benefits.

Policy Objectives, Value Premises, Theoretical Positions, Target Segments, and Substantive Effects of Proposed LTC Policies

While private insurance companies still provide policies within government guidelines, the establishment of a government-sponsored voluntary LTC insurance trust through the CLASS program transfers a greater amount of decision-making and control over resources from private insurance companies in the free market to the government. Gil suggested that social policy analysis should focus on “value dimensions which are most likely to affect attitudes, decisions, and actions concerning resource control, work organization, and rights distribution” (Gil, 1992, p. 79). The repositioning of the LTC insurance product from for-profit companies to the federal government is likely to influence the public perception of LTC insurance. Instead of its previous endorsement as a financial tool to preserve assets exclusively for the wealthy, the government’s leadership is likely to help legitimize the insurance product with the value-based appeal of personal responsibility.

Accessibility and affordability is secured through the CLASS program in order to provide an option for working adults to save for potential future needs and access higher quality services. Inherent in the social insurance design of the CLASS program, personal responsibility is accompanied by the government’s extended responsibility to administer a LTC system and pay out benefits over the lifetime of policyholders. The CLASS program is projected to save Medicaid $2.5 billion in the first ten years without taxpayer dollars, and for enrollees
who are also eligible for Medicaid, the CLASS program will serve as the primary payer (Henry J. Kaiser Family Foundation, 2010).

Projections of CLASS program solvency depend on the balance between the revenue generated from premium payments, the general health of enrollees, and their LTC needs. Thus, estimates suggest that an enrollment of 2% is required for solvency. If fewer enroll, a government subsidy may be needed to offset the cost of claims. Estimated effects of the cost-effectiveness and solvency of the voluntary CLASS program are less accurate beyond the first ten years, and it is plausible that deficit spending may be necessary to continue the program. However, legislation allows for flexibility on behalf of the government to adjust premiums for current and future enrollees and to reduce benefits to the daily minimum.

Incremental policies that provided tax incentives to encourage individual responsibility for care needs in old age were targeted for wealthy individuals, required minimal administration on the part of the government, and reinforced traditional models of insurance in the marketplace. The establishment of a voluntary, national LTC insurance trust provides a means for many more working adults to consider this option. Distinct from the welfare-based Medicaid program, enrollees are likely to have high expectations of receiving goods and services in exchange for what has been previously paid. Consequently, individuals may demand more decision-making power and flexibility in selecting among different types of care, such as in-home health services or other community-based care. Service providers also stand to benefit from additional revenue from LTC insurance payments that may improve quality and assist with building a stronger infrastructure for community-based services and supports that are consistent with the preferences of the expanding older adult population.

Implications of the Policies

Supporters of the CLASS program emphasize its capacity to serve as a mechanism for workers to increase personal control over planning for LTC for more Americans than ever before. The economic downturn and loss of net worth among middle-aged and older persons may be countered though planning to delay retirement. Yet many personal, economic and social
factors can limit an individual’s ability to complete the five-year contribution period and three-year work requirement to become vested in the CLASS program. These eligibility criteria discriminate against a large number of older people and individuals with disabilities who are not able to work, such as retirees, non-working spouses, and people with disabilities. Further, older people have been hit particularly hard during the current recession with high rates of unemployment compounded with longer time periods between jobs compared to younger workers (Schmidt, 2011). For example, more than 2.1 million people age 55 and older were out of work in May 2010 (U. S. Bureau of Labor Statistics, 2010). Plus, early retirement may be forced due to poor health or other factors (Kiefer, 2001).

As family members provide the majority of long term care, it is imperative they have adequate supports to prevent burnout from the caregiving demands placed upon them. The National Alliance for Caregiving and AARP (2009) estimated that 19% of all adults 18 and over provided unpaid care to a family member or friend who is 50 years old or above. Families devote 35.4 hours per week on average to caregiving responsibilities (Evercare/National Alliance for Caregiving, 2007). Greater economic instability may also result from these responsibilities. One study found that around a third of family caregivers quit their jobs or reduced working hours; many lost health insurance benefits and retirement savings; and some suffered from chronic stress (Houser & Gibson, 2008). Among family caregivers, women in mid-career are most likely to leave the workforce entirely (Pavalko & Henderson, 2006).

Gil (1992) suggested that another important policy issue concerns the use of resources—whether the goods and services provided respond to the actual levels of need among members of the community or reflect the “purchasing power” of selected individuals in the free market. Thus, the benefits of the policy must be available to the majority of older persons in need of LTC services and these benefits must remain adequate. In a cost comparison of national averages for the costs of common health care and supportive services for older adults, the CLASS program benefit of $50-$75 per day seems a meager amount in comparison to the expense of nursing home care, however this amount could feasibly pay for one day of adult
day services or between 2 and 3 hours of in-home health care (MetLife Mature Market Institute, 2009). For older people who require more intensive services such as nursing home care due to a higher acuity of medical need, the CLASS program funding will offset $1,500-$2,250 of Medicaid spending per month for every dually-eligible older person (MetLife Mature Market Institute, 2009). Based on the daily benefit amount, the CLASS program will contribute from $18,000 to $27,000 annually towards nursing home or assisted living care costs.

Interactions of the Policy with Forces Affecting Social Evolution

A variety of demographic, economic and sociopolitical issues converge in the debate about LTC options for older adults. "Changes in population size and in age distribution can cause conflicts related to emerging imbalances concerning resources, production, and distribution of goods and services," (Gil, 1992, p. 91). Demographically, as the baby boomers age, the proportion of adults 65 and above will grow by 89%, or four times as fast as the overall population between 2007 and 2030 (Administration on Aging, 2008). Between 2007 and 2015, the number of Americans who are 85 and above—the fastest growing group of older adults—will increase by 40% (AAHSA, 2009a). This rapid increase of persons 85 and above will triple LTC expenditures from 1997 to 2040 (Niefield, O'Brien, & Feder, 1999). In addition to the increased numbers, the diversity among older adults is growing. Between 2004 and 2030, the proportion of older minorities is expected to increase by 183% in comparison with an increase of 81% for white older adults (Administration on Aging, 2008).

The society's value positions about family, market, and state responsibility for social welfare converge on the issue of LTC. Family caregivers are the primary provider of LTC, responsible for about 80% of all elder care in the United States (Pandya, 2005). The family structure, as a result of industrialization, has changed from an extended family system to a nuclear or a blended structure (Bell, 1973; Blumer, 1990). Industrialized societies often boast increased lifespan and greater wealth, but changes in family and community structure may also lead to
vulnerabilities, such as the increasing number of older people living alone (United Nations, 2005).

Changes to the availability and affordability of LTC services could allow family caregivers, who are primarily women, to stay in the workforce rather than quitting work to care for older loved ones. Between 59% and 75% of family caregivers are women who regularly provide instrumental help such as bathing and dressing for older relatives (Henry J. Kaiser Family Foundation, 2002). Middle-aged women make up the majority of American family caregivers and balance work with the demands of caregiving for children and aging parents (Spillman & Pezzin, 2000). In 2009, the average U.S. caregiver was a 48-year-old employed woman with a median household income of $57,200 annually, who spends 20.4 hours per week providing unpaid care to a relative (National Alliance for Caregiving/AARP, 2009). Other important demographic changes, such as more childless women, changes in divorce and marriage patterns, more women in the workforce, and a smaller number of adult children in future cohorts will decrease the availability of family caregivers (Wolf, 2001). While some may argue LTC insurance shifts responsibility from the family to the welfare state, the LTC insurance strategy offers a tool through which individuals can take greater ownership in the process of planning for future care needs. Without this tool, fewer financial resources will be available for a larger population of older adults, increasing the potential for greater conflicts regarding rights among the classes and intergenerational tensions between age cohorts.

Development of Outcomes and Alternatives

An important element of the Gil framework for social policy analysis is to identify the intended as well as the unintended consequences of a given policy. The CLASS program facilitates a means for individuals who are participating in the workforce to plan for their own care and services in old age through government-sponsored lower cost premiums than are currently available in the marketplace. Further, greater availability of purchasing power among older adults in the marketplace will lead to more choice in selecting health care and supportive services, and support a growing infrastructure of
flexible services for older adults.

A balanced view of the potential unintended consequences of this new policy alternative is merited—particularly as applied to its eligibility criteria. The program encourages currently working individuals to enroll and contribute to the CLASS program over the vesting period (and beyond) in order to qualify for benefits. Thus, retirees and the majority of people with disabilities are excluded from the CLASS program. According to the U. S. Bureau of Labor Statistics (2012), the reported labor force participation rate in May 2012 was only 20.7% among people with disabilities, compared to 69.4% among those who did not have disabilities. External forces such as unemployment threaten to further constrict the pool of eligible enrollees, especially during economic downturns. And, interruptions in personal work histories may present a challenge to the vesting requirement.

The inclusion of vulnerable groups such as women who are likely to need ongoing health care in their later years is an important issue. Women make up the majority of nursing home residents (75% female) and home health care users (65% female) according to the Centers for Disease Control and Prevention/National Center for Health Statistics (2009). In 2001, women age 65 and above made up 71% of the Medicaid rolls (Henry J. Kaiser Family Foundation, 2005). Several factors are known to increase the risk of needing long term care, including being a woman, growing older, being single, making unhealthy lifestyle choices, along with health and family history (Administration on Aging, 2010). Recently, the AARP Public Policy Institute reported that millions of women cannot afford to pay for LTC: 70% of women 75 and above were widowed, divorced, or never married, and among the 48% who were living alone, their median income was only $14,600 in 2004-2005 (Houser, 2007).

In the CLASS program, women and men must meet all eligibility requirements individually, regardless of marital status. Therefore at this point in time, spouses cannot be added to the vested spouse's LTC insurance policy. Policymakers must consider if the requirements for the CLASS program restrict eligibility to the extent that those who need the program most are placed at a disadvantage. The CLASS program must do more to ensure gender equality as well as work towards eliminating
Another unintended consequence of this policy lies in its potential to create a two-tier LTC system in which the "have-nots" are further removed from those who have access to more resources. As we enter a time of limited supply of LTC services and unprecedented demand, those with more resources, whether that is from personal wealth or some kind of insurance, will have preferential access to a broader array of presumably higher quality services. Those who cannot afford the insurance premiums will be stuck in the same crisis that exists today—the practice of the "spend down policy" in order to obtain LTC support until they are picked up by the Medicaid program. At the same time, fiscal pressures are forcing many states to reduce Medicaid spending and are limiting resources despite growing needs. Further, Medicaid could become seen as "welfare" by society, adding stigma and blame towards older adults or disabled individuals who are poor or cannot work to pay for LTC insurance or qualify for the CLASS program. Thus, this policy fails to address LTC needs among older adults who are ineligible to enroll in the CLASS program.

Although the CLASS program is a national strategy to support LTC services, it is inadequate due to the limited scope of eligible enrollees. As Gil (1992) stated, "A society's changing concepts of the levels of minimum rights which it guarantees to all its members is an important aspect of its system of rights distribution" (p. 86). A variety of supports will be needed to help all citizens age with dignity and deal with functional limitations, including personal or support services offered in the community to more intensive services such as assisted living or nursing home care. A national LTC insurance program available to every citizen offers a mechanism by which older Americans can plan ahead for their care needs in later life without exorbitant out-of-pocket payment, unaffordable LTC insurance premiums, or the financial and emotional sacrifices involved with surrendering all assets in exchange for care.

Other industrialized countries, including Japan and many countries in Europe, have developed universal LTC systems through a social insurance model that is administered by the government and usually funded through payroll taxes. A recent review of the LTC systems by the Urban Institute
in Germany, the Netherlands, Japan, France, and the United Kingdom suggest that replacing a means-tested model similar to the U.S. Medicaid system with a social insurance model that provides some benefits to all with ongoing medical needs is feasible, popular, and fiscally manageable (Gleckman, 2010). Nonetheless, the CLASS program currently differs in its approach through its voluntary nature of enrollment. The social insurance model has been proven to be viable with mandatory enrollment, but never before has a social insurance model been implemented through a voluntary enrollment. This introduces the potential that higher risk individuals with more needs will enroll while healthier individuals will decline participation, creating a situation of adverse selection that can result in rapidly rising costs (Schmitz, 2009). To limit the degree of adverse selection, enrollment for the CLASS program has been restricted to people currently working, and enrollees must pay premiums to become vested in order to qualify for benefits. A universal program for LTC would also reduce this potential risk.

The universal LTC insurance program in Germany provides an innovative mixed model of ongoing health care for older people that supports formal and family caregivers. Germany’s approach to social insurance served as a model for the development of the United States’ Social Security system, and both countries philosophically support a contributory strategy rather than taxation to financing social programs. In the 1990s, Germany and the United States faced similar challenges with systems of LTC, including: (1) a growing demand for care; (2) increasing costs for individuals; (3) a welfare-based public safety net that first required individuals to spend down their own resources; and (4) quality problems (Gibson & Redfoot, 2007). Population aging in both countries contributed to changes in family structure which reduce the availability of family caregivers and show greater numbers of older people living alone.

In response to these challenges, a universal LTC insurance program in Germany was enacted in 1995. In this system, all workers are required to have LTC insurance either through the government or a private insurance company. Currently 90% of Germans participate in the government-sponsored universal
program that allocates basic services depending upon the individual’s level of functional need, which is funded through a national payroll tax shared equally by employer and employees (Arntz, Sacchetto, Spermann, Steffes, & Widmaier, 2007). Enrollees with no children paid a slightly higher premium to compensate for the increased likelihood of needing more formal care services than others who may rely more on informal, unpaid care. Fiscally, the LTC system built a reserve early in its implementation, followed by a depletion of balances that required increasing the contributions and benefits in 2008 to keep up with inflation, which could be a challenge in the future (Gleckman, 2010). Thus far, the German model has been successful in reducing welfare-based spending. Since the inception of the universal LTC in Germany, spending for nursing home care for the poor in 2007 was less than one-third of the 1995 level (Rothgang & Igl, 2007).

Germany also has several programs to assist family caregivers, whether they are currently working or have already left the workforce through continuing pension contributions. One innovative program for family caregivers ensures that the social pensions (similar to U.S. Social Security benefits) are not reduced as a result of caregiving responsibilities. As long as family caregivers provide at least 14 hours of assistance each week and do not work more than 30 hours in formal employment, they continue their eligibility for social pension benefits.

Recommendations for Future Policy Development and Research

The modification of existing policies or the development of alternative policies, as Gil suggested, begins with “questions concerning the appropriateness of given policy objectives with respect to the issues to be dealt with by these policies” (1992, p. 96). It is essential that the analysis of any plan to improve the access, affordability, and quality of health care and supportive services for older adults include an evaluation of the needs and expectations of all constituents. As policies are being developed to provide for the growing numbers of older persons, it is imperative for policymakers to consider three important issues: (1) the adequacy of proposed benefits relative to the actual cost of supportive services; (2) equal access to
needed goods and services; and (3) affordability. The proposed benefits must keep pace with inflation and allow for adequate purchasing power to enable all older persons to obtain high quality LTC services. Additionally, policymakers must avoid creating a two-tiered system. Services available to poor older adults through the Medicaid program must be funded adequately to promote security, dignity, and respect to all older people in their final years.

At this point in time, conflicting estimations obscure clear projections of short- and long-term efficiency of the proposed CLASS program. The CBO (2009) acknowledges that a number of wider societal changes—such as older adults’ health and disability status, the delivery of medicine, and the changing role of private LTC insurance—are difficult to predict. It is unlikely that the CLASS program could ultimately serve as a replacement for the Medicare and Medicaid programs, and a rigorous program of research and fiscal accountability are warranted going forward. Yet the German model provides some indication of the effectiveness of a universal LTC insurance program for providing access to affordable care options for individuals, and reducing welfare-based government health care spending.

One method to improve the CLASS program is to broaden eligibility criteria. Specifically, it is important to provide individuals who are not currently employed with the option to become part of the voluntary program. As traditional LTC insurance offered through for-profit companies is prohibitively expensive, the CLASS program would provide an affordable alternative. Financial projections are needed to understand how many more people could be served and if the CLASS program impacts the capacity of service providers.

Another concept that should be tested among enrollees in the CLASS program is to incentivize family member involvement in planning for their older parents’ health care needs. Many family caregivers have a strong interest in ensuring the well-being of their older loved ones and finding options to help balance their caregiving responsibilities with work and other family commitments. Families may be willing to make affordable premium payments on behalf of their older loved ones. Further, universal caregiving support through labor market and continued social pension eligibility will enable a stronger mixed system of formal and informal caregivers.
Germany's lack of exclusion criteria in regard to health care status does not seem to lead to fiscal instability of their national LTC insurance program. Will the United States need to ration eligibility or benefits to control costs? This question remains unanswered. As medical technologies like genetic testing for common chronic disease in late life, such as dementia, hypertension, or cancer become readily available in doctors' offices and even local drug stores, criteria beyond the age of the enrollee may influence the longevity of benefits. A lack of exclusion criteria may lead to fiscal instability of the program, while the potential need to ration eligibility or benefits conflicts with values of equality and social justice. Policymakers must also cautiously evaluate the political will for a universal national LTC insurance plan, including the public's proclivity for another contributory approach to financing social insurance, an additional tax, or mandated participation.

Conclusions

A national and voluntary LTC financing system for older adults, as proposed by the CLASS program, is a positive development for individuals, families, service providers, and the government. With the enormity of the emerging older adult population and their ongoing health care needs, a universal LTC insurance program similar to Medicare holds the greatest potential to include women, retirees, and other non-working groups of older people who tend to have poor health and lower financial position. American society must balance the contributions of the family with social responsibility and take steps to reduce delineations of the quality or quantity of health care available among vulnerable populations and improve policies to support family caregivers. As Moss (2004) suggested, the American welfare state is the "ultimate risk manager" which functions to reallocate resources and reduce common social risks for all. A national LTC insurance system similar to Germany's system has the potential to build adequate financial resources to comprehensively and equitably respond to needs of all older persons and support consumer choice in old age.

Note: On October 14, 2011, the Health and Human Services Secretary Sebelius announced that the implementation of the CLASS Program
Long Term Care Insurance Beyond the CLASS Program

has been suspended, citing concerns of fiscal solvency. Issues of financing long term care will continue to be a major social welfare issue, as over 15 million Americans will need these services and supports to carry out basic activities of daily living by 2020. The establishment of a financially stable and universal federal program of long term care insurance is an effective strategy to improve individual care options, enhance the quality of care available, and reduce health care spending.

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Capacity Building Legacies: Boards of the Richmond Male Orphan Asylum for Destitute Boys & the Protestant Episcopal Church Home for Infirm Ladies 1870-1900

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What strategies did early boards of managers of charitable human service agencies pursue to build capacity in a way that sustained their efforts for more than a hundred years? Using primary and secondary documents to focus on two organizations—The Male Orphan Asylum (1846) and the Protestant Episcopal Church Home (1875)—three norms emerged: run it like a business, keep it like a house, and base it in the community, along with a host of associated activities. Based on these norms and activities, three strategies were identified: diversification of resources, working boards, and leadership continuity, all of which have implications for building capacity for sustainability in contemporary community-based human service agencies.

Key words: boards, charity, human service organizations, social welfare history, sustainability

Only time tells if a charitable organization will have continued success in its role as service provider, and organizational stakeholders must live a long time to see if their efforts produce a sustainable endeavor. With this in mind, we studied the deep history of two small to mid-sized centenarian charitable organizations that have stood the test of time in one southeastern United States city. We hoped to discover the strategies their early boards pursued to build capacity, assuming their
foundational norms, activities and strategies would provide indications about how their efforts led to sustained service delivery work for more than a hundred years. We looked for lessons relevant to contemporary social service sustainability that could be drawn from these early capacity building efforts.

The Richmond Male Orphan Asylum

It has been said that on the day after Thanksgiving in 1845 a young, homeless boy came begging for food at the doorstep of the asylum run by the Female Humane Association, one of Richmond’s few orphanages (Barber, 1999). Frustrated that the asylum only served homeless girls, the director encouraged her husband and other benevolent male colleagues to consider establishing an orphan society for destitute boys (Rogers, 1956). On May 16, 1846 the first meeting of a six-member board of managers of The Richmond Male Orphan Society was held in a local church. That same year, the Society was chartered by The General Assembly of Virginia, and the Richmond Male Orphan Asylum opened for business.

Available minutes of the Asylum’s board of managers begin in January 1870. In 1876 the Society revised its charter with the General Assembly, and its stated purpose became “the relief of distressed males and the support and education of destitute children” with powers “to bind out such poor children ... the indentures of apprenticeship to be executed by the Trustees ... on behalf of the Society” (RMOA, 1876, p. 66). The charter further specified that the father, or the mother (if there was no father) could request that a child be placed in the Asylum. Often destitute parents would relinquish a child to the Asylum and these children were referred to as half orphans. In this situation, the records reveal that the parent could petition to have the child returned to them should their circumstances change their ability to take care of the child. If the child was deserted by both parents or orphaned, then it would be up to the overseer of the poor or a member of the overseer’s board to relinquish him in writing to the Asylum.
The proliferation of private charities transcended generations, and as orphanages were attempting to address the needs of destitute children, old age homes were being established by various religious groups to care for the older generation. In February 1875, the Protestant Episcopal Church Home (PECH) was established as a “Home for Ladies in reduced circumstances who have seen better days” (PECH LB, 1875, p. 1). With this establishment came the appointment of a 16-member lady board of managers, with Mrs. Emily Whittle as President and Mrs. Elizabeth H. Peterkin as First Vice President, both wives of Episcopal clergymen serving churches within the city. Just as Dr. W. W. Parker (long-time Board President of the Asylum) was involved in multiple charities, so were Mrs. Whittle and Mrs. Peterkin. Richmond City Directories reveal that Mrs. Whittle was also the first president of the YWCA in Richmond (1887).

On March 25, 1875 the General Assembly of Virginia granted a charter to the Church Home. In this charter was named an all-male, eight member board of corporators. At their first meeting on April 20, 1875, Episcopal Bishop F. M. Whittle was called to chair and Reverend Peterkin appointed as Secretary. The charter granted the incorporators the power to adopt a Constitution and bylaws, and:

to delegate their powers to a board of managers ... sixteen ladies to whom shall be entrusted the entire management of the ‘Home’ under such rules and regulations as they may adopt subject only to the provisions of the Constitution. They shall elect their own officers, and fill by ballot any vacancies in their own body occurring during the year and they shall continue in office until their successors shall be elected. (PECH LB, 1875, p. 2)

Setting the Context

The Richmond Male Orphan Asylum (hereinafter referred to as the Orphan Asylum) and the Protestant Episcopal Church Home (hereinafter referred to as the Church Home) were both chartered by the General Assembly, and both have survived
well over a century. Today the Orphan Asylum is the Virginia Home for Boys and Girls, having established its domain in 1975 as statewide and having added “girls” to its clientele in the last decade. During the 1970s the Church Home joined “with the Diocesan Home and Presbyterian Home to be built and known as Westminster-Canterbury Home,” (PECH LB, 1971, p. 51) a large continuing care retirement community now serving both men and women from Richmond and Central Virginia. Both became highly successful organizations and still serve within greatly expanded domains and contemporary contexts. These two organizations are useful exemplars because they served different populations (destitute male children, and aged and infirm ladies), and the composition of their boards of managers provide a unique comparative view on gender roles and decision-making in charitable organizations from 1870-1900 (Netting & O’Connor, 2005). Both have been operated continuously since their founding, and each assumes a different structural form today. Their early capacity building strategies form the basis of this paper.

Contextually, charitable health and human service organizations proliferated in Richmond during the late 1800s, spurred by religious motivations and these were often led by women. A number of feminist historians have explored how gendered roles permeated the governance and management of charitable agencies (e.g., Ginzberg, 1990; Gordon, 1991; Green, 2003; McCarthy, 1982, 1990, 2003; Scott, 1970, 1993). Early human service organizations in Central Virginia have been studied by a number of historians who have discovered the magnitude of the benevolent work performed by Virginia’s early women (e.g., Barber, 1999; Click, 1989; Green, 2003, 2005; Hamburger, 1999; Lebsock, 1984; Treadway, 1995; Varon, 1998). Civic housekeeping emerged as a public form of moral guardianship, in which women expanded their roles from sewing circles, religious groups, mite societies (from the Biblical expression “widow’s mite”), and clubs to address the charitable needs of poor women and children in their communities (Skocpol, 1992). Thus, the role of women as “lady managers” was unearthed by a number of historians, as until recently the historical concept of “lady boards of managers” (Netting & O’Connor, 2005) had been forgotten (Becker, 1987).
A number of small to mid-sized centenarian private health and human service organizations in Richmond have stood the test of time and have deep continuous roots in previous centuries (Netting, O’Connor, & Fauri, 2009). In this study, we selected two agencies with the most comprehensive early documentation available in the archives of the Virginia Historical Society. Their histories were meticulously documented by early managers who kept minutes and wrote annual reports about how they built the capacity of their charities to survive through economic downturns and hard times and to sustain themselves into the 20th century. Records kept by these boards reveal a great deal that, left uninterrogated, would be lost in understanding these private charitable organizations in regard to policy-making and decision-making processes used by their early boards of managers. Board members’ activities cohered into norms that allowed them to endure within the context of Richmond. Not only did these boards govern and legitimize their organizations, but they oversaw missions and supervised the use of resources. Thus, the narrative left by the board is a form of primary documentation that “works to establish identity ... [and] is central to transmission of the past” (Linde, 2009, p. 4).

The Orphan Asylum had an all-male board of managers, and the Church Home had a lady board of managers and an all-male board of corporators. These boards comprised the governing and decision-making bodies for these organizations, and kept comprehensive collections of board minutes, annual reports, and correspondence. Primary sources of original documents were supplemented with secondary sources such as newspaper accounts and agency histories (Danto, 2008). Minute books and early correspondence are well preserved and available at The Virginia Historical Society (VHS) and these collections provide comprehensive and rich sources of data. We used these primary documents to ask: What strategies did these early boards of managers pursue to build capacity in a way that sustained their efforts for more than a hundred years? Are there lessons that can be learned from these early capacity building efforts?
Norms and Activities

Norms are those deeply embedded, overriding behavioral guidelines or expectations that drive decision-making and behavior. In minutes and reports three norms emerged: run it like a business; keep it like a house; and base it in the community. Using these norms as a guide, examples of activities associated with them are incorporated into the narrative below. Activities are tactical approaches that appeared to contribute to sustaining each norm.

Run it Like a Business

The Orphan Asylum's board of managers and the Church Home's board of corporators were all male. There was a clear separation by gender in both organizations, which was typical for agencies in Richmond in the late 1800s. Central to these male boards was a serious focus on property, legal, and business concerns conducted in the context of the time in order for the charitable enterprise to succeed. The activities that aligned with the norm of running it like a business were: focusing on long term investment and prescribing governance.

Focusing on long-term investment. Male boards in both organizations were particularly focused on institutionalizing long-term investment opportunities. They paid close attention to making money through real estate and loans. Issues surrounding real estate taxes precipitated seeking counsel.

The Orphan Asylum's board bought and sold both real estate and stocks/bonds (especially for railroads), as well as received rent as primary sources of income. Dialogue about real estate, bonds, stocks, rental properties, and various investment strategies was found throughout the Orphan Asylum’s minutes. The board engaged in a variety of long-range fundraising strategies. They received public subsidies of $90 per year when a child was moved from the City Alms House to their Asylum (RMOA, 1870, p. 1). When expected donations and subscriptions were slow, they employed “a suitable collector to be sent out at once to solicit contributions from the citizens generally ...” (RMOA, 1876, p. 68). Employment of the boys in community businesses or nearby farms was a funding source at the Asylum and became a major focus of the board in
the 1870s. After “the President read a paper suggesting the employment of the boys part of the time in making match boxes or in other mechanical labor” (RMOA, 1875, p. 58), the Asylum established a cigar factory. The President, in his annual report, envisioned: “a well managed State Orphan Asylum for boys where instruction in letters and cigar making, or some other industry, were combined might be made largely self-sustaining” (RMOA, 1885, p. 140). When the cigars suffered competition from the manufacture of cheroots and cigarettes, the board considered establishing a cigarette factory of their own using 100 boys.

The Church Home’s board of corporators met once a year (except for called meetings). It elected a 16 member lady board of managers to whom was entrusted the Home’s management. Like the Orphan Asylum’s board, the Church Home’s male corporators focused on the business aspects of the Home. They amended the Constitution as needed, adopted bylaws, and then established the duty of the Treasurer on their behalf to handle “all entrance fee donations, bequests, and other funds. Of these funds, the Corporators shall set apart whatever may be described as a permanent endowment fund, the remainder shall be invested or used ... for the benefit of the institution” (PECH BoC, 1879, p. 14). Considerable effort was expended attending to legalities and responsibilities associated with legacies, complexities of dealing with heirs, investing in bonds, and the value of stocks. By 1899 there was increasing dialogue about the pros and cons of legacies and property left to the Church Home.

The Church Home’s lady board marketed their organization through regional and local papers. In meetings, donations were acknowledged from other cities and states, and were targeted to the Church Home’s endowment fund. For example, when Mrs. James R. Werth sent money collected from friends and family to name a room after her Aunt, the lady board struck upon a new way to raise endowment funds. The idea of “naming” became part of an ongoing fundraising effort and continued well into the next century as part of their institutional fundraising drives. Today it is a standard practice in institutional fund-raising.

Prescribing governance. The Orphan Asylum’s board was
composed of business and professional men, and a physician (W. W. Parker) served as President from before 1870 to 1899 (the year of his death). They ran their agency like a business. In September 1886 the Orphan Asylum’s board approved a new charter, constitution and bylaws, and a revised structure for indenturing the boys. Standing committees were designated as Education and Discipline, Admission and Dismissal, Indenture, and the Industrial School (RMOA, 1887, p. 218), reflecting specialization and a clear division of labor, concepts that emerged later in the soon to surface (1890s-1910s) scientific management movement. Subsequent minutes reflected careful attention to rotating committee membership over the years so that board members experienced all aspects of the Asylum, to the point that they rebuked the President whenever a decision on an issue was made that in their view should have first gone to a committee. There was an effort for strict adherence to their established structure, creating a balance of power within the agency.

The Church Home’s board of corporators was composed primarily of clergymen and lawyers. They ran their annual board meetings with precision, closely following a standard agenda with formal rules of order. They amended their bylaws as needed and were explicit in prescribing board structure. For the organization’s lady board, for example, a specific number of members had to come from area churches, “at least two members from each [Episcopal] church that has been or may be connected with the institution” (PECH BoC, 1878, p. 13). They approved all reports and rigorously followed an established order of business.

The Church Home’s lady board of managers also listed an order of business in their bylaws. At times having a quorum present at meetings was problematic and caused considerable frustration. At one point in 1875 the frustration appeared in the wording of the minutes—missing four meetings in a row without “good cause” meant that “her place on the board [will] be considered vacant” (PECH LB, 1875, p. 12). This became policy. In 1876 the minutes of the Church Home’s board of corporators listed an almost identical order. Earlier, in 1886 the Orphan Asylum’s board had dropped two members from the board for nonattendance.
Keep it Like a House

With no lady board at the Orphan Asylum, the men engaged in discussions about inmate behavior but relied heavily upon the Superintendent, staff, or ladies from the community to deal with daily operations. Just as male board members practiced what they knew best in their professional roles, lady boards brought skills of running households to the Church Home. Thus, the “keep it like a house” norm was typically carried out by women with related activities being making and enforcing house rules, managing budget and supervising staff, and visiting inmates.

Making and enforcing house rules. The Orphan Asylum had explicit rules, but of a different nature from the Church Home, given their young charges. When the boys were invited to attend an Episcopal mission school on Sunday afternoon, for example, the board graciously declined the invitation, saying that the boys should be taught at the Orphan Asylum instead. The following year The President reported that “the frequent escape of boys from the Asylum [had grown] out of the fact that children were allowed to scatter on Sundays and in small squads attend different churches and Sunday Schools without anyone in charge of them.” A resolution was adopted by the board that “the boys under the charge of the Superintendent should be made to attend one Sunday School and Church” (RMOA, 1872, p. 28).

Appended to the bylaws, the Church Home’s lady board developed a set of eight “regulations” designed to regularize Home management. The result was control of inmate behavior. No furniture was to be brought into the Home without board approval; meal times were to be standardized; consent was required to visit the kitchen; complaints had to be directed to the board, not the Superintendent; rooms needed to be kept neat; inmates with a source of income had to contribute to the Home’s maintenance; lights had to be out at 11:00; and no visitors could be received before noon (PECH LB, 1875, pp. 6-7). Regulations were expanded in the course of experience.

Managing budget and overseeing staff. The Orphan Asylum constantly struggled with the dilemma of keeping the number of boys to a manageable level, given the funds available. Over the years, the board often put a hold on admissions “that no
more boys be received by the Asylum until the income of the Society should be increased to an extent sufficient to justify it” (RMOA, 1876, p. 68). The President explained the dilemma of restricting admissions.

It was very difficult to carry [this restriction] because I met with some cases of such absolute destitution that I could only have sent the boys to the almshouse, from whence they would have been sent to us, as we have agreed with the Council of the City to take all boys they might send us in consideration of the city appropriation to our support” (RMOA, 1877, p. 72).

Here one sees the interconnections between resources and acquiring new clients.

Both the Church Home and the Orphan Asylum had Superintendents who received an operating budget and were expected to manage it and report to their respective board of managers. Without a lady board, the Orphan Asylum relied for some period upon Mrs. Gill, who was referred to as “the energetic and sensible wife of our Superintendent.” Subsequently, when Mrs. Gill replaced her deceased spouse as Superintendent at the Asylum, she provided a complete accounting of household expenses in her first annual report, explaining how the garden had produced more than expected and how they had sold produce. Cows provided milk. No clothing had been brought, and only the larger boys wore shoes during the summer. She then carefully itemized the personnel expenses, including the Superintendent, Teacher, Manager of the Cigar Factory, Gardener, Matron, Housekeeper, Cook, Washer, Ironer, and House Servant, along with provisions, clothing, coal, and serving costs (RMOA, 1885, p. 188). A reading of the Asylum’s minutes for the period suggests a competent, albeit untrained, institutional manager.

In the early 1870s President Parker, of the Orphan Asylum board of managers, indicated that he had received reports of mismanagement in the Asylum and he requested that three ladies visit the Asylum once a month for the purpose of examining the management” (RMOA, 1871, p. 12). Since the Orphan Asylum did not have a lady board, its male board called upon ladies from the community to help out in overseeing
operations. Two years later, when the board expressed concern over the appearance of the boys and the grounds, they employed “a reliable white woman to aid in keeping the boys and premises clean” (RMOA, 1873, p. 40).

At the Church Home, “servants” were hired to perform specific duties such as cooking, cleaning, and property maintenance. The oversight of what happened at the Home appeared to be more intense, as the lady board attended to housekeeping details that did not come up in male board meetings unless they involved costly repairs.

Visiting the inmates. It was not until October 8, 1877 that the Orphan Asylum board mentioned “a regulation requiring the appointment of a committee of visitation and supervision for the Asylum” (RMOA, 1887, p. 75). The board then resolved to appoint a committee of three board members to visit and report back. The committee did some visiting, but months went by when they did not manage to perform their duties. Unlike the lady board of the Church Home, the Orphan Asylum’s male visitors did not appear to be required to meet a standard for frequency of visitation and the board at times delegated these types of interactions to community women.

From the beginning, the Church Home’s lady board appointed a monthly visiting committee, typically having two ladies visiting each week. Visiting committees unable to visit the Church Home for the week appointed substitutes. To engage others in the life of the Church Home the board resolved “that any visiting committee can invite the attendance of a Lady outside of the board of managers to accompany said committee in its appointed weekly visit to the Home” (PECH LB, 1875, p. 11). Here the norm of “basing it in the community” is reflected. Several meetings later, the board resolved “that young ladies from all the churches be invited to visit the Home from time to time in a social way to cheer and brighten the otherwise monotonous life of the residents” (PECH LB, 1876, p. 20).

When the Church Home had been operating for about seven years, the lady board became more and more focused on issues faced by residents as they aged. A resident fell, broke her thigh, and the physicians thought they could never set the broken bone without “necessitating much suffering on her part
and very much expense to the Home." A few months later, two lady visitors discovered a very sick resident with whom they stayed until she died. Although minutes offered limited detail concerning illness or injury, there appeared to be concerns that residents were dying because staff did not know what to do when faced with these situations. By the late 1890s, the ladies had hired a student nurse to help them out. Given the nature of the Church Home’s clientele, discharge typically occurred as a result of the inmate dying.

Base it in the Community

The Church Home and the Orphan Asylum arose from the local community, and they were closely tied to the citizenry. Both organizations represented different but related approaches to being what in today’s language would be called community-based and faith-based. Two activities within the norm of basing it in the community were identified—soliciting resources and identifying with Christian values.

Soliciting resources. Both monetary and in-kind contributions were constantly being solicited from the local community by the two organizations. Mrs. Gill, as Superintendent of the Orphan Asylum, came up with the idea of raising money "by the sale of Bricks. ... The children by hundreds have been engaged in ‘selling bricks’ and thus raising money and identifying themselves with this charity" (RMOA, 1884, p. 170). Mrs. Gill proposed other fundraising ideas such as holding a "donation party" and was compensated that same year as the "solicitor collector ... to procure annual and contributing members" (1884-1885, pp. 178-181). In 1885 there were several references to the "Ladies Bazaar."

In a slightly different way, with its board of lady managers, the Church Home periodically opened its doors to the public and held a “pounding” through which they invited community members to make donations by bringing a pound of food or similar household items that could be used as an in-kind contribution to the cause. This annual “pounding” netted in-kind supplies for the winter, everything from flour and potatoes to cups and saucers. In another effort to generate revenue, life memberships were created in 1876 by the Church Home’s lady board at $25.00 each. “This seemed to go toward the
endowment fund. The object of this was not to abridge the annual giving, but to show who are, and have been friends of the Home” (PECH LB, 1876, p. 29). This approach supplemented the ongoing collection of subscriptions that were a part of this organization from its beginning.

The relationship of resource needs and Christian values is reflected in board appeals to the religious community, and they were not above using guilt as a motivator. Annual reports of the Orphan Asylum referred to the moral responsibility of good Christian people to support the cause. “I felt almost ashamed last year to report only $404 contributed by all the citizens of this Christian city” (RMOA, 1889, p. 255) lamented the Orphan Asylum’s President. At the annual meetings of the Orphan Asylum, appeals to local clergy, congregational members, and any other Christian citizens were made. The President told the story of two orphan boys, one of whom died because he was so

enfeebled by insufficient food when we received him that he never rallied. His brother, who was received year before last, lived but a short while after entering the Asylum. It is so sad to think of two orphans dying indirectly from famine within sound of so many Christian church-bells. (RMOA, 1877, p. 72)

Clergy comprised much of the Church Home’s board of corporators, but beyond that their lady board members regularly appealed to clergy to solicit from their congregations.

Identifying with Christian values. Just as resources were solicited from the religious community, there were multiple other ways in which these organizations identified with Christian values. References to God and Christianity were evident in annual reports. Both organizations held annual meetings that were attended by local clergy, held in local churches, and at which offerings were taken. Not tied to one specific denomination, the Orphan Asylum’s annual meeting was held at a different Protestant church every year with different clergy delivering a sermon. The history of the Orphan Asylum was repeated in annual reports as a reminder that the first meeting of the board was held in Reverend Dr. Stiles’ Church on May 16, 1846 with references to “these Christian men, once so well
known in this city, [who] have gone to their reward ... they labored to help their fellow-man and honor God, but they are held in 'everlasting remembrance' in heaven“ (RMOA, 1882, p. 172). This was in keeping with the religious revivalism of the later 19th century.

The Church Home was permeated with religious symbolism and was connected with the Episcopal Church. The very name of the corporation attested to its religiosity. The Orphan Asylum, on the other hand, was more ecumenically oriented but within the boundaries of Christianity. Board meetings of both organizations opened with prayers. Church Home regulations required blessings at each meal and daily family prayers. Provisions were made for the religious instruction of the boys at the Orphan Asylum every Sunday.

When board members died, Christian language was evident. For example, when a member of the Orphan Asylum board died, these words were recorded:

It is much that those of us who remain should in commemoration of his past connections with [the Society] place upon its records a testimonial of his zeal for and fidelity to the cause of charity and of his virtues as the Christian gentleman. (RMOA, 1873, p. 34)

Similarly, the Recording Secretary of the Home’s lady board died and the ladies wrote, “It only remains for us to bow in submission to the Divine will and to thank God for the good example of our much loved friend, who having finished her course in faith now rests from her labours” (PECH LB, 1876, p. 25).

The Church Home’s lady board of managers and the board of corporators were so closely tied that members of each were members of the same family. Commitment, then, was not just to the institution but to one another in families as well as to a larger Episcopal faith community. The Bishop and various Episcopalian ministers dominated the Church Home’s board of corporators. The corporators specified that the lady board must contain at least two members from each of the City’s Episcopal Churches and that if a person moved to another church she would need to vacate her position if that left only one person from her former church on the board. Inmates were
required to be members of the Episcopal Church, and clergy provided references for applicants. The Constitution was revised by the corporators in January 1877 to indicate that all applicants had to reside in the Diocese of Virginia for one year preceding her application and be a member of the Protestant Episcopal Church.

Embedded in hundreds of pages of handwritten notes is evidence that these boards operated using their own life experience for guidance. These were competent citizens who between them knew three things well—how to run businesses, how to manage households, and how to base their activities in community-based religious values and beliefs. Thus, these records provided an opportunity to closely examine the activities of two charitable organizations and their decision-making processes.

Discussion of Capacity Building Strategies

In the previous section, we identified activities associated with norms related to agency coherence over time. Based on these findings, we identified three cross-cutting strategies that worked in the context of the times to build capacity: (1) diversification of resources; (2) working boards; and (3) leadership continuity.

Diversification of Resources

Given the division of labor by gender, running the business and keeping the house were tightly linked through the first strategy of resource diversification. The male boards were intent on fiscal oversight, financial networks, and the details of wisely investing for organizational growth and stability, and the female board demonstrated the ability to raise funds and garnered in-kind contributions in creative ways to support programs. Not surprisingly, the lady board’s fundraising approaches were similar to what women had done for generations in their churches—holding bazaars, sponsoring poundings, asking for contributions to the cause, naming rooms for benefactors, selling bricks, and marketing through church magazines. This resource diversification strategy was also tied to basing it in the community, with particular emphasis upon a Christian community.
The fundraising and revenue-generating approaches used by these two organizations were as broad as those employed by contemporary human service agencies. The Orphan Asylum received public contracts for housing individual boys, forerunners of what today's human service providers call purchase-of-service contracts. Profit-making enterprises such as the Cigar Factory were forerunners of charitable organizations that have for-profit arms, called venturing or social enterprise today. Both solicited annual subscriptions, encouraged life-time memberships, and asked clergy to hold collection days for their causes at local congregations. The President of the Orphan Asylum’s board used most every annual meeting to appeal to Christians to give more, and the faith-permeated Church Home was structured so that two ladies from each Episcopal Church would be on the board as ambassadors to the Episcopalian community with special responsibilities for raising funds from their congregations.

**Working Boards**

There were no professionally trained human service planners, managers, and administrators staffing these agencies. These professional roles came later in the development of American social service agencies. These roles and functions fell to the Church Home and Orphan Asylum volunteer boards. They were involved in every aspect of agency operation, a second major strategy that kept their organizations alive. Provisions were made to cover both running the business and keeping the house. The Church Home did this by gender division, which fit within the context of the times. The Church Home’s lady board of managers demonstrated their abilities over and over again, with the board of corporators avoiding as much as possible anything focusing on household management or inmate care. The Orphan Asylum’s board attempted to delegate daily oversight by calling upon the Superintendent’s wife and ladies in the community to assume the housekeeping and supervision responsibilities.

These boards were “working boards,” and they added community people as needed to be immersed in the planning, management, and administration of their charities. In contrast, boards today tend to be policy and oversight oriented.
These early boards knew that they were ultimately responsible for the organization’s financial health, otherwise their agencies would not be sustained and care provided for inmates. In today’s literature, concern is expressed for boards that do not embrace their role as fundraisers and for boards that are so separated from the workings of their organizations as to not understand their service delivery programs. There is no doubt that these early boards provided lessons to be learned about commitment, involvement, and pragmatism that could enhance current concepts about board functioning.

**Leadership Continuity**

A third strategy used by these agencies was ensuring leadership continuity. These boards engaged in a type of intergenerational nepotism. Even today, on the boards of some of Richmond’s centenarian agencies are members who are in their family’s fifth or higher generation of service. Presidents of boards served continuously in that capacity for decades. Particularly for the lady board, to socialize daughters and nieces to civic housekeeping roles, these young women were invited to come into the Church Home and volunteer time, and eventually some were transitioned into leadership positions on the board of lady managers. In the Orphan Asylum’s male board it appears that socialization and generativity were based on bringing in close colleagues or friends who were viewed as Christian gentlemen, good businessmen, and good community citizens. A few times sons or male relatives were included. Today in similar circumstances we might refer to individuals who are well networked.

Socialized to a gender-based division of labor, the next generation was moved into leadership with an understanding of how running the business and keeping the house were uniquely gendered. Incubated in a community in which these organizations had grown and developed under the guidance of long-standing community leaders, new board recruits recognized structures and activities that were necessary to keep these charitable ventures alive and vital. For example, having a prescribed governance structure served to socialize new members to organizational norms, with violators who did not attend meetings potentially facing being vacated from their
seats. For the lady board, continuity within the programmatic aspects of the organizations was reinforced by the board’s assuming supervising responsibility for services and for visiting the inmates. The deep ties with the local community, specifically the Protestant Christian community, also contributed to leadership continuity. These leadership ties may be relevant to understanding the concept of a faith-permeated organization today because the Church Home was a faith-permeated, sectarian organization characterized by an unmistakable Episcopal presence. The Orphan Asylum, on the other hand, was more of a faith-affiliated organization with Christian symbolism evident in meetings, annual reports, and daily practice, but it was pan-Christian rather than strictly denominationally oriented.

Conclusion

One writer identifies capacity building as developing “coherence [which] is grounded in an ethic of sustainability and meaning; coherent institutions are exactly those that endure over time” (Lejano, 2006, p. 206). The boards of the Orphan Asylum and the Church Home built and sustained two seasoned, charitable human service organizations in Richmond. In historical context, their approaches to social agency governance and management made these charitable organizations viable through a combination of business and caring norms within a shared community, and a faith-based tradition that provided coherence. This was facilitated by a clear division of labor according to gender, well established and reinforced within the context of the times. Men ran the business and women kept the house. These two norms coincided with a community in which men and women were raised to do charitable works as part of their religious expression. They worked in parallel and respected the division of labor. When running the business or keeping the house became problematic or contentious, a binding force was the recognition of a calling on the part of these men and women to do charitable works. Had the motivation simply been to run a business or keep a house, there would have been plenty of times in the history of these organizations to throw up proverbial hands and call it quits.
Deep roots established by these organizations helped hold them together during trying times.

Unencumbered and unshaped by a proliferation of helping professionals who would later arise with the coming of the Progressive Era, these boards were managers in every sense of the word. We can now see the absence of professional agency staff as critical to the lady board of managers of the Church Home (as well as its male board of corporators) and the Orphan Asylum’s male board of managers developing the capacity to perform charitable works and establish agencies that have done so for over one hundred years. There were no professional development officers or CEOs. Likewise, if they had not overseen the untrained staff who were there to deal with intimate details of inmate life, no one would have, because there were no trained supervisors to do this. They did what they knew to do from their life experiences and their socialization to civic life. By the mid-1900s, things changed as trained human service professionals gradually became available and were hired, and the division of labor became less gender-specific. Future research that follows these agencies into the 20th century may reveal additional insights about the changes that accompanied professionalization.

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Employee Benefits and Policies: Do They Make a Difference for Work/Family Conflict?

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This paper examines both the prevalence of employee benefits and whether the existence of any of numerous work/family policies is related to reduced perceived work/family conflict among a 2002 national sample of U.S. employees. We compare the impact of relatively standard employee benefits with more “controversial” work/family policies regarding flexible work time and child care. We determine whether the impact still remains when typical individual employee characteristics, human capital variables, workplace culture variables, and workplace support variables are controlled statistically in multiple regressions. We find that it is the relatively conventional benefits that are most available to employees. However, it is primarily policies pertaining to flexible work time that significantly affect perceived work/family conflict. These effects continue even when supportiveness of the workplace culture and of supervisors and co-workers are controlled. A supportive workplace culture is related to less work/family conflict. Caregiving policies do not impact perceived work/family conflict for this sample of U.S. employees.

Key words: work/family policies, work/family conflict, flextime, childcare, human capital, workplace culture, workplace support

As wives and mothers have continued to enter the U.S. labor force, the potential for stress from work/family conflict has become increasingly important. One estimate, for example, is that 40% of employed parents experience difficulties in work/family balance.
combining work and family demands (Galinsky, Bond, & Friedman, 1993). Indeed, a meta-analysis of sixty-seven studies (Allen, Herst, Bruck, & Sutton, 2000) finds that negative work/family spillover is associated with such consequences as depression, psychosomatic complaints, and lessened marital satisfaction.

In response, some U.S. employers have instituted policies and practices intended to lessen stress from work/family spillover and promote employees' health and psychological well-being (Mitchell, 1997), along with helping themselves attract, retain, and manage a productive workforce (Glass & Estes, 1997; Kelly, 1999). Such work/family benefits range from the well-established, such as sick leave or health insurance (Osterman, 1995), to the less institutionalized, such as flexibility policies and family-care policies (Blair-Loy & Wharton, 2002).

Extant research regarding the effect of the availability of work benefits and policies yields inconsistent findings. The availability of flexible scheduling (Thomas & Ganster, 1995) and family benefits (Thompson, Beauvais, & Lyness, 1999) reduces work/family conflict in some studies whereas, in some other studies, it does not (Galinsky, Bond, & Friedman, 1996; Mennino, Rubin, & Brayfield, 2005).

This study examines both the prevalence of employee benefits and whether the existence of any of numerous work/family policies is related to lessened work/family conflict among a national sample of U.S. employees. In a time of cut-backs in the economy, it is particularly useful to know what benefits and policies are most helpful and should be maintained. We compare the impact of more or less standard employee benefits with more "controversial and ambiguous" work/family policies regarding flexible work time and childcare (Blair-Loy & Wharton, 2002). The research questions are as follows.

What are the most frequently available employee benefits?
Do these employee benefits reduce work/family conflict?
(a) does the existence of any of several time-flexibility policies reduce work/family conflict?
(b) Does the existence of any of several family caregiving policies reduce work/family conflict?
Does the impact of any employee benefit still remain when typical individual employee characteristics, human capital variables, workplace culture variables, and workplace support variables are controlled (i.e., are in the equation)?

Related Literature

Prior to advanced industrialization in the U. S., work and family were integrated, with the nuclear family being the work unit, initially in the home and then in early factories. With the development of technology within the factory system, husbands, wives and their children were separated from one another and under the supervision of others, often strangers. This led to considerable social concern, the shortening of the work day, and work restrictions on women and children, who were relegated to educational institutions. With the growing labor force participation of women, including married women with children in the latter half of the twentieth century, came social concern once again, this time to reintegrate work and family (Perrucci & Perrucci, 2007). Corporations began providing some social welfare benefits, namely health and life insurance, pension plans, and disability protection. At the national level, there came to be employer-mandated participation in worker’s compensation and Social Security (Glass & Estes, 1997).

Children increasingly became economic and social costs that mothers especially, not communities or employers, bore. At the same time that demands on families to raise well-rounded children were increasing, demands and rewards for market work were similarly increasing. As automation eliminated human labor and globalization made labor cheap, workers were encouraged to invest even more in a 24/7 economy (Perrucci & Perrucci, 2007).

The growth in working time is accounted for largely by a family transformation from single (male) earners to dual-earner couples in which wives are employed. Also, an increasing segment of the U.S. population works extremely long hours, namely couples who are highly educated and in high-profile professional and managerial occupations (Jacobs & Gerson,
These couples develop strategies for balancing family with demanding work, including placing limits on their work hours and scaling back in other areas of their lives, such as limiting the number of children they have, reducing social commitments and service work, enjoying less leisure time, and lowering expectations for housework (Becker & Moen, 1999).

A major response was the development of market substitutes for family care, such as for-profit child care centers, for which families, once again, usually must bear the cost. The only national response is the 1993 Family and Medical Leave Act, according to which large companies must provide parents with twelve weeks of unpaid leave. Because the leave is unpaid, the U.S. lags behind twenty industrialized countries in a comparison of parental leave policies (Ray, Gornick, & Schmitt, 2008).

In terms of expected findings in the present study, women (Duxbury & Higgins, 1991), those who are married or partnered (Burke, 1988), and those who care for dependent children (Burke, 1988; Mennino, et al., 2005) are expected to perceive greater work/family conflict. As well, so should those who care for dependent elderly.

In contrast, those who have greater human capital in terms of education, occupation, and autonomy at work are expected to experience less work/family conflict, whereas those who work a greater number of hours per week are expected to experience more work/family conflict (Maume & Houston, 2001; Mennino, et al., 2005). Availability of flex-time opportunities is expected to be related to less work/family conflict (Thomas & Ganster, 1995).

Moreover, a workplace culture that is supportive of combining work and family responsibilities is expected to lessen work/family conflict (Burke, 1988; Maume & Houston, 2001; Mennino, et al., 2005). In fact, Mennino et al., (2005), find that absent a supportive workplace culture, work/family policies do not lessen work/family conflict. However, they and others (Osterman, 1995) use summary indices of benefits and policies, rather than examining the possibility that it is only some individual benefits and policies that impact work/family conflict. That is the focus of this article.
Data and Methods

Data

Data are derived from The National Study of Changing Workforce (NSCW, 2002), which is the most recent publicly available data set gathered periodically by the Family and Work Institute. The NSCW is a nationally representative sample of workers across all the workplaces in U.S. A total of 3,504 interviews were completed with a nationwide cross-section of employed adults. Interviews were conducted by using the computer-assisted telephone interviewing (CATI) system. Calls were made to a stratified (by region) un-clustered random probability sample generated by random-digit-dial methods.

Of the 3,578 eligible numbers, interviews were completed for 3,504 numbers, a completion rate of 98%. This study focuses on the work/family conflicts of salaried workers accounting for gender and race. The total number of salaried male workers in the sample is 1,435 and that of female workers is 1,361. Also, there are 2,183 white and 578 non-white salaried workers.

The NSCW provides detailed information about the workplace-related and work-related personal experiences of the workers such as work-family experiences, workplace benefits and policies, working conditions, household enumeration, personal well-being, child care and education, and elder care. Thus the dataset includes information that is required for this study.

Measurement

Dependent variable. Work-family spillover is an index of 4 items that concern the negative impact of work role on family relationships. For example “In the past three months, how often have you NOT had enough time for your family or other important people in your life because of your job?” The responses are: never (1), rarely (2), sometimes (3), often (4), very often (5). The alpha = 0.59.

Independent variables: Workplace benefits. Workplace benefits comprise nine dummy variables, where having the benefit is coded (1) for Yes, and (0) for No: Pension plan with guaranteed benefit and self-contribution; Employer contributes to variable (401K) retirement plan; Paid vacation days; Paid holidays;
Allowed paid time off for personal illness; Employer offers training opportunities; Employer pays for job related education/training; and Employer offers wellness program.

**Independent variables: Flexible time benefits.** Similarly, flexible time benefits comprise three dummy variables, where (1) is for Yes, and (0) is for No: Can choose own starting/quitting times within some range of hours; Could arrange to work part of the year; and Allowed to work a compressed work week some of the time.

**Independent variables: Workplace culture.** Difficulty taking time during work day for personal family matter where responses are: Not at all hard (1), Not too hard (2), Somewhat hard (3) and, Very hard (4).

Less likely to advance if use flex options: “Is the reason you do not use the flexible schedule options available to you A LOT because” You don’t need them (1), Your job responsibilities really don’t allow it (2) and, You think using them might have a negative impact on your job advancement (3).

Supportive workplace culture is a scale of 5 items such as “There is an unwritten rule at my place of employment that you can’t take care of family needs on company time,” where response categories are Yes (1), No (0).

The following are dummy variables where Yes (1), No (0): Employer offers service to find elder care; Employer operates/sponsors child care center on/near site; Employer provides direct financial assistance for child care; Employer offers pre-tax account for child/dependent care.

**Independent variables: Individual variables.** Gender is a dummy variable where ‘woman’ is coded as 1. Race is also a dummy variable with ‘white’ coded as 1. Most of the minority categories are African American, but all categories except white are grouped together because there are too few respondents in the individual minority categories to analyze them separately. For ease of discussion, they are referred to as non-whites.

Family size is a continuous variable that has been recoded as a dummy variable with more than 0 people coded as 1. Number of children under 18 years is a continuous variable. Special care for elderly relative is a dummy variable where Yes (1), No (0).

**Independent variables: Human capital variables.** Education is determined by the question: “What is the highest level of
schooling you have completed?” The responses are: less than high school (1), high school or GED (2), trade or technical school beyond high school (3). Some college (4), two-year Associate’s degree (5), four/five-year Bachelor’s Degree (6), some college after BA or BS but without degree (7), professional degree in medicine, law, dentistry (8), Master’s Degree or Doctorate (9). Education is used as a continuous variable.

Hours of work at main job is an interval-level variable. Occupation is a dummy variable measured by the open-ended question: “What kind of work you do or what is your occupation?” In the dataset there is a variable that has 2 categories of occupation: managerial or professional (1) and others (2).

The variable “workplace autonomy” is determined by a scale of 5 items such as “I have the freedom to decide what I do on my job.” Response categories are: strongly disagree (1), somewhat disagree (2), somewhat agree (3), and strongly agree (4). The fifth item is, “Can you choose your own starting and quitting times within some range of hours?” Responses are: no (1) and yes (2). The alpha is 0.70.

Satisfaction with income is determined by the response categories: not satisfied at all (1), not too satisfied (2), somewhat satisfied (3), very satisfied (4).

Independent variables: Workplace support. Supportive supervisor is a scale of 10 items such as “My supervisor or manager keeps me informed of the things I need to know to do my job well.” The responses are: strongly disagree (1), somewhat disagree (2), somewhat agree (3), strongly agree (4). The alpha = 0.90.

Coworkers’ support is a scale of 2 items, such as “I have the support from coworkers that I need to do a good job.” The responses are strongly disagree (1), somewhat disagree (2), somewhat agree (3), and strongly agree (4). The alpha = 0.68.

Methods of Analyses

All the variables are tested by running frequency distributions, and all the variables have more-or-less normal distributions with acceptable skewness and kurtosis. Next, factor analyses are conducted to construct scales for the variables that consist of more than one item. Items with factor loadings greater than 0.50 are included.

Finally, we test the given research questions through a series of analysis programs that include running the
descriptive statistics of all the variables (data not shown), and regression analyses (Tables 1 & 2).

Table 1. Unstandardized Coefficients from the Regression using Work-family Spillover as Dependent Variables and Workplace Benefits and Policies as Independent Variables (N = 1064)

<table>
<thead>
<tr>
<th>Workplace Benefits and Policies</th>
<th>Model</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Workplace Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Availability of personal health insurance through job (yes)</td>
<td>0.58</td>
<td>0.59</td>
</tr>
<tr>
<td>Pension plan with guaranteed benefit and no self contribution (yes)</td>
<td>-0.21</td>
<td>0.21</td>
</tr>
<tr>
<td>Employer contributes to variable (401K etc.) retirement plan (yes)</td>
<td>-0.23</td>
<td>0.24</td>
</tr>
<tr>
<td>Receive paid vacation days (yes)</td>
<td>0.53</td>
<td>0.47</td>
</tr>
<tr>
<td>Receive paid holidays (yes)</td>
<td>-0.59</td>
<td>0.44</td>
</tr>
<tr>
<td>Allowed paid time off for personal illness (yes)</td>
<td>0.10</td>
<td>0.27</td>
</tr>
<tr>
<td>Employer offers training opportunities (yes)</td>
<td>0.03</td>
<td>0.28</td>
</tr>
<tr>
<td>Employer pays for job-related education/training (yes)</td>
<td>-0.72**</td>
<td>0.31</td>
</tr>
<tr>
<td>Employer offers wellness program (yes)</td>
<td>0.28</td>
<td>0.23</td>
</tr>
<tr>
<td><strong>Flexible Time Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can choose own starting/quitting time (yes)</td>
<td>0.15</td>
<td>0.22</td>
</tr>
<tr>
<td>Could arrange full-time/part-time in current position is want (yes)</td>
<td>-0.82****</td>
<td>0.23</td>
</tr>
<tr>
<td>Could arrange work part year (yes)</td>
<td>-0.18</td>
<td>0.30</td>
</tr>
<tr>
<td>Allowed to work a compressed work week some of the time (yes)</td>
<td>0.53**</td>
<td>0.22</td>
</tr>
<tr>
<td><strong>Workplace Culture</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty taking time during work day for personal/family matter</td>
<td>0.96****</td>
<td>0.11</td>
</tr>
<tr>
<td>Less likely to advance if use flex options</td>
<td>0.78****</td>
<td>0.10</td>
</tr>
<tr>
<td><strong>Care-giving</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer offers service to find child care (yes)</td>
<td>0.23</td>
<td>(0.35)</td>
</tr>
<tr>
<td>Employer offers service to find elder care (yes)</td>
<td>-0.30</td>
<td>(0.29)</td>
</tr>
<tr>
<td>Employer operates/sponsors child care center on/near site (yes)</td>
<td>0.33</td>
<td>(0.38)</td>
</tr>
<tr>
<td>Employer provides direct financial assistance for child care (yes)</td>
<td>-0.06</td>
<td>(0.34)</td>
</tr>
<tr>
<td>Employer offers pre-tax account for child/dependent care (yes)</td>
<td>0.08</td>
<td>(0.23)</td>
</tr>
<tr>
<td>Constant</td>
<td>5.63****</td>
<td>(0.80)</td>
</tr>
<tr>
<td>F</td>
<td>12.81****</td>
<td></td>
</tr>
<tr>
<td>R²</td>
<td>0.20</td>
<td></td>
</tr>
<tr>
<td>Adjusted R²</td>
<td>0.18</td>
<td></td>
</tr>
</tbody>
</table>

Note: ****p < .001, ***p < .01, **p < .05, *p < .10
Findings

An overview of employee sample characteristics (data not shown), including the variety of conventional employee benefits and work/family policies that are available to them, indicates that the sample is 49% female, 79% white, and 75% partnered. On average, employees have two children, and 35% give special care for an elderly relative.

In terms of human capital, employees have a two-year Associate's Degree, on average, and 33% are in managerial/professional occupations. Most employees work full-time, forty-three hours weekly on average. They enjoy considerable autonomy at work (13 on an 18-point scale, on average), and are relatively satisfied with their income (2.8 on a 4-point scale, on average). Their workplace culture, including supervisors and especially co-workers, is relatively supportive.

Relatively conventional benefits are most available to employees. Specifically, 70% or more have personal health insurance through their job; have an employer who contributes to a variable retirement plan (401k, etc.) and who pays for job-related education and training; and receive paid vacation days and paid holidays. In addition, over two-thirds (68%) are allowed paid time off for personal illness. In contrast, a minority of employees (42% or less) have flexible work time available to them. Moreover, one-third or fewer employees have caregiving policies at their place of work.

Paid time-off policies are commonly available to employees as a "package." For example, paid holidays is correlated (r = 0.65, p < .001) with paid vacation days; paid time off for personal illness policies is correlated (r = 0.41, p < .001) with paid holidays and (r = 0.41, p < .001) with paid vacation days. Additionally, those who receive personal insurance through their jobs receive paid holidays (r = 0.50, p < .001) and paid vacation days (r = 0.51, p < .001).

In terms of flexible work time policies, ability to work full-time or part-time is correlated with ability to work only part of a year (r = 0.38, p < .001). Caregiving policies are also correlated such that employers who offer a service to find childcare also offer a service to provide elder care (r = 0.56, p < .001), operate/sponsor a childcare center on or near the work site (r = 0.55, p < .001), and provide direct financial assistance for childcare (r = 0.38, p < .001).
Table 2. Unstandardized Coefficients of the Regression using Work-Family Spillover as the Dependent Variable and Workplace Characteristics as Independent Variables (continued next page)

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
<th>Model 5</th>
<th>Model 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Variables</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Gender (female)</td>
<td>-0.38*</td>
<td>0.09</td>
<td>0.15</td>
<td>0.28</td>
<td>0.34</td>
<td>0.50**</td>
</tr>
<tr>
<td></td>
<td>(0.21)</td>
<td>(0.21)</td>
<td>(0.22)</td>
<td>(0.23)</td>
<td>(0.22)</td>
<td>(0.24)</td>
</tr>
<tr>
<td>Race (white)</td>
<td>0.50**</td>
<td>1.03****</td>
<td>1.04****</td>
<td>1.11****</td>
<td>1.28****</td>
<td>0.98****</td>
</tr>
<tr>
<td></td>
<td>(0.24)</td>
<td>(0.23)</td>
<td>(0.24)</td>
<td>(0.24)</td>
<td>(0.24)</td>
<td>(0.26)</td>
</tr>
<tr>
<td>Family size (partnered)</td>
<td>0.17</td>
<td>0.41</td>
<td>0.38</td>
<td>0.84</td>
<td>0.72</td>
<td>1.29**</td>
</tr>
<tr>
<td></td>
<td>(0.56)</td>
<td>(0.53)</td>
<td>(0.54)</td>
<td>(0.56)</td>
<td>(0.54)</td>
<td>(0.60)</td>
</tr>
<tr>
<td>Number of children under 18 years</td>
<td>0.28***</td>
<td>0.23***</td>
<td>0.25***</td>
<td>0.25***</td>
<td>0.27***</td>
<td>0.26***</td>
</tr>
<tr>
<td></td>
<td>(0.08)</td>
<td>(0.07)</td>
<td>(0.08)</td>
<td>(0.08)</td>
<td>(0.08)</td>
<td>(0.08)</td>
</tr>
<tr>
<td>Special care for elderly relative (yes)</td>
<td>0.58**</td>
<td>0.51**</td>
<td>0.50**</td>
<td>0.38*</td>
<td>0.23</td>
<td>0.26</td>
</tr>
<tr>
<td></td>
<td>(0.22)</td>
<td>(0.20)</td>
<td>(0.21)</td>
<td>(0.22)</td>
<td>(0.21)</td>
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<td>Human Capital Variables</td>
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</tr>
<tr>
<td>Education</td>
<td>0.11**</td>
<td>0.12**</td>
<td>0.10*</td>
<td>0.07</td>
<td>0.08</td>
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<tr>
<td></td>
<td>(0.05)</td>
<td>(0.05)</td>
<td>(0.05)</td>
<td>(0.05)</td>
<td>(0.06)</td>
<td></td>
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<tr>
<td>Hours of work at main job</td>
<td>0.09****</td>
<td>0.09****</td>
<td>0.09****</td>
<td>0.06****</td>
<td>0.06****</td>
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<tr>
<td></td>
<td>(0.01)</td>
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<td>(0.01)</td>
<td>(0.01)</td>
<td></td>
</tr>
<tr>
<td>Occupation (managerial/professional)</td>
<td>0.50**</td>
<td>0.62**</td>
<td>0.55**</td>
<td>0.68***</td>
<td>0.56**</td>
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</tr>
<tr>
<td></td>
<td>(0.24)</td>
<td>(0.25)</td>
<td>(0.25)</td>
<td>(0.25)</td>
<td>(0.26)</td>
<td></td>
</tr>
<tr>
<td>Autonomy</td>
<td>-0.17****</td>
<td>-0.19****</td>
<td>-0.18****</td>
<td>-0.04</td>
<td>-0.04</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(0.03)</td>
<td>(0.03)</td>
<td>(0.03)</td>
<td>(0.03)</td>
<td>(0.04)</td>
<td></td>
</tr>
<tr>
<td>Satisfaction with income</td>
<td>-0.83****</td>
<td>-0.88****</td>
<td>-0.84****</td>
<td>-0.50****</td>
<td>-0.53****</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(0.12)</td>
<td>(0.13)</td>
<td>(0.12)</td>
<td>(0.12)</td>
<td>(0.13)</td>
<td></td>
</tr>
<tr>
<td>Workplace Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paid vacation days (yes)</td>
<td>0.85**</td>
<td>0.93***</td>
<td>0.57*</td>
<td>0.65*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(0.36)</td>
<td>(0.35)</td>
<td>(0.34)</td>
<td>(0.36)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paid holidays (yes)</td>
<td>-0.50</td>
<td>-0.76**</td>
<td>-0.48</td>
<td>-0.50</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>(0.35)</td>
<td>(0.35)</td>
<td>(0.34)</td>
<td>(0.36)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allowed time off for personal illness</td>
<td>-0.60**</td>
<td>-0.38</td>
<td>-0.35</td>
<td>-0.40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(yes)</td>
<td>(0.27)</td>
<td>(0.26)</td>
<td>(0.25)</td>
<td>(0.27)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer pays for education/training</td>
<td>-0.04</td>
<td>-0.05</td>
<td>0.20</td>
<td>0.18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(yes)</td>
<td>(0.26)</td>
<td>(0.24)</td>
<td>(0.24)</td>
<td>(0.26)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Numbers in parenthesis are standard errors; ****p < .001, ***p < .01, **p < .05, * p < .10.

Regarding the impact of traditional employee workplace benefits, Table 1 shows that only two of the nine benefits are statistically significant, and barely so. That is, if the employee receives holidays and job-related education/training paid by the employer, there is less work/family conflict.
Table 2 (continued). Unstandardized Coefficients of the Regression using Work-Family Spillover as the Dependent Variable and Workplace Characteristics as Independent Variables

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
<th>Model 5</th>
<th>Model 6</th>
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<tbody>
<tr>
<td></td>
<td>Model 1</td>
<td>Model 2</td>
<td>Model 3</td>
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<td>Model 3</td>
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<td>Model 6</td>
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<td></td>
<td>Model 1</td>
<td>Model 2</td>
<td>Model 3</td>
<td>Model 4</td>
<td>Model 5</td>
<td>Model 6</td>
</tr>
<tr>
<td>Flexible Time Benefits</td>
<td>Allowed to work part-time (yes)</td>
<td>-0.87****</td>
<td>-0.76***</td>
<td>-0.88***</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Allowed to work compressed work week (yes)</td>
<td>0.60***</td>
<td>0.61***</td>
<td>0.60***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workplace Culture</td>
<td>Difficulty to take time off</td>
<td>0.58****</td>
<td>0.41****</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Less likely to advance if use flex options</td>
<td>0.25**</td>
<td>0.24**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supportive workplace culture</td>
<td>-0.25****</td>
<td>-0.17****</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workplace Support</td>
<td>Supportive supervisor</td>
<td>-0.06**</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Supportive coworkers</td>
<td>-0.20**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Constant</td>
<td>9.48****</td>
<td>8.92****</td>
<td>8.97****</td>
<td>8.81****</td>
<td>8.36****</td>
</tr>
<tr>
<td></td>
<td>0.59</td>
<td>(0.83)</td>
<td>(0.87)</td>
<td>(0.89)</td>
<td>(1.12)</td>
<td>(1.30)</td>
</tr>
<tr>
<td>N</td>
<td>1355</td>
<td>1318</td>
<td>1243</td>
<td>1173</td>
<td>1125</td>
<td>952</td>
</tr>
<tr>
<td>F</td>
<td>5.63****</td>
<td>23.23****</td>
<td>16.72****</td>
<td>15.20****</td>
<td>20.95****</td>
<td>17.35****</td>
</tr>
<tr>
<td>R²</td>
<td>0.02</td>
<td>0.15</td>
<td>0.16</td>
<td>0.17</td>
<td>0.27</td>
<td>0.28</td>
</tr>
<tr>
<td>Adjusted R²</td>
<td>0.02</td>
<td>0.14</td>
<td>0.15</td>
<td>0.16</td>
<td>0.25</td>
<td>0.27</td>
</tr>
</tbody>
</table>

Note: N is the total number of cases; numbers in parenthesis are standard errors; **** p < .001, *** p < .01, ** p < .05, * p < .10.

Two of four policies pertaining to the provision of flexible work time significantly affect work/family conflict. Specifically, having the option to work either full-time or part-time in the current work position reduces work/family conflict. Inexplicably, to be able to work a compressed work week (e.g., four days) is related to greater work/family conflict. Perhaps it is trickier to schedule with a spouse who works a five-day week.

In addition to these policies, a workplace culture in which employees have no difficulty taking time off during the work
day for personal or family matters and in which there are no penalties regarding advancement if one uses flex-time options is related to less work/family conflict.

Additionally, none of the five employer-provided caregiving benefits is statistically significant. Specifically, employer-provided services to find childcare or eldercare, employer operation of an on-site childcare center, and employer provision of financial assistance or a pre-tax account for child or adult dependent care do not impact employees’ perception of work/family conflict.

A final part of the analysis determines whether the impact on work/family conflict of the significant flexibility and childcare variables in Table 1 retain significance in Table 2 when four blocks of relevant independent variables are entered into the equation. These include a set of individual employee characteristics, human capital variables, workplace culture variables, and workplace support variables.

Model 1 in Table 2 regresses work/family conflict on five employee characteristics, namely gender, race, partnered status, number of dependent children, and whether the employee is providing special care for an elderly relative. It can be seen that all but partnered status have significant impact on work/family conflict. Specifically, there is the suggestion \( p = < 0.10 \) that women perceive less work/family conflict than men. However, in Model 6, with all blocks of variables in the equation, women appear to experience more work/family conflict than men. White employees, those with dependent children, and those who care for an elderly relative experience more work/family conflict than non-whites, and those with no dependents at either end of the age continuum.

When the second set, human capital variables, are added to individual characteristics in Model 2, we see that all five of the former significantly affect work/family conflict. Higher-placed employees in terms of education and occupation, and those who work longer hours per week, perceive more work/family conflict. On the other hand, employees who have more autonomy in their jobs and who are satisfied with their income experience less work/family conflict. The addition of the block of human capital variables to the equation affects the impact of the individual characteristic variables very little; namely, gender (woman) loses its marginal significance.
Employee Benefits and Policies

The block of traditional workplace benefits is added to the equation in Model 3. Only paid time off for personal illness is related to less work/family conflict. Receipt of paid vacation days is related to more work/family conflict here as well as in Model 6 when all blocks of variables are in the equation. The significant effects of all human capital variables are not changed in Model 6.

In Model 4, a block of three flexible-time benefits is added to the equation. Two of these policies significantly impact work/family conflict. Specifically, the opportunity to work either full-time or part-time reduces work/family conflict. On the other hand, the opportunity to work a compressed week increases work/family conflict and remains so in the final Model 6. Having the option of flex-time is not related to work/family conflict.

Apart from formal policies, the effect of workplace culture is examined in Model 5. It can be seen that the existence of a supportive workplace culture lessens employees' perceptions of work/family conflict. However, the more difficult it is to take time off and the less likely is advancement if employees use flex-time options, the greater the work/family conflict. These effects persist for Model 6 when all blocks of variables are in the equation.

Finally, the supportiveness of supervisors and co-workers is added to Model 6. The more supportive the supervisor and co-workers, the less the perceived work/family conflict.

Summary and Conclusion

This study examines the prevalence of an extensive number of employee benefits and whether the existence of numerous work/family policies is related to reduced work/family conflict among a national sample of U.S. employees. In general, it is conventional benefits that are most available to the employees, such as health insurance, contributions to retirement plans, job-related education/training, sick days, vacation days and holidays. In contrast, only a minority of employees have flex-time and care-giving policies available to them at their workplaces, yet it is flexible scheduling that is most desired by employees (Rogers, 1992).
Despite the prevalence of the conventional employee benefits, few are related to reduced work/family conflict, namely paid holidays and paid education/training. And correlated with the scarcity of family caregiving policies is the lack of their effect on work/family conflict. This may be a statistical artifact in that only about ten percent of employees have access to such policies. But it could be that the lack of an effect is somehow related to the fact that relatively little support for family caregiving is a part of the culture in the United States.

Rather, it is flexible work-time provisions that more likely reduce work/family conflict, especially the option to work part-time and the lack of sanctions for actually using flextime options. These effects continue even when supportiveness of the work culture and of supervisors and co-workers are in the equation. Indeed, the effect of flexible time benefits persists even when all blocks of variables—individual, human capital, and workplace benefits, as well as workplace culture and support—are controlled (i.e., are in the equation in Model 6). It is a matter of both/and rather than either/or when examining impacts on work/family conflict. And, despite the many controls, women and those in traditional childcare roles continue to perceive more work/family conflict.

References


Patterns of Residential Mobility of People with Schizophrenia: Multi-level Tests of Downward Geographic Drift

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This study tests the geographic drift hypothesis that the negative SES-MI correlation results from individuals first developing conditions such as schizophrenia and then moving frequently because of their disability to low income and urban areas, and to neighborhoods with high concentrations of SMI persons. This is a secondary analysis of hospital records of 1,667,956 individuals in Massachusetts, USA, between 1994 and 2000. It employs a longitudinal cohort design and techniques of multi-level modeling. Downward geographic drift of those with schizophrenia was found to be small, but greater than other groups examined. The small level of drift was best explained by pre-existing socioeconomic conditions, and only secondarily by a diagnosis of schizophrenia, and this was true across a wide spectrum of diagnostic and demographic groups. Study hypotheses were largely supported, with downward drift confirmed, and with stronger evidence for low SES as a cause rather than a consequence of geographic drift.

Key words: schizophrenia, residential mobility, geographic drift, socioeconomic status, social causation, social selection, population density, ghettoization

For over 70 years now, an ongoing issue in the sociology of mental illness has been the debate between proponents of social causation and social selection explanations for the dramatically elevated rates of mental illness among those in the lowest income groups. Since the research of Faris and Dunham (1939), numerous studies have documented higher
rates of serious mental illness, especially schizophrenia, in low income, often inner city areas, and substantially lower rates in higher socioeconomic status (SES) areas. What has not been established are the primary reasons for these disparities. On one hand, proponents of social causation believe that unfavorable social conditions, such as unemployment, social stress, isolation, and lack of social support are central in the development of schizophrenia. On the other hand, advocates of social selection contend that schizophrenia is primarily an individual condition that develops as a result of genetic and other biological predispositions that only secondarily leads to low SES.

Theoretical Background

Theoretical perspectives on the selection-causation debate are rooted in and informed by an immense, yet slowly evolving body of research on the etiology of schizophrenia. Although theories that focus on strictly biological and psychosocial causes garner the most popular attention, there is continuing support for the stress-diathesis hypothesis—the idea that schizophrenia is caused by a genetic predisposition that is triggered by environmental and psychosocial stressors (Jones & Fernyhough, 2007; Portin & Alanen, 1998; Russo, Vitaliano, Brewer, Katon, & Becker, 1995). These stressors emerge at various developmental stages, and may involve such diverse conditions as prenatal environment, influenza, dysfunctional families, social labeling, and economic and social disenfranchisement. These have been alternatively hypothesized to lead to structural brain abnormalities, dysfunctions involving various neurotransmitters, and eventually a wide range of psychological and behavioral symptoms of schizophrenia such as social autism, tangential thought, hallucinations, and delusions. What have not been established are the relative salience of these conditions and the specific dynamics of their interactions.

It is recognized by many, based on genetic studies of monozygotic twins raised separately, that genes cannot account for more than 41% to 65% of the variation in susceptibility to schizophrenia (Cardno & Gottesman, 2000). Furthermore, there is no consensus on whether the inherited genetic vulnerabilities are externalized and manifested as dysfunctional
psychosocial patterns, or whether such patterns are internalized and manifested as dysfunctional psychological and neurological functioning.

The various theories of the etiology of schizophrenia, as noted above, undergird several major hypotheses regarding the negative correlation between rates of mental illness, including schizophrenia, and socioeconomic status (see Hudson, 1988, 2005). On one hand, the social stress hypothesis has several versions that involve economic stresses, e.g., unemployment (Brenner, 1973), poverty, noisome and stressful working conditions (Link, Dohrenwend, & Skodol, 1986; Link, Lennon, & Dohrenwend, 1993), etc.; cultural stress or shock (Parker, Kleiner, & Needelman, 1969), e.g., migration (Cantor-Graae & Selten, 2005), or family fragmentation and stresses (Kulka, Veroff, & Douvan, 1979), e.g., high levels of expressed emotion (Tanaka, Mino, & Inoue, 1995). In contrast, the social selection hypotheses propose that endogenous biological processes lead to either: (a) geographic downward drift, involving residential moves from higher to lower socioeconomic communities; (b) intergenerational social drift, typically involving the failure to attain the SES status of the family of origin; or (c) intragenerational drift, the decline from higher to lower SES status within an individual’s adult years. Although evidence for the social selection hypothesis, and specifically the geographic drift version of it, is minimal for mental illness in general, there have been several studies that suggest that geographic drift may be more salient for schizophrenia (Dohrenwend et al., 1992; Loeffler & Haefner, 1999; Murphy, Olivier, Monson, & Sobol, 1991; Rodgers & Mann, 1993; Silverton & Mednick, 1984). However, even with schizophrenia there have been no consistent findings. Finally, there are some who propose that social causation and social drift may both be relevant either for the same individual in an interactive manner, or for different diagnostic or population groups.

The current study specifically focuses on geographic drift among those with schizophrenia, since it is in this arena that social selection finds some support, albeit rather weak. This study follows up on a broader test of the social causation and social selection theories that were recently conducted by Hudson (2005). The study reported here is unique in that it employs a longitudinal and multilevel design to track the
residential movement of individual patients over a seven
year period between neighborhoods through a U.S. state. It
is also one of the most extensive, since it uses a database of
1.7 million individuals from the state of Massachusetts in the
United States, one which includes 22,810 patients diagnosed
with schizophrenia in 45 different hospitals.

The purpose of this study is to test the geographic drift hy-
pothesis for those with schizophrenia, one that suggests these
individuals first develop this condition and then subsequently
move frequently, ending up in low income and dense inner
city areas, and in areas with high concentrations of other seri-
ously mentally ill persons. This study aims not only to describe
these patterns of movement, but to determine the degree to
which they take place prior to or after the individual’s first
known hospitalization for schizophrenia, as well as the extent
to which they can be accounted for by unfavorable pre-exist-
ing SES conditions.

Research Background

Research on residential mobility among those with schizo-
phrenia has fallen into two broad areas. The first has been
concerned with describing rates and patterns of mobility, but
with little attention paid to specifically testing the geographic
drift hypothesis. Related to this body of research are studies
considered with migration and immigration, and with obser-
vations about the clustering or ghettoization of seriously men-
tally ill (SMI) persons. The second line of research consists of
more specific efforts to test the hypothesis that the negative
SES-MI correlation can be accounted for by the downward
social drift of people suffering from mental illness.

Descriptive Studies

Although a few studies have unexpectedly found that
those with schizophrenia move less frequently than other SMI
groups (Lessage & Tansella, 1989; Lix et al., 2007; McCarthy,
Valenstein, & Blow, 2007), others report higher than average
rates of mobility (Lix et al., 2007), as well as generally high
rates of mobility within neighborhoods with many such
persons (Silver, Mulvery, & Swanson, 2002). Those among this
group who do move frequently are more likely to be young
and living in low income neighborhoods that are located in the central city. They are also more likely to have co-occurring substance use disorders than those who move only once (Lix et al., 2007). Similarly, Lix and his colleagues (2006) found that marital status, income quintile, and use of physicians are consistent determinants of mobility among the seriously mentally ill.

There have also been several qualitative studies with very small samples that have sought to explore the dynamics of residential and institutional mobility among the seriously mentally ill, and have focused on the phenomenon of "institutional cycling" as a coping mechanism of such persons and their caretakers when confronted with the dynamics of social control (DeVerteuil, 2003; Hopper, Jost, Hay, Welber, & Haugland, 1997). Hopper et al. (1997, p. 659), for instance, conclude on the basis of interviews with 36 homeless mentally ill individuals that, "Shelters and other custodial institutions have acquired hybrid functions that effectively substitute for more stable and appropriate housing for some persons with severe mental illness." Similarly, DeVerteuil (2003, p. 361) argues, on the basis of his interviews with 25 women in a Los Angeles shelter, that such churning or institutionalized cycling is essentially a new strategy for managing indigent populations on the part of resource-strapped service providers.

A related line of research shows relatively high rates of schizophrenia among migrants, particularly those in the second generation (Cantor-Graae & Selten, 2005; Cochrane & Bal, 1987; Malzberg & Lee, 1956). Yet, more in-depth analyses reveal that rates of schizophrenia among first generation migrants in receiving contexts are comparable to those in their countries of origin (Cooper, 2005). In addition, there is no evidence of selective immigration, or that people with schizophrenia are more likely to immigrate than others. This line of research has provided evidence, at least for people of African and African Caribbean origin, that social causation, involving the stresses and lack of social supports inherent in resettlement, plays a more central role than does differential selection into low-income social strata. An early review of this research questioned the broadness of the concept of migration and the assumption of "culture shock" as being useful for explaining variations of mental illness among migrant groups (Parker et al., 1969).
In perhaps one of the most seminal studies to date, Dohrenwend et al. (1992) conclude that it is unlikely that the higher risks of schizophrenia for migrants to Israel can be explained by their low socioeconomic status. Unlike the case with anxiety and the other disorders examined, these researchers found that the association between low socioeconomic status and schizophrenia was largely attributable to social selection rather than to social causation. In a recent review of the research on migration and mental health, Bhugra (2004) concludes that migration is a multifaceted phenomenon, that critical dimensions involve whether the migration is forced or voluntary, and whether it is undertaken individually or in group, and also argues that stresses and cultural clashes that confront the second generation account for many of the elevated rates of mental disorder among these groups.

A related area of study focuses on the geographic clustering of seriously mentally ill persons. These clusters have been variously referred to as psychiatric ghettos, service dependent population ghettos (Wolch, 1980), zones of dependence (Johnston, Gregory, & Smith, 1994), or the public city (Beamish, 1981). They are typically found in some declining parts of the inner city and are characterized by: (a) service-dependent and socially-marginal populations; (b) many mental health facilities; (c) and low-cost rental accommodations (Dear & Wolch, 1987). While there has been much speculation about the negative impacts of such clustering, a study of the phenomenon in Dunedin, New Zealand, found a decidedly mixed picture (Law & Gleeson, 1998). The researchers reported that although the concentration provided some economies of scale for services and a relatively benign environment for people with serious mental illness, the most detrimental aspects included its poverty, poor housing stock, and under-funded services.

As important as is the description of residential mobility of people with schizophrenia, including ghettoization, confirmation of these patterns leaves unanswered the question about whether such concentrations are the cause or consequence of schizophrenia and similar disorders. Mobility, clustering, and downward drift, although closely related, are largely independent phenomenon, and proving or disproving one such pattern says little for the question of downward geographic drift.
Studies with Positive Findings on Geographic Drift

During recent decades, there has been continuing research that supports the notion of social selection, specifically that downward geographic drift is an important dynamic that accounts for the negative SES-MI correlation. Some positive support for this idea has come from a study by Dembling, Rovnyak, Mackey, & Blank (2002) who examined geographic migration patterns of 11,725 state psychiatric patients in Virginia over the course of 18 years. They found that one third of their sample migrated between counties over the course of the hospitalizations, more often toward lower income communities. However, the statistical effect is more modest than is portrayed in the researchers’ narrative, as only somewhat over half (56% to 59%) moved to communities with less favorable SES characteristics, and by how much cannot be determined from the published report.

Another research team (Rodgers & Mann, 1993) reanalyzed data from four earlier studies on intergenerational social mobility and found evidence for downward geographic drift, and that the failure to adequately control for differences in the cohorts of mentally ill and normal populations resulted in an underestimate of such drift in prior studies. Several studies (Loefler & Haefner, 1999; Munk & Mortensen, 1992; Murphy et al., 1991; Silverton & Mednick, 1984) have also reported evidence for social drift, even prior to first known hospitalization. Loefler and Haefner (1999, p. 93), for instance, concluded that “the biography of schizophrenics shows that ... selective processes like downward drift or nonstarting processes, lead to the migration of schizophrenics into unfavourable areas or schizophrenic residents staying in poor areas, while healthy residents leave these districts.” One of the most recent studies, conducted by DeVerteuil et al. (2007), compared the residential mobility of an urban cohort with schizophrenia with a matched cohort with no mental illness using secondary data sources, and concluded that those with schizophrenia were much more likely to move from the suburb to the inner city, and less likely to move from the inner city to the suburb, compared with those without a mental illness. Much of this research has been hamstrung with inadequate samples, lack of controls, or failure to document the actual magnitude of the purported drift.
Studies with Negative Findings on Geographic Drift

As weak as is the evidence that supports geographic drift, there are even fewer studies that contradict this hypothesis. One of the first was that of Lapouse et al. (1956) who examined the moves of patients with schizophrenia in a city for 20 years prior the onset of their schizophrenia. They concluded that these patients were initially concentrated in low-income neighborhoods, with negligible evidence of further downward drift. Their use of a control group revealed that others did not move up socioeconomically compared with those with schizophrenia.

More recent studies have also provided evidence for the idea that the concentration of persons with schizophrenia in the inner city is not simply a result of geographic drift, but instead reflects the socioeconomic status of their original areas of upbringing (Harrison et al., 2001). In a re-analysis of results from several earlier studies using log-linear models, Fox (1990) concluded that the earlier reported support for social drift was largely a methodological artifact. In addition, a recent Swedish study provides strong evidence that childhood social disadvantage is predictive of risk of schizophrenia (Hjern, Wicks, & Dalman, 2004).

Studies with Mixed Findings on Geographic Drift

Periodically researchers have investigated the possibility that both social causation and social selection, as manifested through downward geographic drift, best account for the observed socioeconomic disparities in the distribution of persons with schizophrenia. And it is not surprising that it is these studies that have had the most mixed findings. One of the earlier of these was that of Turner and Wagenfeld (1967, pp. 104-113) who found, using the Monroe County (NY) psychiatric register data, some evidence for minor effects of social causation, but stronger evidence that individuals with schizophrenia failed to replicate the social status of their families of origin. One of the most well-known of the early studies was that of Dauncey, Giggs, Baker, & Harrison (1993) who investigated the lifetime residential mobility of 67 patients with schizophrenia in the city of Nottingham beginning in 1978. Although they found some data suggest downward drift,
they interpreted their results to indicate that the disparate socioeconomic distribution started early in the lives of their patients and was largely set by the time of their first contact with mental health services. Other early studies with mixed findings include those of Kohn (1972), Dunham (1976), and Giggs and Cooper (1987), and as noted earlier, that of Dohrenwend et al. (1992).

Perhaps the largest study to date was one conducted by Hudson (2005), who undertook a longitudinal secondary analysis of a statewide database of patients who had been psychiatrically hospitalized in 45 psychiatric units throughout Massachusetts. Hudson tracked 34,000 patients between residential moves over the 7 years of the data collection (1993-2000) and examined changes in the socioeconomic conditions in their initial and final zipcode of residence. These data showed that within the seven years of this study there was only evidence of very slight levels of downward mobility for the psychiatric patients as a whole (14.5% experienced declines, compared with the 13.3% who saw increases), with the exception that there are data to suggest a slight tendency toward downward geographic drift among those with schizophrenia and neurosis. Of the 5,035 patients on psychiatric units with diagnoses of schizophrenia, 17.2% saw decreases in the SES of their home community (with a decreased SES z-score of .76), which was only slightly but significantly greater than the 15.2% who saw increases (with a mean increase in SES $z = .68$). However, because neither schizophrenia nor geographic drift were the central focus of this study, and sufficient statistical control for alternative explanations could not be used, the study leaves important questions unanswered regarding downward psychiatric drift of persons with schizophrenia.

In recent years an increasing number of researchers have introduced multilevel modeling to the effort to disaggregate neighborhood and personal predictors of the differential rates of serious mental illnesses, including schizophrenia. An initial review of this research, published by Allardyce and Boydell (2006) does, in fact, provide evidence in favor of the independent impact of impoverished community conditions over and above that of the low socioeconomic status of the afflicted individuals. The reviewers report that, “To date, there
are few examples of multilevel analyses in schizophrenia research; however, the small number of studies suggests that there may be a neighborhood social contextual effect that influences rates of schizophrenia and other psychotic disorders" (p. 592).

On the whole, research produced some support for the possibility that downward geographic drift is an important dynamic accounting for a portion of the negative SES correlation of socioeconomic status with those with the most severe mental disabilities, such as persons with schizophrenia. Yet, small samples, limited time frames, and diverse conceptualizations of mobility and downward drift, difficulties in disaggregating individual and neighborhood effects, as well as several studies that have contradicted the hypothesis, all call into serious question the salience of the geographic drift hypotheses. It is for this reason that the current study aims to address several of the limitations of past research, and to investigate the following questions and associated hypotheses:

*What are the patterns of residential movement of patients with schizophrenia, in respect to the frequency and types of moves made?* It is hypothesized that these moves, whether more or less frequent, will be to neighborhoods with greater population density, lower socioeconomic status, and greater concentrations of seriously mentally ill persons more often than the opposite.

*To what extent does the phenomenon of geographic drift occur prior to first known psychiatric hospitalization for schizophrenia? To what extent is drift associated with age?* It is hypothesized that, although downward geographic drift begins prior to first acute psychiatric hospitalization for schizophrenia, it will be accelerated following the first such hospitalization, and with advancing age.

*To what extent do these moves account for socioeconomic disparities in the distribution of persons suffering from schizophrenia?* It is furthermore hypothesized that downward drift will account for a portion, but not all the negative correlation between SES and MI for persons diagnosed with schizophrenia.
Can declines in residential socioeconomic conditions be attributed to characteristics of the individuals or to the communities that they live in? Finally, it is hypothesized that the extent of downward drift itself reflects pre-existing negative socioeconomic conditions to a greater extent than individual characteristics such as the diagnosis of schizophrenia.

Method

Overview

This is a longitudinal analysis of the experience of patients who were hospitalized in acute facilities during the seven year period from FY1994 to FY2000, with comparisons made between key subgroups of patients based on their ICD-9 diagnosis: (a) one or more diagnoses of schizophrenia; (b) no schizophrenic diagnoses, but other mental health diagnoses; and (c) medical diagnoses only (n = 1,667,956). A key feature of this study is that records of hospital episodes at the patient level are not duplicated, and individual patients are tracked between hospitals and communities. This is a multilevel study in that it models both levels and rates of change (slopes) of three dependent variables: (a) community socioeconomic status; (b) population density, as a proxy for urbanization; and (c) population rate of persons with serious mental illness among those with multiple hospitalizations, based on both individual predictors—particularly a diagnosis of schizophrenia—as well as characteristics of the community at first recorded hospitalization.

Sample

This research uses data collected as part of the Commonwealth of Massachusetts' Case Mix database, maintained by the state’s Division of Health Care Finance and Policy (MDHCFP FY1994-FY2000), and is supplemented by data from the STF-3C file of the 2000 U.S. Census. This is a state-wide health reporting system in which all acute facilities in Massachusetts are mandated to submit a report on each discharged patient. While all 1,667,956 person-level records for the 1994-2000 period are initially included (including 22,810 with schizophrenia), only those patients with a known zip code of residence, as well as a uniform health identification number.
(UHIN) were used to prevent duplication of the episode records. Of these, patients with two or more hospitalizations in each of a minimum of two years were selected to permit a sufficiently stable identification of changes in conditions in community of residence as patients moved around the state. This resulted in the final selection of 571,980 patients for the testing of the final models, of whom 11,220 had received a diagnosis of schizophrenia on one or more occasions during their period of hospitalization. Although this study has examined the experience of a substantial proportion of the Massachusetts population during the designated years, because of the necessary exclusions noted above, it remains a sample study, subject to sampling error. For this reason, appropriate inferential tests are reported.

Variables: Dependent

Three dependent variables were computed to evaluate changes in patients’ living circumstances based on their zip codes of residence at the time of each hospitalization. These measure three different types of geographic drift and consist of changes in: (a) socioeconomic status of the home community (zip code of residence), based on STF-3C data from the 2000 U.S. Census on the educational, occupational, and income profile of the home zip code (this is presented in detail in an earlier study by Hudson in 2005); (b) community population density (persons per sq. mile) as a proxy for urbanization; and (c) mean proportion of seriously mentally ill adults, obtained from an earlier small area estimate study based on the 2002/2003 National Comorbidity Replication data (Hudson, 2009). An equation for the linear slope of the values for each patient with two or more hospitalizations in at least two separate years was computed to characterize the direction and rate of change in community SES, population density, and concentration of seriously mentally ill (SMI) persons. Other descriptive statistics, such as frequency of moves and average distance were also computed. Distances in miles between subsequent moves were derived by computing the straight-line Euclidian distance between the centroids of the successive home zip codes.
Variables: Predictors

A key person-level predictor is the diagnostic group, which was based on primary and secondary ICD-9 diagnoses that were dichotomously recorded (1/0) and then grouped into the following categories: (a) those with one or more diagnoses of schizophrenia; (b) those with other psychiatric diagnoses, but no diagnosis of schizophrenia; and (c) those with only medical and no psychiatric diagnoses during any of their hospitalizations, as well as standard demographic variables such as age, gender, race (Caucasian, African-American, Hispanic, Asian-American, and Other), and veteran's status. Also included as predictors were type of insurance at first hospitalization, characterized by three dummy variables (1/0): Any/none, Public/private, Managed care vs. fee-for-service, HMO/Non-HMO; and also, length of period of hospitalization and total hospital episodes.

Community-level predictors were computed for each patient residence at first known hospitalization (whether psychiatric or medical), and these include community SES, population density, and rate of SMI, parallel with the above noted drift variables. Other community-level predictors examined at point of first hospitalization were rate of individual poverty, unemployment, mean household income, housing affordability, and percent of population urbanized.

Data Reliability

Analyses of administrative datasets are often confronted with questions about data reliability, especially when such data are obtained through multiple sources. In this case, several studies have been conducted, both by Hudson, Dorwart, and Wieman (1998) and by the Division of Health Care Finance and Policy (MDHCFP, 1998), which provide evidence of the data's reliability in crucial areas. The reliability of the data on age, gender, and race were assessed by this researcher through an analysis of the consistency of these fields across multiple hospitalizations of the same individuals. These analyses demonstrated very high levels of reliability or inter-rater agreement among the three different facilities of a subgroup of patients with multiple hospitalizations within any three month time span. Agreement about gender, age, and racial affiliation were all very high, at 0.93 or above (MDHCFP, 1998). A similar
procedure was used to examine agreement between separate facilities as to patients' diagnoses. The resulting Kappa reliabilities range from the slight (0 - .19) to the substantial (.60 -.79). Substantial reliabilities were found for schizophrenia (.74) and senile/pre-senile organic psychosis (.67), and moderately strong reliabilities were found for affective disorders (.54), adjustment reaction (.48), and alcohol dependence (.59).

Regarding the information on the patient's insurer, MDHCFP published an analysis of these fields, comparing their own data with that of selected facilities and insurers, including Medicaid, for 1994 (MDHCFP, 1998). This analysis indicated a good to a very good level of agreement. In the case of Medicaid, there were precise matches in 69.4% of the cases.

**Analysis**

Preparatory steps for the analysis included the development of SPSS data files for each of the seven years, and the merging of these files into a single master file containing 5.2 million discharge records, based on a uniform health identifier number (UHIN), an encrypted social security number that links episodes of the same individual over the multiple years. For those 3.8 million episodes with both valid identifiers and zip codes, zip code-level data were merged so as to include data on socioeconomic status and other community-level characteristics for each episode, as well as computations of distances between subsequent communities.

After computing means or percentages for key variables for individual years for each patient, a file with 1,667,989 patients was generated that included flags for the diagnostic groups, the three primary dependent variables for up to seven years of hospitalizations, as well as the other variables. From these data, best-fitting linear slopes were computed, using a SPSS syntax file for each of the three dependent variables for each patient, as well as flagging variables on patients and community characteristics for the time of initial hospitalization. This was done both for the aggregate of the seven years, and in the case of the group of people with schizophrenia, it was also done separately for the years before first psychiatric hospitalization (medical-only episodes) and for years subsequent to initial psychiatric hospitalization.
To check if the three indicators of drift are sufficiently independent, correlations were computed between the three slopes and found to range from weak to minimally strong, specifically: change in SES and Population Density, \(-0.28\) \((p = 0.000)\); SES and SMI rate, \(-0.548\) \((p < 0.000)\); and Density and SMI rate, \(0.608\) \((p < 0.000)\). Thus, although these indicators of downward drift are clearly related, they cannot be treated as a unitary process; downward drift clearly has alternative interpretations.

After computing descriptive statistics, including percentages, means, and zero-order correlations between key variables, and rescaling selected variables to a similar metric, predictive models of each of the three dependent variables—slope of community SES, density, and SMI rate—were estimated using the multilevel module in LISREL Version 8.8 using a randomly selected 50% calibration sample of the cases \((n = 286,814)\). The initial step involved computing intercept-only models for each of these variables, and subsequent full models that included the fixed dichotomous predictors, and level 1 (person) and level 2 (community) predictors, including slopes. Each of these was then recomputed two to four times using a process of backward elimination of non-significant predictors. These full models were assessed by comparing their deviance statistics with the corresponding intercept-only model, as well as computing (using Excel) the intraclass correlation coefficients and the pseudo-\(R^2\)'s (PRE) for both Level 1 and Level 2, based on formulae recommended by Luke (2004). In addition, each of the three full models, as well as their corresponding null models, were recomputed on the remaining validation sub-sample of 285,990 cases, with coefficients and deviance statistics reviewed for agreement between the two.

Results

The Sample

Data used in this study permit comparisons between those in Massachusetts who have been hospitalized on one or more occasions with diagnoses of schizophrenia \((n = 22,810)\) with those hospitalized with other mental illnesses but no schizophrenia diagnoses \((n = 368,408)\), or with no psychiatric diagnoses \((n = 1,276,752)\), a sample that represents over a
quarter of the population of the state. Those suffering from schizophrenia have a similar mean age as the medical cohort (48.2 vs. 49.2) as the larger patient population, and are considerably younger than those with mental illness (MI), but no schizophrenia (56.6). However, variation in age among this group is substantially less, with only 1.2% under 18, compared with 5.6% of the medical population; and 22.8% were over 65, less than the 32.4% from among the latter group and the 43.3% in the MI group. Those with schizophrenia are evenly split between males and females (50.7% vs. 49.3%), in contrast to the disproportionate number of females among the regular MI population (56.6%) and especially, and those with solely medical diagnoses (65.3%). A disproportionate 9.3% of those with schizophrenia are African-American, compared with the 5.1% among the MI group and 5.4% among those with only medical hospitalizations. And not unexpectedly, those with schizophrenia live in lower SES communities ($z = -0.38$ vs. -0.31 and -0.20), and more urbanized areas, with a mean population density of 6,630 persons per square mile, versus 4,954 and 4,498 for the other two groups. The communities of those with schizophrenia have a slightly higher proportion of total SMI adults (5.7%) than the communities of the MI (5.5). These diverse demographic and SES profiles could, in the end, account for differential patterns of downward drift, and for this reason results of tests for such a possibility will be reported in later sections of this article.

**Hypothesis 1: Patterns of Residential Movement**

This study clearly supports the hypotheses that those with schizophrenia move more frequently and further than those with no schizophrenia, to communities with lower SES profiles, greater population density, and higher rates of seriously mentally ill persons. Those with schizophrenia moved a mean of .40 times a year, about 50% more often than other mentally ill persons (.27), and almost three times more often than those with no mental illnesses and only medical diagnoses (.15). Similarly, these moves were to locations at a mean of 3.9 miles away, compared with 2.6 and 1.5 miles for the two comparison groups.
In respect to the changes in the characteristics of these home communities, there are clear increases in the population density of their home communities, but only a slight increase in the community rate of SMI persons. For example, those with medical diagnoses only saw only a slight decline of -.016 in SES between moves; those in the MI group, about twice (-.029) the decline. Among those with schizophrenia—but prior to any hospitalization on a psychiatric unit—there was a -.035 annual decline, but after first psychiatric hospitalization, the rate peaks at -.063 per year. Because of the massive size of the sample, all of these changes are statistically significant at least the p < .01 level. The reader is cautioned that p-values and other inferential statistics reported in this study are used merely to assess generalizability, and should not be interpreted to imply effect sizes. Some highly ‘significant’ findings may possibly not represent meaningful correlations, differences, or effects simply because of the massive sample size. Thus, the reader is advised to critically consider the actual correlation or substantive effect size, independent of the p-value.

Hypothesis 2: The Question of Early Geographic Drift.

The descriptive statistics reported earlier support the second hypothesis of this study, that although downward drift begins prior to first known psychiatric hospitalization, it is accelerated subsequent to such hospitalization, in respect to declines in SES, increasing urbanization of place of residence, and increasing concentrations of seriously mentally ill persons. Whereas prior to acute psychiatric hospitalization, SES declined an average of .035 units a year, afterwards the decline accelerates to .063 units per year; similarly, the mean increase in density was 576 per year, subsequent to the first psychiatric hospitalization, the rate of increase goes up to 666 per year. The post-psychiatric hospitalization rate of increase of .006 in the SMI rate suggests that over a decade after such a hospitalization, the typical person afflicted with schizophrenia will have seen an increase of over 6% in the population rate of SMI persons in their home zip code, more than the national rate of 5.35% (Hudson, 2009). As was the case with the previous rates of change reported, each of these is significant at the p < .01 level or better.
Figure 1. Changes in Initial Community SES, By Age Decade and Diagnostic Group

Although the seven year period of the study is substantial, it is only a small portion of the typical life span. For this reason, two analyses were conducted of the relationship between age and downward drift. When mean levels of community SES, density, and SMI rates at first hospitalization are computed for the various age groups, as defined by decade, a consistent improvement is seen over the range of age cohorts in initial community of residence. Whereas the initial community SES was -.65 for those age 0-19, in the oldest group (100+) experiences a much less severe level at -.13; similarly, their mean urban population density declines from 6,335 to 4,379, and their community SMI rate declines from .061 to .051. However, due to wide variations, the zero-order correlations with age are negligible to small, although significant, with SES, at .087; density, at -.079; and SMI rate, at -.130 (p < .000). These analyses were then replicated separately with each of the three diagnostic subgroups, with the direction of changes and correlations found to be consistent across all three groups, including those with schizophrenia. However, the strength of the correlations between age and community characteristics for those with schizophrenia was at a negligible level, although significant (SES: $r = .022$, $p < .001$; Density: $r = -.023$, $p < .001$; SMI: $r = -.200$, $p < .003$). Figure 1 depicts increased levels of initial community SES, based on advancing age, for the three
diagnostic groups. Thus, no evidence has been uncovered for additional downward drift prior to or after the identified period of active hospitalization as captured in the primary analyses of this study.

Figure 2. Changes in Mean Community SES, By Diagnostic Group

Hypothesis 3: Impact of Geographic Drift on SES Disparities

This study examined the extent that residential moves increase the disparities in the distribution of persons with schizophrenia between low and high SES communities. Figure 2 shows a slight decline in mean community SES from an already low z score of -.37 for those with schizophrenia to a low of -.40 for those with six or more years of hospitalizations (lower line). Those with other types of mental illness—illustrated by the middle line—saw a decline from -.30 to -.33, and those with only medical causes of hospitalization lived in communities with only nominally low SES conditions (z = -.19), and saw very small declines by the end of the period examined, at -.21. Thus, although disparities in community SES increase on average the longer the period of hospitalizations, these declines only slightly increase the disparities evident at the start of the recorded history of these people's hospitalizations, beginning for many prior to any psychiatric hospitalization. These descriptive statistical indicators, thus, show that initial community conditions may play a more decisive role in accounting for the greater disparities in downward drift when the same patients are examined, more than the diagnosis of schizophrenia itself.
Table 1. Zero-order Correlations of Changes in Neighborhood Conditions (Slopes) with Selected Person and Community Predictors (N = 574,573)

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Rate of Change in Community Conditions of Patients*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Socio-economic Status</td>
</tr>
<tr>
<td>Person-Level Predictors</td>
<td></td>
</tr>
<tr>
<td>Gender [female = 0; male = 1]</td>
<td>-.011</td>
</tr>
<tr>
<td>Age</td>
<td>.041</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>-.004</td>
</tr>
<tr>
<td>Black</td>
<td>-.081</td>
</tr>
<tr>
<td>Caucasian</td>
<td>.107</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>-.116a</td>
</tr>
<tr>
<td>Other</td>
<td>.016</td>
</tr>
<tr>
<td>Diagnostic Group</td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>-.066</td>
</tr>
<tr>
<td>Other MI, no schizophrenia</td>
<td>-.056</td>
</tr>
<tr>
<td>Medical diagnosis only</td>
<td>.076</td>
</tr>
<tr>
<td>Initial Community Conditions</td>
<td></td>
</tr>
<tr>
<td>SES</td>
<td>.663a</td>
</tr>
<tr>
<td>Population density</td>
<td>-.119a</td>
</tr>
<tr>
<td>Rate of SMI</td>
<td>-.588a</td>
</tr>
<tr>
<td>Other Initial Community Indicators</td>
<td></td>
</tr>
<tr>
<td>Unemployment</td>
<td>-.356a</td>
</tr>
<tr>
<td>Percent urban</td>
<td>-.066</td>
</tr>
<tr>
<td>Rent as % household income</td>
<td>-.107a</td>
</tr>
<tr>
<td>Household income</td>
<td>.583a</td>
</tr>
<tr>
<td>Poverty</td>
<td>-.428a</td>
</tr>
</tbody>
</table>

Note: *non-negligible correlations (> .10). All correlations reported include all individuals who had two or more separate hospitalizations in at least two separate years; *p < .000 for all reported.
Hypothesis 4: Impact of Initial Community Conditions on Geographic Drift

Whereas the diagnosis of schizophrenia has only a negligible to weak zero-order correlation with the rate of decline in the recorded period of hospitalizations in community socioeconomic status \((r = -0.066; p < .000)\), population density \((r = 0.108; p < .000)\), and rate of serious mental illness \((r = -0.145; p < .000)\), the conditions of the community that the patient lived in the first time he or she was hospitalized, had considerably stronger effects. The lower the initial SES, the more likely the patient would see further declines in SES \((r = 0.663; p < .000)\), as well as increases in population density \((r = -0.119; p < .000)\) and rate of SMI \((r = -0.588; p < .000)\). Similar but somewhat less dramatic effects on SES were found when population density \((r = -0.105; p < .000)\) and rate of SMI \((r = -0.218; p < .000)\) were examined. Table 1 reports these zero-order correlations, with non-negligible coefficients (those above \(r = 0.10; p < .000\)) designated with superscript. A variety of other indicators of community conditions were also found to have substantial correlations with the patterns of change of the half million \((n = 574,573)\) individuals with multiple hospitalizations over two or more separate years. However, a full test of the effects of initial conditions, along with diagnosis, requires multivariate statistical controls, and it is to these results that we will now turn.

To test for the simultaneous impact of the contributions of diagnosis and initial neighborhood conditions on the subsequent patterns of geographic drift, three multilevel models were estimated. These used patient demographics, type of insurance, and diagnosis as level 1 predictors, and initial community characteristics as level 2 predictors (see Table 2). Models were re-estimated after deletion of non-significant predictors, until all remaining coefficients were significant at the .05 level or better.

The two most powerful effects predictive of subsequent SES decline were the diagnosis of schizophrenia, associated with a -0.0166 decline per year in SES, and initial community SES, a .0059 annual decline. Those with a diagnosis of schizophrenia had an average annual rate of decline of .017, greater than others during the period of their hospitalizations. This positive relationship with initial SES indicates that those who started out in well-to-do communities saw increases in SES,
Table 2. Full Multilevel Models of Changes in Community SES, Population Density, and SMI Rate (n=286,814)

<table>
<thead>
<tr>
<th>Model Parameters</th>
<th>Rates of Change</th>
<th>Community SES</th>
<th>Population Density</th>
<th>SMI Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fixed Coefficients</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intercept</td>
<td>0.0124</td>
<td>0.0159</td>
<td>0.0009</td>
<td></td>
</tr>
<tr>
<td>Diagnosis: Schizophrenia</td>
<td>-0.0166</td>
<td>-0.0039</td>
<td>-0.0002</td>
<td></td>
</tr>
<tr>
<td>Diagnosis: Other mental illness</td>
<td>-0.0311</td>
<td>-0.0026</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis: Medical prob. only</td>
<td>-0.0315</td>
<td>-0.0026</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance: Public</td>
<td>0.0006</td>
<td>0.0000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance: None</td>
<td>-0.0007</td>
<td>0.0004</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race: African American</td>
<td>-0.0022</td>
<td>0.0021</td>
<td>0.0001</td>
<td></td>
</tr>
<tr>
<td>Race: White</td>
<td>-0.0004</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race: Hispanic</td>
<td>-0.0031</td>
<td>0.0015</td>
<td>0.0001</td>
<td></td>
</tr>
<tr>
<td>Number of Episodes</td>
<td>-0.0013</td>
<td>0.0025</td>
<td>0.0002</td>
<td></td>
</tr>
<tr>
<td>Span of Hospitalizations</td>
<td>-0.0020</td>
<td>0.0036</td>
<td>0.0005</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>0.1200</td>
<td>-0.0600</td>
<td>-0.0100</td>
<td></td>
</tr>
<tr>
<td>Initial SES</td>
<td>0.0059</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Population Density</td>
<td>21</td>
<td>619</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial SMI Rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household Income</td>
<td>1,200</td>
<td>110</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Random Coefficients**

**Level 1: Person Level (n=286,749)**

| Intercept | 0.0028 | 2.18E-03 | 7.67E-06 |
| Number of Episodes | 0.0001 | -1.40E-04 | -3.94E-07 |
| Span of Hospitalizations | 0.0001 | 6.00E-05 | 4.06E-07 |
| Age | 0.0400 | .0040 | 3.86E-05 |

**Level 2: Community Level (n=497)**

| Intercept | 0.0002 | 7.51E-07 | 2.43E-08 |
| Initial SES | 0.0002 |
| Initial Density | 0.0000 | .0290 |
| Initial SMI Rate | | |
| Household Income | 50 | 113 |

NOTES: See table 6 for goodness-of-fit statistics. All solutions converged within 12 iterations. Predictors without any significant coefficient for any of the models were dropped, and model recomputed. These consisted of: Gender, Race (Asian/P.I. & Other), Insurance (HMO, Private, None), Housing Affordability, Vet Status, Poverty, and Unemployment. After estimation, coefficients for rescaled variables are reported in original scale.

1 p < .05. All other parameters are significant at p < .001.
2 Only variances, not covariances, of predictors are reported here for brevity.
3 For the intercept only models, the following coefficients were computed for the intercept: Rate of Change in Community SES—fixed -0.0010; Person Level 0.0054, Community Level 0.0044; Rate of Change in Population Density—Fixed 0.0241, Person Level 0.0049; Community Level 0.0018; Rate of Change in Rate of SMI Adults—Fixed 0.0041, Person Level .0000, Community Level 1.2039E-06.
Table 3. Goodness-of-Fit Indices for Multilevel Models of Changes in Community SES, Population Density, and SMI Rate (n=286,814)

<table>
<thead>
<tr>
<th>Model Parameters</th>
<th>Rates of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Community SES</td>
</tr>
<tr>
<td>Random Coefficients Level 1: Person Level</td>
<td></td>
</tr>
<tr>
<td>Intraclass Correlation</td>
<td>.992</td>
</tr>
<tr>
<td>Pseudo-R² *</td>
<td>.871</td>
</tr>
<tr>
<td>Intercept Only Model</td>
<td></td>
</tr>
<tr>
<td>Intraclass Correlation</td>
<td>.549</td>
</tr>
<tr>
<td>Level 2: Community Level</td>
<td></td>
</tr>
<tr>
<td>Intraclass Correlation</td>
<td>.008</td>
</tr>
<tr>
<td>Pseudo-R² *</td>
<td>.995</td>
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<tr>
<td>Intercept Only Model</td>
<td></td>
</tr>
<tr>
<td>Intraclass Correlation</td>
<td>.451</td>
</tr>
<tr>
<td>Goodness-of-Fit</td>
<td></td>
</tr>
<tr>
<td>Deviance (-2LL): Calibration</td>
<td>-1,251,466</td>
</tr>
<tr>
<td>Deviance (-2LL): Test Data</td>
<td>-1,260,088</td>
</tr>
<tr>
<td>Free Parameters</td>
<td>30</td>
</tr>
<tr>
<td>Intercept Only Model</td>
<td></td>
</tr>
<tr>
<td>Deviance (-2LL): Calibration</td>
<td>-680,455</td>
</tr>
<tr>
<td>Deviance (-2LL): Test Data</td>
<td>-689,118</td>
</tr>
<tr>
<td>Free Parameters</td>
<td>8</td>
</tr>
</tbody>
</table>

Notes: See table 5 for parameter estimates. All solutions converged within 12 iterations. Predictors without any significant coefficient for any of the models were dropped, and model recomputed. These consisted of: Gender, Race (Asian/P.I.), Insurance (HMO, Private, None), Vet Status, Poverty, Unemployment. *Computed as a proportional reduction of error measure, comparing each full model to its corresponding null or intercept only model, based on formulas from: D.A. Luke. (2004). *Multilevel modeling* (pp. 35-37). [Sage University Paper 143]. Thousand Oaks, CA: Sage Publications. The n used in these formulae was the harmonic mean n for all second level units.

and those who came from poor areas saw further decreases in SES, an effect that adds to the tendency of a diagnosis of schizophrenia to be associated with declines.

For each standard deviation (z = 1.0) less in initial community SES, the patient would experienced about a 6% decline in SES over the course of a decade, with other factors held constant. In addition, the greater the patient’s age, the more likely were they to see increases in community SES (b = .12), a finding consistent with the previous bivariate analyses (see Figure 1). Contributions of a variety of other predictors were significant, but had negligible to minimal effects, indicating
that the pattern involving the simultaneous effects of SES and schizophrenia is generalizable across a variety of demographic groups.

Changes in levels of population density—a proxy indicator of urbanization—were most powerfully predicted by medical diagnosis ($b = -0.0315; p < .000$) or by a non-schizophrenic mental illness ($b = -0.0311; p < .000$). Movements to less urbanized areas are associated with non-medical diagnosis, more likely not involving schizophrenia, whereas there was only a slight effect of schizophrenia on causing movement to more urbanized areas ($b = -0.0039; p < .000$). The single most powerful predictor was the patient’s initial communities’ level of urbanization ($b = -6.19; p < .000$), associated with moves to even more urbanized areas. Similarly, the most significant predictor of the tendency to move to areas with greater concentrations of SMI persons was also initial urbanization ($b = 0.0061; p < .000$), but neither this nor other predictors had substantial effects in explaining such patterns.

All three estimated models were evaluated through comparison with their corresponding null or intercept only equivalents, and in each case substantial decreases in the deviance statistic indicates improved fit with the combination of level one and level two predictors (see Table 3). Pseudo-$R^2$ (PRE) measures for levels 1 (individual) and 2 (community), for each of the three models indicate that the full model, which includes slopes of key predictors, as well as the fixed effects of dichotomous predictors, all brought about a very substantial proportionate reduction of error (PRE), compared with the corresponding null model, ranging from .77 to over .99.

Discussion

The results of this study confirm a modest level of downward geographic drift, but paradoxically minimize its origins in social selection. Specifically, these results show that the nominal level of geographic drift is primarily the result of low SES to begin with and is only minimally influenced by the diagnosis of schizophrenia. On one hand, downward geographic drift clearly takes place during periods of active hospitalization, more so for those with schizophrenia than for others. Yet, even for this population, downward drift is modest, such that
it does not substantially increase disparities in community socioeconomic conditions as schizophrenia progresses. But more important, the extent and speed of decline in socioeconomic circumstances is predicted more powerfully by the patients’ initially poor community conditions than by the diagnosis of schizophrenia itself. Most important is the combination of the two that best explains the extent of downward geographic drift across a very wide spectrum of diagnostic, age, racial, gender, and other demographic groups in Massachusetts. In short, the rich grow richer and are able to move to higher SES areas; the poor are forced into even poorer areas, and this is particularly the case for those who suffer from schizophrenia.

One of the unique features of this study is that it has examined downward drift, not only in terms of socioeconomic conditions, but also in respect to urbanization and the geographic clustering of seriously mentally ill persons. Not unexpectedly, the study provides clear evidence of the propensity of persons with schizophrenia to move to denser or more urbanized areas. These are not necessarily poorer areas, but a positive correlation was found between moves to low SES and to urbanized areas. It may be that a greater availability of services in dense urban areas stimulates such moves, however, this interpretation is not supported by a negligible to slight tendency of this population to move areas of higher concentration of seriously mentally ill persons. It may be that the gentrification of many inner city areas, along with policies in Massachusetts aimed at dispersing group homes for the psychiatrically disabled, have in recent years minimized the ghettoization of the mentally ill as has been documented in previous decades.

Although this study examined the pre-psychiatric hospitalization period of those with schizophrenia, a limitation of this research which continues to be relevant here is that it has been only able to examine a maximum of seven years of hospitalizations for the same individuals. It could be that prior to any recorded hospitalization that the patients saw much more substantial downward drift. Yet, unexpectedly, controls for age show that the older the patient, the higher their community SES, the less urbanized their home community, and lower the concentration of SMI persons. In addition, the older the patient the greater was the rate of improvement for each of these characteristics of their home community, suggesting that the experience of the seven year period examined is most
likely not generalizable across the life span, and even that over the long run, there are improvements in community circumstances. However, this cannot be concluded definitively since the analyses of the impact of age covered different cohorts of individuals who have lived in varying historical periods.

As extensive as this study is, it nevertheless has a few additional limitations. It necessarily leaves out the experience of all those who have had fewer than two years of hospitalizations and the experience of those who move out of the state. Although it is possible that those who have been minimally hospitalized could experience greater socioeconomic declines than those who have been hospitalized more frequently, the assumption of this study has been that if downward geographic drift exists, it is most likely found among the most disabled who are generally hospitalized the most often. The sample employed in this study does not include those without zipcodes, specifically, the homeless, thus extreme changes in neighborhood SES involving homelessness in poor communities, as a beginning or ending ‘residence,’ will be underestimated.

Another limitation is that the full power of multi-level analytical algorithms could not be utilized in the current modeling. The two levels analyzed here—persons and communities—leave out the episodes level. Rates of change or slopes based on episodes were computed as a preparatory step to multilevel modeling, rather than as an integral part of it. This was done to minimize the intractability of modeling variations in changes in the 1.5 million episodes over the many individuals and communities involved. However, this is not a serious limitation since inferential tests based on the smaller sample sizes of individuals and communities, as was done in this study, make it less rather than more likely to detect significant effects. Even with the exclusion of the episode level, the study has more than sufficient statistical power to test the hypotheses of interest.

Another limitation is that this is a retrospective study that does not allow for experimental controls (e.g., random assignment of patients to diverse communities). Thus, it is entirely possible that unmeasured conditions may account for the effects that have been detected. Finally, it needs to be noted that the database used did not include direct measures for SES on the individual level, but only indirect proxy measures, such as type of insurance (i.e., none vs. some, public vs. private). These
are insufficiently reliable measures to permit examination of individual SES, and thus, the focus of this study has been on community SES, which in prior studies has often proven more salient than the individual indicators of SES (Allardyce & Boydell, 2006).

Perhaps the most important implication of these findings is that the socio-economic disadvantages of those with serious mental illnesses, such as schizophrenia, are not so much secondary complications of biologically-rooted disease processes, but instead, are integral in the early development of such conditions. It is not so much that people with schizophrenia are selectively excluded from favorable communities, but that the disadvantages inherent in low SES communities aggravates schizophrenia as well as the future residential opportunities for people with and without schizophrenia or other mental illnesses. This study shows that although geographic drift is commonly assumed to be a mechanism of social selection, its existence is actually more closely associated with processes of social causation. Unfavorable socioeconomic conditions are causally implicated in both the early stages of schizophrenia, as well as downward geographic drift, and thus, of processes of social disintegration.

Although the details of the dynamic processes in the early course of schizophrenia are yet to be fully elucidated, these findings highlight the importance of interventions on multiple systemic levels. Traditional mental health services, such as psychiatric hospitalization, psychotropic medications, and counseling, need to be carefully linked or integrated with socioeconomic supports, whether these involve supported housing, assisted employment, assisted education, or psychiatric and vocational rehabilitation. Community building, especially in low income areas with high concentrations of SMI persons, needs to supplement competency building efforts targeted to persons in need. Community building needs to happen in locales and programs of maximum need, such as inner city neighborhoods and psychiatric clubhouses, but attention also needs to be paid to community building in institutions such as middle and secondary schools and general hospitals where many persons exhibit the early manifestations of serious mental illnesses.
Acknowledgement: The Office of Academic Affairs, at Salem State University, kindly provided partial financial support for this project.

References


Book Reviews


Over the last couple of decades, scholars have extensively documented the rising levels of wealth and income inequality in the United States. With the economic recession and the Occupy movement, popular accounts of the divide between rich and poor abound. Joining this chorus is Charles Murray’s *Coming Apart*, in which Murray aims to “induce recognition of the ways in which America is coming apart at the seams—not seams of race or ethnicity, but of class” (p. 12). Murray argues that a “new upper class” and a “new lower class” diverge in terms of their behaviors and values, restricting (until his last chapter) his discussion of this cultural divide to Whites. As Claude Fisher and colleagues acknowledged in *Inequality by Design*, which systematically dismantled Murray’s previous book, *The Bell Curve*, Murray’s work is “not easily ignored.” 

Like *The Bell Curve*, *Coming Apart* has garnered much critical commentary. This attention is undeserved, as the content of the book offers little that is new.

Drawing heavily on Brooks’ *Bobos in Paradise*, Part One of the book focuses on the new upper class—those highly educated, mostly liberal, latte- and boutique beer-sipping, NPR-listening, organic food-eating elites who are married, raise their children according to what Hays might call “intensive methods” (Murray fails to acknowledge Hays’ book, *The Cultural Contradictions of Motherhood*, or Lareau’s book, *Unequal Childhoods*, on parenting models and ideologies), work industriously, and are civically-engaged. These elites are disconnected from those in the lower classes—both spatially and culturally—and are ignorant of what current life is like at the bottom, living in “SuperZip” bubbles where their neighbors are similarly hardworking and cognitively gifted. Accordingly, Murray retreads *Bell Curve* territory.

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Part Two centers on the new lower class, after a lesson on America’s “founding virtues” (i.e., marriage, industriousness, honesty, and religiosity). Murray constructs two fictional neighborhoods, upper-class Belmont and lower class Fishtown (based on real neighborhoods near Boston and in Philadelphia respectively) to highlight trends from 1960 to 2010. “Fishtown” families are largely female-headed, and women have children out-of-wedlock to gain status or to establish independent households. The men are not only absent from their children’s lives but idle. Crime is relatively high. Lastly, social capital is low—in large part (as Murray infers based on General Social Survey data and his read of Putnam’s *Bowling Alone*), because families, even “believers,” are less likely to go to church now than in the past.

Part Three explores why Murray thinks this matters. In essence, civic life in disadvantaged areas (but not in wealthy neighborhoods) is dead, the founding virtues are in decline, and people are unhappy. Murray worries that the new upper class has lost its “confidence in the rightness of its own customs and values” and needs to “preach” the virtues to others (p. 289). “Nonjudgmentalism” must end.

As in his other work, Murray’s “data” are often suspect. The 1960 starting point for charting moral decline is never adequately defended. He uses anecdotes or hypothetical scenarios as support, often stating that other data do not exist (collecting his own data never seems to be an option). Moreover, Murray posits causal relationships when only correlations exist throughout the book, and some of the quantitative data employed lack validity. For example, he explains that he was unable to find data on “the state of personal integrity” and so relies on data on bankruptcy and crime as proxies for honesty. This is absurd. Numerous studies on moral behavior exist. Recent work by Piff even demonstrates that the upper class is more prone to unethical conduct. None of this research makes it into the book.

Murray does get many things right. There is a growing divide between the haves and have nots, and America is highly residentially-segregated. Yes, rates of out-of-wedlock births are higher among the lower class, and single mothers have a difficult time raising children without a second income
and a second set of supervising eyes. Yes, poor neighborhoods are often characterized by criminal activity and low levels of collective efficacy. None of this is news.

Murray largely discounts the larger structural changes in the economy as contributing to the fate of the lower class and their retreat from the “founding virtues.” He quickly dismisses macroeconomic forces causing declining real wages for less educated men. Absent are discussions of spatial mismatch, discrimination, and access to a decent education, factors that might constrain even the “cognitively-gifted” in the lower class from ever realizing their potential. Altogether, he chooses to “focus on what happened, not why” (p. 12) and fails to discuss research that unpacks why we see many of these worrisome trends. How can one suggest a solution when one does not understand the causes?

Rebecca Joyce Kissane, Department of Sociology & Anthropology, Lafayette College


The chapters in this volume exhibit a uniformly high quality, and, moreover, span a wide spectrum of human rights, discussed below. In appended materials, the editors helpfully include The Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, and the International Covenant on Civil and Political Rights. There is a consistent emphasis on praxis.

The editors and authors of this volume make and clarify the important link between progressivism and human rights. D. Q. Thomas proposes in the Foreword that the broad perspective of human rights is a framework for an alternative and affirmative brand of progressive American politics; progressives can finally come out of the cold. What then are the challenges that progressives face? A few include the following: (1) transforming our criticality into a positive agenda; (2) recognizing that a limitation of our Bill of Rights is that most articles are cast as negative rights (“Congress shall make no law...”)
rather than as positive rights to employment, food, etc.; and (3) moving boldly out of the margins of American political life into the broad stream.

The chapters span the expanse of human rights, highlighting America's official distance from international human rights. In Section I, Hassmann provides a comparative perspective on human rights in industrialized countries; Abramovitz discusses welfare in the U.S.; Albisa reviews the role of the Supreme Court; and Kaufman contends that local institutions need to play a role in translating international human rights treaties and conventions. In Section II, chapter authors highlight the great and deep significance it would have if the U.S. adopted human rights. That is, human rights are cut of one cloth, whether they be the rights of women (Merry & Shimmin), the rights of children (Todres), or the rights to health care (Zaidi). Authors of chapters in Section III examine the impact of inequalities relating to persons with disabilities (Stein & Lord), indigenous peoples (Berger), mother-headed families (Neubeck), LGBT persons (Mertus), and victims of disasters (Finger & Luft).

What the recession and horrific economic inequalities in the U.S. have brought about—understandably not predicted by the authors—is the Occupy Wall Street movement (OWS), which I contend would have been embraced by the authors of Human Rights in the United States, had the book not already been in publication.

Americans (left-left, left, socialists, anarchists, or center) have failed to recognize international human rights doctrine and law. This is an important point of departure for the editors and authors. While their emphasis is on the importance of grassroots activism and public discourse, I would have liked more discussion of the failure of the United States to ratify international human rights treaties, such as those of the Organization of American States. Progressives have little traction when it comes to defending, say, the right to earn a living, when that right is relegated to Congress, politicians, unions or when that right is trivialized altogether. Likewise, we have little traction about the rights of the people compared with the rights of corporations. The authors seem to recognize the implications of the U.S.'s non-ratification of treaties, but
not those for human rights or corporate personhood rights. For example, corporations that manage apartment complexes can impose outrageous regulations on residents, and towns cannot intervene, for instance requiring that residents must walk directly from their cars or bus stop to their apartments without stopping to talk with other residents. If it is taken for granted by Americans that they only have civil and political rights and that corporations’ rights are on a par with persons’ rights (sometimes trumping them), we have a lot of hard work ahead of us. Using this as a text, I would supplement it with OWS materials (twitter feeds, FaceBook pages, and web pages). I would (and do) give course credit to students who engage the occupiers in a conversation about the relevance of human rights to the Occupy movement. This is entirely consistent with the activist orientation of the editors and authors of this fine book.

Judith Blau, Sociology Department, University of North Carolina & Director, Human Rights Center of Chapel Hill & Carrboro


In the wake of recent national debates about widening disparities in wealth and income in American society, Whither Opportunity: Rising Inequality, Schools and Children’s Life Chances is a particularly timely and poignant publication. In this large edited volume of 25 studies, the authors attempt to disentangle the relationship between growing income inequality in America and its impact upon student achievement, educational attainment and labor market outcomes for children from low and high income families. Collectively, the studies provide a powerful and compelling reminder that disparities in educational achievement and life outcomes between poor and affluent children are not merely related to what happens while they are in school, but are also profoundly affected by what is occurring outside of school in their homes and communities. The authors also point out that, despite numerous policy
initiatives aimed at “closing the gap,” the divide is growing.

This book will be of both practical and methodological interest to scholars with an interest in social stratification, education policy and the sociology of education. The editors have assembled a variety of studies that address issues pertaining to inequality and its impact on student achievement, school performance and child development. Several of the studies also offer policy proposals to offset the effects of poverty on educational attainment and life outcomes.

*Whither Opportunity* is divided into 5 substantive sections: The Developing Child and Adolescent, The Family, Neighborhoods, Labor Markets, and Schools, with each section providing a comprehensive analysis of how inequality operates in relation to that topic. Several of the chapters in the book build upon the argument that academic outcomes are strongly influenced by family income, parent education and home environment. For example, Sean Reardon presents a compelling empirical study showing that the “income achievement gap” is nearly twice as large as the Black-White achievement gap, and that it has been growing despite the stability of the relationship between parents’ and children’s educational achievement. The Family section highlights the persistently strong link between the social location of a child’s family and the limited potential for social mobility in American society, despite increased educational opportunity. The Neighborhoods section is the strongest for highlighting the tensions, debates and conflicting findings within the field, related to the effects of class and neighborhood quality on life chances and academic attainment. The Labor Market section explores the effects of employment opportunities on student outcomes, with several studies building on the vast body of research that has established the strong relationship between the two. Finally, many of the chapters in the Schools section address the ongoing debate over the effects of class on life chances and academic outcomes. Several authors in this section consider how social factors such as race, residential segregation, social networks, and immigrant status influence educational attainment.

The book’s strengths rely upon each chapter’s detailed methodological approach, and with this detail, its ability to provide insights for future research on the relationship
between education and rising social inequality in American society. Several national and local databases were incorporated in a number of the chapters, and some studies rely upon econometric methodology, in line with the policy-oriented direction of the book.

The policy-oriented focus, however, limits the book’s ability to explain the process of schooling as dynamic and multifaceted. Throughout, schools were presented as one dimensional black boxes, where inputs into schools were associated with predictable outputs. With this view, it comes as no surprise, as nearly each study in the edited volume suggests, that poorer students fare worse than richer ones. Although several of the last chapters in the book discuss school reform models that either employ internal behavior changing models such as the “No Excuses” approach of the Harlem Children’s Zone or external comprehensive community-based models, such as the Broader Bolder Approach to educational reform, the analyses still fail to ask how schools and individuals within schools have agency and can interact and react to rising inequality.

In the end, *Whither Opportunity* provides a comprehensive review of inequality’s effects on achievement and education in America. However, when one finishes reading *Whither Opportunity*, a lingering question remains: is describing the mechanisms of unequal opportunity enough? The answer to this question is no, and requires initiation of another discussion that will focus researchers to ask not only what is happening when inequality increases in an age of expanding educational opportunity, but also, how can we ensure that in an age of increasing inequality and increasing educational opportunity, equitable outcomes are achieved?

*Catherine Kramarczuk Voulgarides, Metropolitan Center for Urban Education, New York University*


This latest work by Anita Hill simultaneously contributes to gender studies and the social inequality literature by linking personal stories of homelife and research to the
predatory lending practices associated with the national foreclosure crisis.

As Hill states herself, she "outlines the trajectory from the slave cabin, to segregated housing, to rampant discrimination in mortgage lending practice and now to reverse redlining —targeting women and communities of color for toxic mortgage agreements." Focusing on the combined factors of class, gender, and race, Hill emphasizes the need to understand historic institutional discrimination and its relationship to modern day insidious practices, such as those practices prevalent in the nation's lending institutions. The unique approach of connecting personal stories to institutional practices is a particularly powerful approach. The story of her own family is woven with that of other struggling American families trying to achieve the American dream of home ownership. The quest for equal opportunity has never been a joke to the single women, African Americans, Asian Americans, and Latinos who have experienced losses in the current economy. Hill notes that 65 percent of the wealth among these groups has been lost.

This book includes numerous anecdotal accounts of socio-economic struggles of single or divorced women which, as noted by the author, are interwoven with discussions of culture, law and literature. The reader sees a different Anita Hill, one other than the female attorney who accused Clarence Thomas of sexual harassment in the 1991 Supreme Court confirmation hearings. Hill's stories begin with her own ancestors and family as she describes the story of Mollie Elliot, her maternal great-grandmother who, as a single parent at age seventeen, experienced great difficulties after slavery ended. Hill, influenced by a retired African American school teacher, left her small rural farming community in Lone Tree, Oklahoma to pursue her desire to "earn a living with her mind" at Oklahoma State University. Unlike her ancestors, Hill reaped the benefits of the emphasis on women's rights and racial equality, thus experiencing a more positive path to equality of opportunity.

The concept of finding home is central to Hill's focus on building an inclusive democracy. As African Americans migrated from the rural south to improve their lives, she reminds us that the famous African American accommodationist, Booker T. Washington, urged the black community to gain equality by acquiring homes and becoming model neighbors.
Unfortunately, given the recent housing crisis, low income families were exploited when they acquired homes through predatory lending practices. Hill therefore proposes a "new narrative" which focuses on creating a society where there is a sense of belonging and where everyone can secure the full opportunities available in American society. Hill's emphasis is on an inclusive democracy and her role in helping to bring that about.

Consciousness-raising is an important element of the truly American stories found in this work. In her introduction, Hill points to Lorraine Hansberry's struggle for home ownership which is chronicled somewhat in her well-known play, *A Raisin in the Sun*. However, socially aware readers quickly make the association between Hill's narratives and the struggling African American family portrayed in Hansberry's work. *A Raisin in the Sun* chronicles an African American family's home ownership struggle. Surprisingly, some years back when Hansberry's play was done at a local predominantly white college here in North Carolina, there was a startling misinterpretation of the realities of African American life. Early ads (which were later corrected) listed the play as a comedy. This faux pas alone signals the lack of social awareness and lack of sensitivity to African American life experiences as well as other groups experiencing social inequality. We see this insensitivity as well as we listen to wealthy and out-of-touch potential candidates for the next U.S. Presidency express the desire to eliminate the federal food stamp program in a country where far too many folk suffer from hunger and homelessness.

The narratives in the book make for interesting reading and confirm what social scientists already know about social inequality and the struggle for equal opportunity in America. Discussions of President Barack Obama as representative of what Hill considers "finding home" are of less interest because we have already heard so much of all this because of his prominence. We also recognize the challenges President Obama faces in his struggles as the first African American President.

*Wilma Peebles-Wilkins, Dean Emerita, School of Social Work, Boston University*
There is a long history of violence being perpetrated against individuals because of their race, religion or sexual orientation. In recent decades, laws—often called hate crime or bias crime laws—have been passed to increase the penalty for crimes such as assault and battery if a bias motive can be proved. There is disagreement as to whether these laws are effective and which groups they should cover. The inclusion of gender as a protected category has been particularly controversial. Gendered Hate: Exploring Gender in Hate Crime Law examines issues that arise in the passage and enforcement of bias crime laws that include gender.

The first chapters of the book provide background on the history of bias crime laws and gender bias crime laws, in particular. Next, using empirical research conducted in New Jersey, including legislative histories, media reports and interviews with prosecutors, investigators, politicians and advocacy groups, the book examines some of the complex issues that occur when states seek to address the problem of violence against women through this kind of legislation. New Jersey was chosen as a case study because it was one of the first states to enact a bias crime statute, and it is one of twenty-six states where the statute includes gender as a protected category. The final chapter of the book discusses implications of the study beyond the New Jersey context and offers policy recommendations and suggestions for future research.

A major focus of the book concerns the particularly controversial question of whether gender bias statutes should cover the crimes of rape, sexual assault and domestic violence. Hodge argues that these crimes should be covered, not only because they are committed by men against women, but also because they are often motivated by the desire of the perpetrator to reinforce male supremacy and to intimidate women as a group. However, Hodge’s study finds that many of those with significant involvement in the process of enacting and enforcing gender bias crime laws showed significant resistance to viewing rape, sexual assault and domestic violence as bias crimes. For example, some of the individuals interviewed
considered rape as motivated by a desire for power, control or sexual gratification and saw domestic violence as arising out of problems in an individual relationship. But the crimes were not seen as stemming from hatred of women as a group. Also, some prosecutors interviewed expressed the view that rape, sexual assault and domestic violence could be more easily prosecuted under other criminal statutes without the additional burden of having to prove a gender bias motive.

Hodge contends that because women do not constitute a stigmatized minority group, it can be more difficult for the society to identify gender bias than to identify biases based on race, religion or sexual orientation. As a result, it can be difficult to convince the public, as well as those who make and implement laws, that there is a connection between violence against women and broader issues of gender subordination.

*Gendered Hate* inspires the reader to think deeply about the complexity of distinguishing between a violent crime committed against a woman based on a bias motive and the same crime committed without that motive or with a different one. When should a violent crime committed by a man against a women be deemed a bias crime? It would not ordinarily be considered to be a gender bias crime, for example, if a woman was assaulted by a man in the course of a robbery or if a verbal dispute between a man and a woman resulted in a physical assault. Otherwise, every assault committed by a man on a woman would have to be deemed a gender bias crime. Hodge’s argument is that a gender bias crime occurs when the motive of the perpetrator is to subordinate the victim on the basis of gender and to send a message of intimidation to women as a group. But these kinds of motives may seem difficult to conceptualize and prove whether the crime is rape, domestic violence, a sexual assault or a non-sexual physical assault. Gender bias crime laws are controversial in many states because the lines of demarcation between a crime with a gender-bias motive and a crime without that motive are not easy to define. The book sheds a great deal of light on this very difficult problem, but not surprisingly, it does not completely resolve the issue.

Hodges’s analysis of the nature of gender bias would have been enriched by a deeper exploration of some arguable differences between gender and race, religion or sexual orientation as motivations for bias crimes. This reader was not convinced,
for example, that a physical attack on a woman is analogous to a cross-burning or the painting of a swastika or sends the same message of hostility and exclusion to members of the larger group, as is the case when an individual in one of the other categories is victimized.

In a number of places, the book recounts several highly-publicized mass killings or serial murders of women that have occurred in recent years. While these stories were compelling examples of violence against women, they sometimes seemed to weaken rather than strengthen the argument that gender bias laws are needed because violence against women is an everyday occurrence.

Overall, *Gendered Hate* is a very interesting book. It makes a valuable contribution to the complex and controversial subject of gender bias crime law. The book would be useful to students in courses focusing on gender issues, to scholars doing research on bias crime laws and to anyone interested in gaining a better understanding of the response of the legal system to the problem of violence against women.

Twila L. Perry, Rutgers University School of Law–Newark


Readers of this journal are doubtless familiar with the data that demonstrate growing income and wealth inequality in the United States. They are likely also familiar with the enormous increase in the numbers of Americans—the majority African-American and Latino—who have been incarcerated or placed under legal supervision since the 1980s. Less familiar, perhaps, is the chasm that divides the ways in which the wealthy and politically powerful and the rest of us are treated in the legal system.

Glenn Greenwald, described on the dust jacket as a “former” constitutional and civil rights lawyer, is a regular contributor to *Salon*, where he writes about foreign policy, militarism, and, especially, abuses of power, secrecy, and duplicity on the part
of political elites. These themes are ever-present in *With Liberty and Justice for Some*, a book that can be characterized as a contemporary muckraking tome (though it’s relatively brief at 271 pages) that documents much that has gone awry in our body politic over the last 40 or so years.

Starting from a discussion of first principles as understood by the nation’s founders and enshrined in the Constitution, Greenwald states that “liberty was not only consistent with, but premised on, the inevitability of outcome inequality” in income and power; however, “Law was understood to be the sine qua non ensuring fairness” where inequality would not be accepted (p. 3). This idea is enshrined in the often-stated claim that the United States is a “nation of laws, not of men” (sic.).

Greenwald dates the beginning of the country’s downward plunge to what amounts to lawlessness on the part of political elites to Gerald Ford’s pardon of Richard Nixon, a pardon that he suspects was pre-arranged when Nixon picked Ford to succeed him. He proceeds to remind the reader of a succession of events involving Presidents and their advisors where most of the patently guilty were either pardoned or never properly investigated or charged: the Iran-Contra affair in the Reagan administration, the secret deal-making by George H.W. Bush with Saddam Hussein in the latter’s war on Iran, and the host of illegal activities from the “outing” of Valerie Plame to the politically motivated firing of associate attorneys general by Alberto Gonzales, to the authorization and use of rendition and torture by George Bush and his administration. Greenwald is clearly incensed by the claims of executive immunity made by recent presidents, and he spares no criticism of Barack Obama who, in 2008, ran as a Constitutional lawyer who criticized many of his predecessors’ extra-legal actions, but as President has continued some of them and, in any case, has repeatedly stated that he is not interested in looking back (that is, prosecuting Bush and those in his administration who are likely guilty of war crimes) but rather in “moving forward.” The author cites (p. 48) a revealing study about “moral pliability,” finding that “those in positions of power not only violate rules much more readily [than the powerless] but feel far less contrition about their violations because their power leads to a consuming, blinding sense of entitlement.”
In addition to reviewing the disturbing events related to war and foreign policy, Greenwald investigates the ways in which the telecommunications industry has been manipulated to invade, unlawfully, telephone and internet communications; the roles that lobbying and financial contributions have played in influencing the behavior of members of Congress from both political parties; the passivity—even the collusion—of the press in investigating official wrong-doing; and, more familiarly, the 2008 financial disaster that has harshly affected so many middle and working class families who have lost jobs and homes, but which has barely affected those who were responsible for it.

In a last chapter (5), “American Justice’s Second Tier,” Greenwald details how—in contrast to how the rich and powerful have evaded justice—those at the bottom of our society have been treated increasingly harshly, in many cases imprisoned for long terms for relatively low-level crimes. And he reports that the defense bar is so under-financed and inadequate that the poor are unable to get justice.

*With Liberty and Justice for Some* is, on the one hand, an easy read; that is, its style is journalistic yet filled with details. Its impact is disturbing and, while not at all a sociological text, its information provides a basis for understanding why so many in our society feel alienated from politics and civic engagement more generally.

*Marguerite Rosenthal, Prof. Emerita, School of Social Work, Salem State University*


With increasingly volatile food prices and ever-rising rates of hunger, there is growing international consensus that our food system is in crisis—and that to address the crisis, we must invest in agriculture. The best way forward, however, is subject to intense debate between radically divergent viewpoints. In *Accounting for Hunger: The Right to Food in the Era of Globalisation*, Olivier De Schutter, Caitlin Cordes, and the other contributors take on some of the most contentious issues in
these debates—free trade, biofuels, food aid, and others—from a refreshing, rarely-heard perspective: that of the right to food.

The authors emphasize that if we are serious about ending hunger, we must start from the reality of the hungry. Of the approximately one billion people who are hungry, 50% are smallholder farmers living off two hectares of cropland or less; 20% are landless laborers; 10% are pastoralists, fisherfolk, and forest users, and 20% are the urban poor. That means that roughly 80% of the hungry have livelihoods connected to food production. This paradox is explained by the fact that most are growing crops not for their own consumption but to be sold into markets that are largely outside of their control. They are, therefore, net food purchasers, but without fair prices for their crops or fair wages for their labor, they cannot purchase adequate food. They are not hungry because of a lack of food; they are hungry because they are poor.

Analyzing policies from the realities of this 80%—the world’s most vulnerable food producers who are living in poverty—helps explain why so many measures to end hunger have failed, despite decades of effort. A right-to-food approach, the authors emphasize, looks beyond aggregate measures such as gross domestic product and average annual income to whether current policies are actually benefiting the most vulnerable and food insecure. Increasing the amount of food a country produces, for instance, will not help those who lack purchasing power to buy that food. The authors point out that focusing on supply and demand detracts attention from the power imbalances that actually drive hunger. Efforts to increase yields as a way to boost farmer incomes, for example, distract from the fact that transnational corporations set global prices, while smallholders continue to have little or no power over the market.

The authors also put a right-to-food lens on the issue of trade liberalization, an oft-proposed antidote to the hunger crisis. A landless farmworker or indebted peasant who has already been pushed outside the margins of the economy in his or her own country is not going to benefit from trade barriers being lifted between countries. As the authors explain,

...the expansion of volumes of traded goods is not an answer to hunger if it leads, not to poverty reduction
and decreasing inequalities, but to the further marginalization of those who are not benefiting from trade and may instead be more vulnerable by trade liberalization. (p. 24)

While avoiding ideological discussion of trade liberalization, the authors emphasize that without accompanying national and international policies to support and protect those most vulnerable, trade liberalization is not a solution to hunger.

What is most impressive and instructive about this book is that by employing a right-to-food framework, the authors are able to move critical issues beyond polarizing debates by focusing on the needs of the hungry and asking what can be done to advance their right to food. In addition to trade liberalization, the authors approach agribusiness transnational corporations (TNCs) in such a manner. They highlight ways in which TNCs are undermining the right to food across the food chain, while also citing the tremendous potential for TNCs to shift their practices in ways which could support the right to food, from paying their workers livable wages to supporting the rights of farmers to save seeds.

It should be noted that the book is an edited volume with three chapters by the editors, De Schutter and Cordes, and five by other contributors. Most of the work referenced here is from the chapters written by the editors, by far the strongest in terms of their right-to-food analysis and framing. Some of the other chapters, most notably the chapter on biofuels, cover important subject matter but fail to adequately address the fundamental issue of how the most vulnerable populations are impacted. Also, the chapter on "How to Phase Out Rich Country Agricultural Subsidies without Increasing Hunger in the Developing World" fails to address the fact that small-scale farmers in the U.S. and Europe are facing many of the same challenges as small-scale farmers in the Global South and that subsidies are simply one component of entirely misguided agricultural commodity policies. These weaker sections of the book, however, provide an opportunity for the reader to make use of the right-to-food framework so effectively laid out in other chapters.

Christina Schiavoni, Director, Global Movements Program, WhyHunger
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Articles should be typed in a 12 point font, double-spaced (including the abstract, indented material, footnotes, and references), with one inch margins on all sides. Tables may be submitted single-spaced. Please provide a running head and keywords with manuscript. Include tables and figures in the same document as the narrative. Keep identifying information out of the narrative. Put identifying information in a separate document with full contact information and any acknowledgments. Aim for approximately 18 pages, not counting tables and references. Avoid footnotes and endnotes if possible. Overall style should conform to that found in the Publication Manual of the American Psychological Association, Sixth Edition, 2009.

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Please use gender neutral phrasing. Use plural pronouns and truly generic nouns (“labor force” instead of “manpower”). When dealing with disabilities, avoid making people synonymous with the disability they have (“employees with visual impairments” rather than, “the blind”). Don’t magnify the disabling condition (“wheelchair user” rather than “confined to a wheelchair”). For further suggestions see the Publication Manual of the American Psychological Association or Guide to Non-Sexist Language and Visuals, University of Wisconsin-Extension.

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