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9TH EDITION

AN INTRODUCTION TO HUMAN SERVICES

Policy and Practice

BETTY REID MANDELL | BARBARA SCHRAM

Ninth Edition

An Introduction to Human Services

Policy and Practice

Barbara Schram
Northeastern University, Emerita

Betty Reid Mandell
Late of Bridgewater State College

Paul L. Dann, Ph.D.
New England College

Lynn Peterson

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INTRODUCTION

In the previous eight editions of this text, we have used the analogy in our preface of taking a ride on a seesaw to describe how we learn and teach about the human service field. When we sit on the end of the seesaw closer to the ground, we can observe in vivid detail a troubled individual struggling with his or her particular life circumstances. Based on this observation, we can describe the direct services and systems-change interventions that might be available to that individual in the local network of human service programs. Then we can map out the steps that need to be taken to provide that individual with the most appropriate social services and emotional support.

But as we soar high above the ground on our seesaw, we see that lone individual in less detail. Now we can see how that single life situation complements or conflicts with others in the community. From this vantage point, we can also learn about the world events and cultural or sociopolitical forces that might influence that individual's fate. At this height, we focus less on one person's struggle and think instead about the ways in which a community or a whole society can tackle the vexing problems of violence, abuse, poverty, physical or mental handicaps, and lack of opportunity. Looking at individuals in the context of society also helps us sort out, among many conflicting schools of thought, how their problems came about and how their problems might be prevented or solved. As human service providers, we are always looking at both the intimate portrait and the big picture. The direct services and the indirect services we provide can help alleviate suffering. Both are equally important. In this text, we place more emphasis on social systems than on individual psychology because we believe it is important for beginning students to understand the context of the field before they take specialized courses in counseling, psychology, and human development.

Our understanding of social problems and the social services they require is made far richer but much more ambiguous by this dual set of perspectives. Most importantly, this prevents us from accepting simplistic, one-size-fits-all solutions to complex human problems.

The seesaw analogy also expresses our feelings about the vast changes we (both clients and providers) have experienced since the first edition of our book. As we look back, we realize with surprise that in our first edition, the term *AIDS* (Acquired Immune Deficiency Syndrome) did not appear anywhere in the text. It is hard to believe that a disease that had spread so quickly and taken such a high death toll was barely recognized as a major social problem when our book first went to the printer in 1983. After many years during which AIDS was a virtual death sentence, things are finally improving, at least in developed countries. Many people with AIDS are now living several years beyond the one to two years that used to be their predicted life expectancy. New medications, public education, a societal increase in condom use, and perhaps the postponing of early sexual activity appear to be helping to contain this devastating medical and social problem.

In an earlier edition, we noted with regret that the problems of lack of affordable housing, mortgage foreclosures, and the increasing homelessness that has resulted from these situations have risen to alarming proportions. Temporary shelters have become permanent institutions, and most of us have become used to seeing people sleeping on the streets. Previous solutions to the housing crises, such as subsidized public housing, have virtually been abandoned, but neither new ideas nor the will to implement them has surfaced. We worried that the entitlements and social services designed to help people through hard times seemed to be diminishing as the cries for tax relief were becoming louder and more insistent. Now it is clear that the restructuring of welfare in the United States has done very little to solve this thorny problem.

Since our first edition, some awesome positive changes have occurred in the rest of the world. The tearing down of the Berlin Wall and the breaking up of the Soviet empire have diminished the ominous threat of nuclear destruction. We have noted with pleasure the dismantling of the racial-segregation system in South Africa and the rising emphasis in many quarters on the positive rewards of diversity in our own country. Lately, though, we have noted with alarm a growing wave of anti-immigrant and anti–minority group sentiment among large portions of our population.

In this country we have applauded the increased spirit of volunteerism that has been spreading across the land and the continued healthy growth of the self-help movement. We also have been pleased to see an increase in programs that provide a multitude of services to people who daily struggle with physical, emotional, or educational handicaps. We are also pleased that the discrimination around, and the stigma attached to, issues of gender identity and the redefinition of legal partnerships have shifted in a positive direction.

In the introduction to our last edition, we predicted that there would soon be a congressional solution to the vexing problems of delivering adequate physical and mental health care for all our citizens. We anticipated then that we would soon be writing about some new form of universal national health insurance. But we proved to be poor prophets. During the last several years, universal health care proposals had been completely wiped off Congress's agenda. Private, managed health care schemes, most of them sponsored by for-profit companies, proliferated, leaving many citizens uncovered. Finally, in 2010, after countless revisions and compromises as well as unprecedented partisan political discord, The Affordable Care Act (ACA) was passed by both houses of Congress. But, as we go to press, there are many legal and legislative efforts pending that seek to repeal or greatly weaken the health care bill. Students of human services need to closely follow the news about the current and evolving status of health care coverage, since the provisions for mental and physical care are likely to impact all of the people we serve (as well as ourselves and our families).

As we write this preface to our latest edition, we cannot help but note the alarming rise in violence in the world and in our society. Although crime statistics in many of our cities have shown a remarkable decrease, school and workplace shootings, explosions, and similar violent acts have shattered many lives and occupied the worried attention of pundits and citizens. The secure worlds of the middle class schoolyard and workplace have been irretrievably altered. Along with the loss of life has gone a substantial amount of our sense of security and comfort.

Many of the gains that have been made in civil liberties, in communication technology, and in the embrace of a multicultural society may be whittled back as our government attempts to stop further terrorist acts. We cannot even begin to estimate what losses this will bring to our clients.

Perhaps the most important message of this text in all its editions is that our work is always intimately connected with the history, current events, and future of society. Every shift in the social fabric has huge impact on the daily lives of the people you are learning to help. In our many years in the field, there has never been another time when knowledgeable, skillful human service workers have been so needed. To act with and on behalf of clients and communities, students need to understand the root causes that underpin social service interventions and social policy. As new workers enter this field, they will be called on to be generalists, to be able, for example, to counsel elderly citizens so that they can obtain the services that will sustain them in their homes. Later on, human service workers might need to advocate for them when a faceless bureaucrat decides the services are no longer needed. When day care facilities or job-training programs for teen parents lose their funding, we need to know how to create coalitions with other groups to go to the courts and legislative chambers. We need to know how to design new programs or protect

existing ones. But you will also have to learn how to present your arguments in a professional way, marshaling accurate evidence of need, proposing creative strategies, and documenting the potential for success of your programs.

NEW TO THIS EDITION

- A new Chapter 6, Social Welfare Programs and Policies, combines the information from the previous edition's Chapters 6 and 7 for a more concise presentation about how social welfare programs and poverty interrelate.
- An expanded chapter on working with diversity (Chapter 7), with updated discussions of immigration and working with LGBTQ clients.
- Additional and updated interviews in Chapter 2.
- Numerous updates to reflect the current state of the field of human services.
- An increased focus on practical application.
- Updated references throughout.
- Many new photos and graphics to help illustrate chapter content and to make the chapters engaging. In addition, a new streamlined design makes the text easier to read.
- The addition of Learning Outcomes at the beginnings of chapters to let students know what they will learn by reading the chapter.

ORGANIZATION OF THE TEXT

To make this book more accessible to the beginning student, we have organized the chapters into three sections. In the first, we present the context of human service work, answering the major questions students are probably asking: "What is a human service agency, what do human service workers do, and what are the barriers that keep people from using human services?" Then we describe how human service work has changed through the years, discuss different strategies, and explore the attitudes, values, skills, and knowledge that bind together all workers, regardless of their problem area or credentials. After that, we discuss the conflicts and dilemmas that are likely to occur as we try to incorporate the values of our field into our daily practice. Finally, we pose and then try to answer questions about the social welfare system. We discuss the major social welfare programs and how we can keep ourselves up to date so we can guide our clients through the ever-changing maze of rules and regulations.

In the second section, we examine in detail the ways in which human service workers implement each of the direct and indirect program strategies. This section begins with a chapter on working with diversity. Subsequent chapters describe the skills involved in interviewing, working on individual cases, working with groups, planning programs, and organizing to change or improve programs.

In the third and shortest section, we present information that human service workers need to know about the legal issues that are likely to be involved in our work. Fittingly, the final chapter offers words of wisdom about keeping your spark alive and avoiding human service worker burnout. This is an especially important chapter because in the next several years all of us will be challenged to work harder and more creatively until the current wave of slash-and-burn budget cutting has abated, if it ever does.

FEATURES OF THE TEXT

Each chapter ends with a summary, so you can review the information that has been presented. These summaries can also be read before beginning the chapter, which can be helpful to the student who likes to study a road map in advance of a journey. Questions for discussion and resources for further information on the topics just discussed are also included at the end of each chapter.

Interviews with human service workers and quotes from case records throughout the text keep it lively and help readers feel greater empathy for problems that might be distant from their own life experiences. The interviews of human service workers that are included in each of the chapters are primarily composites that include the work of several people who have held similar positions in human service agencies. The many political cartoons and photos are intended to add depth to the narrative, stimulate thinking, and raise questions for discussion.

We hope that the charts, checklists, and samples of interventions will continue to be useful as you venture out to an internship or job. All the examples have been drawn from the authors' many years of work in social service agencies. Among them, we have had experience in a family service agency, a neighborhood poverty program, a shelter for youth at risk, a large recreation center, and a research bureau. The authors have taught for many years in college human service programs. On campus and in community agencies, they have led training groups and done research on adoption, children and adults with special needs, mental health, and the social welfare system. Additionally, they have raised their own children and have struggled through the many crises and developmental milestones that families confront. They have struggled to provide support to their families and have turned to other human service workers when they needed more guidance.

This field of human services is filled with many "alphabet agencies" and jargon, so when new terms are introduced, they are highlighted and their definitions are provided in a Glossary at the end of the text.

ACKNOWLEDGMENTS

We thank the following reviewers for their input on revising this edition: Natalie Cooper, Kentucky Community and Technical College; Susan Holbrook, Southwestern Illinois College; Heather Jones, Luzerne County Community College; and Tim Lindsey, Bethel College, Mckenzie.

A NOTE ABOUT THE AUTHORS OF THIS EDITION

It needs to be noted that Betty Reid Mandell, who co-authored the first eight editions of this text with me, has recently died. For this ninth edition, Paul Dann and Lynn Peterson have worked on revising the chapters for which Betty Mandell had taken primary responsibility. As current practitioners in the field of human services, they bring updated perspectives to those chapters. Also, I had the privilege of getting to know and respect them when they were Human Service majors at Northeastern University and students in the Human Service classes that I taught. I have enormous appreciation for their efforts to keep this text current and to continue our past efforts to make it highly readable and user-friendly. We all welcome each of our readers to the seesaw!

Barbara Schram, 2019
Emeritus Professor,
Northeastern University

To our clients, our students, our colleagues, and our families,
with thanks for all they have taught us.

ABOUT THE AUTHORS

Barbara Schram graduated from Antioch College, and received master's degrees in both sociology and social work from Columbia University and a doctorate from Harvard University with a specialization in education and social policy. She worked as the program direction of a large recreational and cultural organization, planning programs for children and young adults and supervising staff who delivered these services.

Barbara spent several years as the director of a community agency in a low-income urban area, helping parents become involved in their children's education and effect changes in the schools that better reflected their cultural background and values. She spent 26 years at Northeastern University, where she originated and then taught in the Human Services program. She designed appropriate courses and supervised student internships.

Barbara has done extensive volunteer work with citizen groups involved in interracial and special needs adoptions, improving services for persons with learning disabilities, and improving prison education programs.

In addition to this text she has written more than 20 articles and a book entitled *Creating the Small-Scale Social Program: From Idea to Implementation to Evaluation.*

Betty Reid Mandell was Professor Emerita at Bridgewater State College in Massachusetts. She was the editor of *The Crisis of Caregiving: Social Welfare Policy in the United States,* Palgrave/Macmillan, 2010, as well as the co-editor of *New Politics*.

Paul L. Dann, Ph.D., is the Director of the MS in Clinical Mental Health Counseling and the MS in Human Services at New England College, and has taught at the College since 1997. He teaches Cultural Foundations, Graduate Capstone, and Research Methods. Paul has his MA and Ph.D. in Human and Organizational Systems and also serves as the Executive Director of NFI North, a non-profit multi-service mental health and human services agency providing care to children, youth, families, and adults throughout New Hampshire and Maine.

Paul is and has served as a Board member of multiple non-profit and behavioral health organizations. He is a former Research Fellow at the Institute for Social Innovation and trains nationally on effective leadership development, resiliency, and culture. Paul is a dynamic public speaker, and in his free time, he's the front man for a regionally recognized blues band.

Lynn Peterson was a student of Barbara Schram's at Northeastern University, where she earned her Bachelor's degree in Human Services. The practical, hands-on approach of *The Introduction to Human Services* and *Creating the Small-Scale Social Programs* books provided her with essential skills to working in the field of human services. In her "Strategies of Intervention" class with Dr. Schram, Ms. Peterson's team planned and executed a successful human service professionals' retreat on Thompson Island. Following work as a congregate housing coordinator for Elder Services of the Merrimack Valley, Ms. Peterson earned a Master's degree in Urban and Environmental Policy and Planning at Tufts University, with a focus on affordable housing. She has worked in the affordable housing field as a planner, developer, and funder. While working at the Women's Institute for Housing and Economic Development, she developed supportive housing and education programs for low-income women. She was a contributing author to *Shut Out: Low Income Mothers and Higher Education in Post-Welfare America.*

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What Are Human Services? What Do Human Service Workers Do?

1

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Learning Outcomes

- Students will be able to frame an overall statement of what human service workers do.
- By reading the three accounts of one student's struggles with her parent's alcohol use disorder, readers will be able to identify 25 different human service roles that she encountered.
- Through learning about the daily work of a person who oversees a substance use disorder program, students will be able to identify the various human service roles she fills.
- Students will be able to describe both the internal and external barriers that keep people who have problems from finding the help they need.

How do we explain what human service workers do? That is a logical question for a beginning student to ask and for an introductory text to answer. But the answers are not as straightforward as you might expect. A professor of human services described the challenge of answering this seemingly obvious question.

> While I was in college, my friends and family kept asking me, in a challenging way, "Exactly what is a human services major?" They wondered what a big guy like me was doing studying for that kind of a field. I'd try to give them a short, clear answer. They never seemed completely satisfied.
>
> That was irritating enough when I was in college, but even after I graduated with a bachelor's degree in human services, my friends and relatives kept right on asking me what I was really going to do to earn my living. If I fell back on my stock answer, about how I was in the business of helping people to help themselves, I always sounded hopelessly muddled.

How do you explain all the things you are *really* doing when it looks as if you are just "hanging out" on a street corner with a group of teenagers? As a young **outreach worker** hired by my town, "hanging out" was a large part of my job description. Sometimes I'd be playing pool or shooting baskets with the kids in the local recreation center. Later on in the day, I might spend a few hours drinking coffee with a family around their kitchen table. I took kids on camping trips. I held their hands when they ended up in the hospital with an overdose of drugs or a broken leg from a gang fight or football game. I'd chew the fat with the clerks at juvenile court and visit with my kids going in or coming out of the courtroom.

I was a sounding board for the parents, the kids, the local merchants, and the police. Of course, I can't point to an adult and say it's because of my work that he made it up and out of trouble. But I think that what I did made a difference in some of the kids' futures.

Twenty years later, one of my students complained to me that she had the same problem. How could she justify the usefulness of spending three hours sitting in front of a television set with five adults who have developmental disabilities? How could she explain what she was doing when she was eating a hamburger in a fast food restaurant or throwing a Frisbee around the park with her clients? She'd get frustrated when one of her friends would say, "You get paid for doing that? You have to go to college to learn how to do that? Now, my major"—engineering, business, computers, etc.—"that's real work!"

Helping is such a natural part of our everyday lives that it is hard to think of it as a specialized activity for which people must be trained. Think back over the past few weeks. Chances are that someone—a coworker, friend, or relative—has asked you for help. Perhaps a friend was having trouble with a love relationship and needed to talk about it. If you listened with empathy and tried to understand her view of the problem, you were giving a human service.

An attentive listener and a strong shoulder to cry on might have been all that your friend needed. However, if the same type of problem continued to occur, she might need more than a warm, accepting friend. She might need to talk with an experienced counselor who has helped other young adults juggle the conflicting needs of intimacy and independence.

PERSONAL PROBLEMS ARE A PART OF ALL OF OUR LIVES

All of us, at different times in our lives, will be on both sides of the helping process, giving support or asking for support. Problems are part of living, and no one—regardless of education, income, or profession—is immune. When the economy dips or a hurricane hits the coast, thousands of people from all walks of life lose their jobs, their homes, and their sense of security. If we live long enough, we will have to cope with the death and illness of many people we care about. And throughout the lifespan, we will face our own critical junctures, transitions, and changing capacities.

People can follow many different routes to find help. The route they choose is likely to be influenced by:

- The nature of the problem
- Someone's hunch about the causes of the problem
- The resources available in the local community
- The cost and the person's ability to pay
- The climate of the times that creates fads about "the right thing to do when you have problem X, Y, or Z"
- The history of the circumstances that person is confronting
- Luck or chance.

HUMAN SERVICE NETWORKS OR DELIVERY SYSTEMS

Referrals are sometimes made by word of mouth. When people are in pain, they often ask the advice of someone they trust. A member of the clergy, a doctor, or even a hairstylist can often inspire the courage to walk into a social service agency. Many now **Google search** the web for information about their problems and for suggestions of places to go for help. The opinions of people who have used different services are, of course, very varied. A potential client must sort through a maze of conflicting thoughts and feelings. Too much information can be just as debilitating as too little, but that is a common problem of our cyber culture. Human service workers spend a great amount of time, energy, and creativity getting accurate messages out to the public. Throughout the pages of this text and in your own work in the field, you will quickly discover that there is no simple path to finding help. Because people are complex, human service problems are multifaceted. So we have had to create a variety of social services. Programs that cluster around one particular problem area are called **human service networks** or **delivery systems**.

A paper written by Kathy Holbrook, a first-year student at Westwood Community College, paints a vivid picture of the variety and complexity of one of these networks. The assignment was called "The Helpee Paper." Kathy's instructor asked the students to think back to a time in their lives when they faced a painful personal crisis. They were asked to describe that situation and then evaluate the help they received from professionals, volunteers, family, or friends.

In the many years the instructor has assigned this paper, there has never been a student who was unable to remember a painful episode. Students have written about homesickness at camp; the death of a pet; problems with drugs, alcohol, and eating disorders; the divorce of parents; and conflicts around the choice of a college or career. Because the students select their topics, they decide how much personal information they want to reveal.

Some students choose to share their papers with the class. While listening to these stories, class members feel the intensity of the emotions that conflict engenders. They also learn about the complex barriers that surround the acts of asking for and receiving help. In addition, the students receive a true-to-life picture of the patchwork quilt of agencies and worker roles that make up each of the human service networks.

After reading about Kathy's attempts to tread her way through the human service network of alcohol use disorders, you will read about two other paths Kathy might have followed if her problems had developed differently. As you read these three accounts, try to identify all the human service agencies and workers Kathy encountered.

My Experience Receiving Help

by Kathy Holbrook

When I read the assignment for this paper, I had mixed feelings. On the one hand, it opens up a lot of wounds. On the other hand, I know that if I want to be a human service worker, I have to learn from my own experiences. And every time I talk about the problems my family had with my dad's alcoholism, it can help someone else. That's the main lesson I learned from the Alcoholics Anonymous (AA) meetings I've attended. Well, I guess I've started this paper already.

(*continued*)

I can't pinpoint when the problem began. As I look back, I realize the problem was always with us, but I didn't have a name for it. I thought the way we lived was just the way things were in everyone's family. We had a big house in Westwood. My father worked for years for the same stock brokerage firm. He could make or lose thousands of dollars a day of other people's money. It was high pressure all the time.

When I was little, we didn't see much of Dad. He had to work very hard to keep up with the rest of the community. People where we live keep moving: a bigger house, a pool, a summer place on the lake, a boat, Ivy League colleges for their kids. Mom was the "typical" housewife. She did all the chauffeuring to Scouts and swim team, and came to all our plays alone when Dad was in the city. The first ten years, it seemed like we were mostly like everyone else. I knew Mom and Dad always kept liquor around, because they did a lot of entertaining.

But in my first year of high school, everything got worse. Sometimes I'd get up in the morning and Dad would be asleep on the sofa with his clothes on. Sometimes he wouldn't get up for breakfast. I'd hear Mom phoning his boss, saying he was sick or that he couldn't get the car started. I began to notice that she often didn't tell the truth about Dad.

Then he started coming home during the day. He'd drink until he'd pass out, sometimes right in the living room. I'd ask Mom if I could have friends over, and she'd say I couldn't. After a while, no one was invited to our house for dinner parties anymore. I felt as if we were living in a cave with a locked door across it. Mom even kept the window blinds down in the afternoon. I think she didn't want the neighbors to see Dad at home, especially when he hadn't shaved or changed his clothes.

I tried to talk to my brothers about it, but they would blow me off. My brother Dennis and Dad got into such a bad fight that Dennis moved into his girlfriend's room at college. Chuck, my oldest brother, has always been a bookworm. He'd just crawl into his room and read or listen to music all the time. Even at dinner, we were never together anymore. If we were all there, Mom was nervous or Dad would get up and leave in the middle. She'd cook a big meal and he wouldn't come home or he'd say the food was no good and he'd yell. He never hit her, but he would slam his glass down so it would break or knock over his chair when he left the table.

My mom started to go to church a lot. The priest came to our house to talk to my dad. Finally, I came home from school one day and Mom said we were leaving. We would stay at my aunt's house until Dad packed his things and left. Then we could come back. That's when she told me that he was an alcoholic. He was sick and it wasn't his fault, but he had to make himself well if we were going to be a family again.

We stayed at my aunt's house for two weeks. Mom finally went to court and got a restraining order. The marshal made Dad leave the house, and he wasn't even supposed to visit us. The only time we got together was at the meetings with our psychologist, Dr. Hightower. I hated those sessions. My brother Dennis would shout insults, and Dad looked like he was going to cry. Chuck wouldn't say anything.

Mom and I started going to Al-Anon meetings together. That's a support group like AA, but it's for the families and friends of people who drink too much. I had one teacher at school whom I really liked, so one day I broke down and told her about Dad. She took me by the hand to see the school counselor. He was the one who got me to go to my first Alateen group. We all had problems with family members who are struggling with a substance use disorder. I went to see the counselor a few times during activities block. I liked talking to him alone in his office, but I wasn't comfortable in the group. There were kids in it I didn't trust. I was sure they would spread it around about my family being such a mess.

Dad went to an inpatient recovery center. His company wanted him back so badly that they sent someone to our home from the personnel department to convince him to go into a program. They were willing to pay for his treatment through his health insurance. We

had family meetings with him at the hospital. My mom would see the same social worker because she was pretty depressed by now. I think she took medication for her nerves. He stayed there for three months. Then he went to the state rehabilitation office and got vocational counseling because he knew he couldn't go back to the tension of wheeling and dealing in the stock market. It was too stressful a place for him, and he thought that most of the people in his company drank too much at business lunches and dinners.

Last January, the whole family celebrated the seventh anniversary of Dad's sobriety. We went to his AA group. It was a terrific family reunion. Father Brian was there, too, because he had so much to do with helping my family get straightened out. The only dark spot is Dennis. He came to the party, but he is still very angry. He holds Dad responsible for all the bad times. Actually, I think Dennis is drinking now, too. He is very bitter.

I'm not glad that I had to go through this mess, but some good things came out of it. Dad is a really laid-back guy now. He sort of takes things as they come. He and Mom are closer than ever.

Through this, I got interested in the field of alcohol addiction counseling. I have paid my dues. I'd like to work in schools teaching kids about alcohol and drug abuse. I've been a member of Students Against Drunk Driving (SADD) and have become very self-confident. I can speak before groups now, and I don't feel like I have to please everyone anymore. I speak my mind.

Alternative Scenario 1: What Might Have Happened to Kathy

I came home from school one day, and Mom said we were leaving. We would stay at my aunt's house until Dad packed his things and left. Then we could come back. That's when she told me that he was addicted to alcohol. He was sick and it wasn't his fault, but he had to make himself well if we were going to be a family again.

Until then, Dad had never lifted a hand to anyone in the family, but now he was so angry with Mom, he tried to strangle her. Finally, Mom phoned a shelter for survivors of domestic violence called Renewal House. They sent a van to pick us up. Would you believe we heard about it from my aunt's cleaning woman? She had a sister who was a survivor of intimate partner violence and she lived there for a couple of months. They won't give out their address over the phone in case there is someone looking for you who might hunt you down and hurt you. They have to be secretive.

The whole thing was really humiliating and scary. But the center director was our lifeline. She told Mom about everything she needed to do. Mom started getting very short-tempered. I couldn't blame her, but it was awful for me. I didn't like living there and not being able to go to my friends' houses or to after-school clubs. All I did was go to school and come home. I went to a social worker at the Westwood Mental Health Clinic, but I didn't like him.

After two years, my folks got divorced. I have seen very little of my father, and it hurts that he doesn't call. He is remarried. Mom went back to school, so she was never around, and I hated where we lived. Dennis and Chuck have just gone their own ways.

By the time I began my sophomore year, the entire situation really got to me and I started to have thoughts of wanting to hurt myself. I called the Samaritans, a hotline for people who are thinking about suicide. The woman on the phone talked to me for a few nights and then suggested I go to Alateen at the Mt. Auburn Hospital. I stuck with that group and made a lot of friends there.

Now I am a member of ACOA, Adult Children of Alcoholics. Groups have been really important for me. There are other people out there like me, and we are tough survivors.

(*continued*)

I'm also active in SADD, Students Against Drunk Driving. I think when I finish my degree, I'd like to become an organizer. The women from MADD, Mothers Against Drunk Driving, are really dynamite people. I'd like to try to change the laws that make alcohol so available.

Alternative Scenario 2: What Might Have Happened to Kathy

Finally, I came home from school one day and Mom said we were leaving. We would stay at my aunt's house until Dad packed his things and left. That's when she told me that he was addicted to alcohol. He was sick and it wasn't his fault, but he had to make himself well if we were going to be a family again.

We stayed with my aunt and uncle for four or five months. I began to notice that Mom was changing. She had always had one or two drinks to keep my Dad company, but I never saw her as a drinker. She started not getting up to give me and Chuck breakfast. Some days, she didn't even get dressed.

I started not coming home so as to avoid the whole scene. I did a lot of stealing things from local stores. I always had a pocket full of change. I even tried drinking beer with the high school kids, but luckily it just made me fall asleep. I know that with both my parents being addicted to alcohol. I could easily become addicted also. I won't even take a social drink now.

The youth patrol officer would pick me up, give me a lecture, and send me home. The only things that still mattered to me were Scouts and my brothers. My Scout leader was more like a mother than Mom was. She took me to a child-guidance clinic and the worker there tried to get my Mom to come in and talk. When she wouldn't do it, they filed a complaint with the Department of Social Services. They accused her of neglecting me and took me out of my aunt's house. I was very angry, but the worker found me a foster home. I didn't have a choice, so I went. Ms. Braun is an older, single lady whose kids have grown up. She was what I needed, strict but very loving.

Ms. Braun got a lawyer from legal services, and she fought to adopt me. She doesn't always understand about this generation. At times, I resent her. I was in a group for teenagers who have been adopted. It was good to talk it over with the leader and the other kids. I found out I had it really good. The leader signed me up to get a "big sister" from Catholic Charities. I could really talk to her. She was attending Westwood Community College. Dolores is the one who convinced me I could go to college and maybe study for the same degree.

For a while, I saw a psychiatrist, and I was on antidepressant medication. I don't feel I need to use it now that I am getting on with my life.

I sometimes think about what would have happened to me if I hadn't had Dolores, my Scout leader, and my foster mother. They were able to see that even when I was acting up, I really did not want to be in trouble. Even the youth patrol officer gave me positive support. He had the right combination of toughness and caring.

Though I'm in human services now, I want a job in a business firm. I want to dress up, buy a decent car, and get away from all of these problems.

The Helpers That Kathy Encountered in the Three Versions of Her Story

In the three scenarios described in the previous section, Kathy, a young woman who could have been sitting next to you in a college class, encountered 25 different helpers. Although each had a different title and performed somewhat different tasks, they all offered human services. How many of these did you identify?

1. Priest
2. Psychologist
3. Family therapist

4. High school counselor
5. Teacher
6. Vocational counselor
7. Self-help group leaders (AA, Al-Anon, Alateen, ACOA)
8. Personnel department counselor
9. Rehabilitation specialist
10. Addiction counselor
11. Social worker (at drug clinic)
12. Shelter director
13. Shelter volunteers
14. Hotline worker
15. Organizer for a social action group (e.g., SADD, MADD)
16. Transitional assistance counselor
17. Therapist (in college counseling center)
18. Scout leader
19. Youth patrol officer
20. Child protective services worker
21. Foster parent
22. Adoption caseworker
23. Lawyer (at public legal services)
24. Psychiatrist
25. Volunteer Big Sister

All of these 25 people brought to their work a different mixture of education, training, and life experience. In Kathy's high school, there might have been a school counselor, school social worker, or school psychologist. Any one of them might have started Kathy on the path to finding services. All of them have been certified by their school boards and have advanced degrees.

The family therapist, the counselors, the rehabilitation and vocational workers, and the shelter staff director are likely to have graduated from college with two- or four-year degrees. Some might have studied beyond college, earning specialized degrees in clinical psychology, counseling, social work, rehabilitation, health education, or perhaps one of the newer fields, such as family systems therapy, addictions counseling, or human sexuality.

Several of the workers Kathy encountered had little or no formal education in the helping professions. Hotline workers, mutual aid leaders, and foster parents often have education and training totally unrelated to the helping professions. For some of these individuals, providing human services is their central career, but for most of them, it is something they do on a part-time, interim, or volunteer basis.

In the past, these part-time or volunteer workers were not always viewed as an important part of the human service network. In recent years, however, that attitude has begun to change. Now these workers are being offered on-the-job training through workshops and seminars. Often they can earn academic credits that enable them to obtain college degrees and grow in knowledge, self-confidence, and public respect.

Helpers Have Many Different Agency Affiliations, Backgrounds, and Orientations

Human service workers are found in a wide variety of settings, ranging from a storefront center to the carpeted offices of the personnel department in a high-tech firm. Some human services, especially for the middle and upper classes, are provided in the homes or offices of private

practitioners. But the majority of professional human service workers are financed by the public and are found in social service departments, community mental health centers, hospitals and health clinics, college counseling centers, and ministers' or rabbis' offices. Many private nonprofit groups, such as the Family Service Association, the Jewish Family Service, Catholic Charities, the Protestant Federation, and the Salvation Army, conduct large numbers of direct-care and social change programs. Although most human services are provided on an outpatient basis, some are given in **residential treatment centers** or **community residences**.

Many valuable social services are offered by citizen groups, which conduct programs that advocate for the rights of tenants, immigrants, veterans, homeless families, or some other special population. Citizen groups often hire human service workers to educate and mobilize the public. They work toward changing behaviors such as substance use, violence, or destruction of the environment. Often they lobby public officials or the courts to change the way social programs are funded and laws are enforced.

Although there is no way to collect accurate statistics on the number of people in this country who conduct or attend mutual aid groups, it is possible that these groups are now the single largest source of human services. These groups, usually patterned on the model developed by **Alcoholics Anonymous (AA)**, tackle every conceivable emotional, social, and physical problem that affects some subgroup in the community.

Most human service agencies are entirely or partially funded through grants from the local, state, or federal government. Many others are private nonprofit groups, often sponsored by religious denominations that raise money from fees, public appeals, and philanthropic foundations.

A smaller but fast-growing type of agency is the private, profit-making one. Some of these operate on the model pioneered by the fast-food restaurant chains. Entrepreneurs develop a model for a preschool child care center or to serve people with head injuries, for example. These agencies make their profit entirely from the fees paid by consumers and insurance companies or in performing under a contract with a public agency. Opinions are many and mixed about the emergence of for-profit social services. This is a controversial topic that you will likely debate in your classes and internships. This movement is often called the "privatization of social services."

Most staff members earn a salary, but agency volunteers work just for the gratification they receive. And there are differences in the hours that workers are on duty. A family worker in a day care center has to work evening hours to telephone or meet with working parents; a counselor for a group of adults with disabilities might live in a community residence, working a few days a week around the clock.

Some agencies expect their workers, volunteer or paid, to operate within a particular treatment model or theoretical orientation. Their approach to the clients may be built on the theories of Sigmund Freud, Erik Erikson, or B. F. Skinner. You will read the work of these pioneer scholars in introductory psychology or human development classes. Other theories, such as those of Carl Rogers, Jean Baker Miller, or William Glasser, you are likely to read about in counseling courses or hear spoken of in your fieldwork (Hackney & Cormier, 2013; Okun & Kantrowitz, 2015). The **12-step** and **co-dependency** models, on which many addiction support groups are based, are currently much in vogue.

In addition, some agencies adhere to a specific set of religious or ethical principles. A staff member in a social service department of a Catholic hospital, for example, would be expected to suggest to clients only those options that are acceptable to the overarching principles of that religion. These agencies are currently referred to as "faith-based social services."

There is no overall approach that everyone in the human service field agrees is the most effective. Variations among counselors' styles make it difficult to compare their methods and outcomes. With no clear evidence that one theorist has found the best method for creating mental

health or social change, most counselors evolve a method created out of bits and pieces of many theories. This eclectic approach is further refined through years of experience. Finally, styles are filtered through the individual personalities of workers and the demands of the population they work with. With the widespread movement to **managed health care** programs, for example, much of a counselor's action plan is dictated by how long the client's health care provider will pay for mental health services.

Differences in social welfare laws from state to state add more diversity to the field. As you read about the history of social welfare in the United States, you will learn about the tug of war that has been going on between the federal government and the states in responding to social needs. Diversity and uniformity of social programs exist side by side. On the one hand, you could travel from California to Maine and find reasonably similar **Head Start** preschool programs in each state. On the other hand, if you visited foster care agencies in each state as you went from west to east, you would find 50 different sets of rules and regulations. Head Start is a federal program, so the rules that govern it are made in Washington, D.C., and disseminated to each state. But foster care and adoption laws are made on the state level, so we find wide variations in these programs. These discrepancies underscore our assertion that human service workers cannot assume that they know what social services exist, even in their hometown. In order to practice their profession, they must know how to construct a current, accurate profile of the services available in each community.

Source: Marcel Mooij/Shutterstock

Many workers try to help people with disabilities engage in a wide variety of life activities. These two men are practicing for a mini-marathon they will enter the next week.

FINDING THE APPROPRIATE HUMAN SERVICES PROGRAM WITHIN ALL THIS VARIATION

Your local town hall is usually the first place to begin the search for an appropriate social service agency for a particular human problem. There you will probably find the local health, recreation, and education departments; juvenile and elder services; and the like. The workers in these departments can describe the social services they fund, monitor, or license. They might have listings of services in each area.

The next sources we turn to in exploring the human service network are the directories of social services published in hard copy or on the Internet by various private agencies. One type of directory is comprehensive; it lists a broad range of social problems and the agencies that deal with them. This sort of directory is generally compiled and distributed by the group that coordinates and raises funds for social services in a particular town. Such groups include the United Way, Community Chest, Community Council, Social Service Coalition, and Red Feather Agency. The table of contents of this kind of directory might start off looking like this.

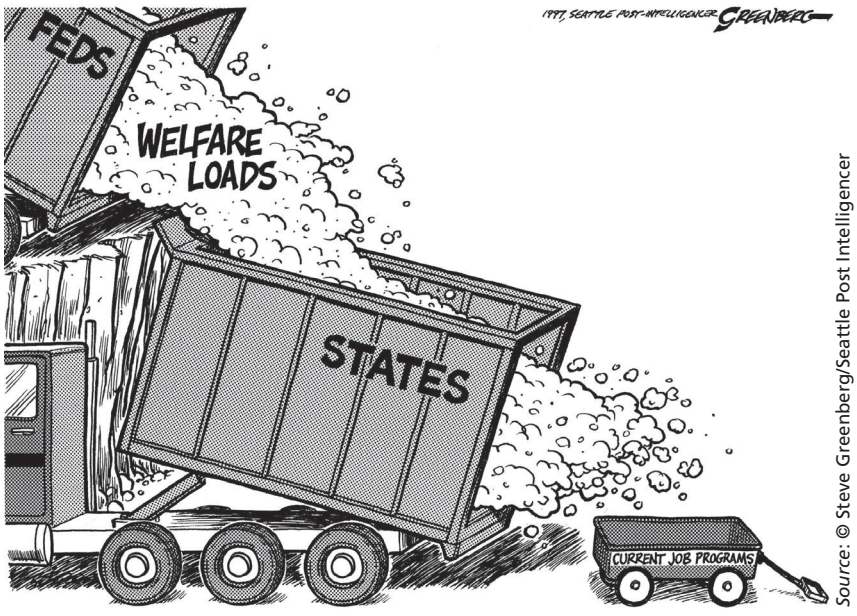
a	b	c
abortion	bereavement support	child care centers
abuse, physical	birth control	children's services
addiction	block associations	consumer protection
adoption	bulimia	correctional institutions
aging		counseling
AIDS		

The other types of directories are problem specific; they focus on one particular service area. Individual booklets might list all the services for the developmentally delayed, addiction support groups, or early-childhood centers. Some directories are published by national organizations, which have chapters across the country; others are just for local child care centers, children's services, consumer protection divisions, or correctional institutions.

Some directories list only objective information about an agency: location, activities, costs, and eligibility requirements. Some on-line subjective directories provide a more in-depth picture by describing agency services and then evaluating their quality of service. Subjective directories are much more difficult to compile than factual listings. Each agency must be visited, all its materials must be read, and data must be found that offer feedback on the care that clients have received. And they must then be updated regularly.

Many agencies maintain hotline phone services. One can call them, for example, to get information on sexually transmitted diseases, learn about various forms of cancer, or find a service agency for stepfamilies. Another phone service, called 2-1-1, provides free and confidential assistance and referrals to local human service resources in the area of the caller. Recognizing that an aging population, as well as the growing number of young people moving from one city to another, face a host of perplexing life issues with no one to turn to for advice, this service will connect callers to agencies whose job it is to help people facing a crisis. Perhaps the weather is cold and there is no heat in the house, or perhaps a single mother cannot leave for her job because the babysitter has not shown up, or maybe there is no food in the house and a pay check or disability check will not arrive for days; now these people can dial 211 on the phone and find assistance.

Newspapers also contain information about new agencies that are opening or about the special projects and problems of agencies. The calendar page of your local newspaper often lists



Source: © Steve Greenberg/Seattle Post Intelligencer

In recent years, there has been a big push to get people out of what many deemed a "failed" welfare system. However, too often, the buck has simply been passed from federal to state and local governments with insufficient job opportunities and job training, leaving families without the money for food, shelter, and health care.

workshops, seminars, and meetings of support groups. Often notices are placed by social agencies seeking volunteers or donations. Computer bulletin boards and chat rooms on the Internet can also be rich sources of information on virtually every social problem and program. In addition, the classified section of a local newspaper as well as listings on web sites can provide clues to the social service networks in a town. A listing of services for older adults might include items such as these.

- American Association of Retired Persons (AARP)
- Congregate Living programs
- Council on Aging
- Day-activity programs
- Road Scholar educational programs
- Legal Services for Older Adults
- Exercise programs
- Homemaker/home health aides
- Meals on Wheels
- Elder living communities
- Recreation centers
- Residences
- Retired and Senior Volunteer Program (RSVP)
- Shuttle bus service
- Social action or issue groups
- Visiting nurses

INTERNAL AND EXTERNAL BARRIERS THAT PREVENT PEOPLE FROM GETTING HELP

Despite the problems caused by her father's addiction to alcohol, Kathy was quite fortunate in some ways. Her town had a variety of social services, and she was able to find and use them. For many people, things do not work out as well. Perhaps they resist seeking help or have difficulty locating, choosing, paying for, or using it.

Many barriers are encountered on the pathway to seeking help. When they are insurmountable, small problems balloon into large, often tragic ones. Because barriers interfere with our ability to serve prospective clients, we need to develop skills to recognize them and try to overcome them.

Some barriers, such as feelings of indecision and ambivalence, are inevitable. How could Kathy's father be certain that he had crossed the line that separates a social drinker from someone who is addicted to alcohol? How could he be certain that he needed professional help? How could he be sure that the hospital or group he ultimately chose was the right one for him? These kinds of feelings we call **internal barriers** to receiving help.

Other, more tangible barriers can stand in the way. Often there are no beds available in a detoxification unit when the person is ready. Frequently there is not enough money to train or pay staff to learn about a new treatment modality. The red tape of bureaucrats in government and in the insurance industry often interferes with a well- thought-out service plan. We call these **external barriers**.

We cannot always remove or mitigate the impact of internal and external barriers, but we must be aware of them. Both the people in the program and the worker interact within the constraints these barriers impose and are challenged to work creatively around them, using all the intervention strategies we will describe in Chapter 3.

Following is a list of barriers to finding and using human services. The first six are primarily internal barriers that will need to be dealt with in the therapeutic relationship. The last five are more external to the person seeking help and are most appropriately dealt with by using the strategies of organizing and advocacy. But here, as with most categories, lines do blur. Each of the first ten barriers is followed by some inner thoughts or questions that reflect them. We will discuss the last one in more detail.

1. **The Difficulty of Evaluating the Seriousness of a Problem**

   - Does my child have a learning disability that needs special help, or is she just developing a little bit more slowly than the other kids in the class?
   - Is it normal to be so furious at my parents? Are other teenagers as depressed as I am?
   - Is this kid in my class just mischievous, or is there some other more serious problem? Does he just have a high energy level, or does he actually have attention-deficit hyperactivity disorder?

2. **The Tendency to Deny the Gravity of a Problem**

   - I'm just a social drinker who sometimes has a bit too much. I can stop anytime I decide to. Can I really?
   - Well, I know he hits me once in a while. But don't all marriages go through rough spots?
   - There is no discrimination in this company; we just can't seem to find any qualified supervisors who are not white and male. No one can say I didn't try, can they?

3. **The Fear of Being Judged, Labeled, or Punished**

   - If I tested positive for HIV, will I lose my job and my medical insurance? Will my family support me?

- If I ask for an evaluation of my child's learning problems, will he be labeled developmentally delayed or be placed in a low track for the rest of his schooling?
- I know I don't have enough food in the house, but if I apply for the Supplemental Nutrition Assistance Program (SNAP), will my neighbors begin referring to me as a "welfare cheat"?

4. The Suspicion or Distrust of Human Service Workers and Agencies

- I know they assure you that complaints of child abuse are anonymous, but how do I know they won't give out my name? Maybe my neighbor will come after me.
- If I admit how mad I get at my child, will they try to take her away from me?
- If I agree to a voluntary commitment to the hospital for an evaluation, will I be permanently confined against my will?

5. The Shame of Not Being Able to Solve One's Own Problems

- I don't see any other men bursting into tears when they get turned down for a job. Why can't I act like a "real" man?
- I was always taught that you don't air your dirty linen in public; so, although I know the landlord is not giving me enough heat, won't I look like a crybaby if I complain to the rent board?
- How can I ask for help paying my medical bills? My family has always taken care of its own.

6. Fear of the Unknown

- If we start marital counseling and I say what I really think, will we end up in divorce court?
- Maybe this school isn't as good as it should be, but if the parents start making decisions, won't it get worse? What do they know about education?
- Living at home might be lonely for our son, who has developmental delays, but maybe when he's older we'll think about his moving into a community residence. How can we be sure he won't be hurt if he moves out into the world?

7. The Difficulties of Choosing the Appropriate Program and Helper

- I've heard about three programs for children with autism; how do I know which one is best?
- Our committee has interviewed six candidates for the job of hotline director, and they are all different. What kind of person (race, gender, age, degree) would make the best director?
- My family has been going to this clinic for three years, and we don't seem to be getting along any better. Whom can I talk with to see if maybe we should try another approach?

8. The Inadequacy of Services

- Will there be anyone in that program who understands my culture and speaks my language?
- Will any of the other staff have the same disability that I do?
- No one wants to have this prison (halfway house for people with substance use disorders, drop-in center for teenagers) in the neighborhood; should we locate it on the edge of town, even though it can't be reached by public transportation?

9. The High Cost of Services

- We don't have enough money for our day camp, so we have to save the spaces for those most in need. But how do you decide whom to reject?
- I know that your mom needs assisted living, but Medicaid doesn't pay the full cost, and we never get those payments on time anyway.

10. Past History, Reputation, or Public Image of a Program

- First it was the antipoverty program, then Model Cities, and now it's privatization. I've seen them all come and go. Our neighborhood never seems to get any better. Why should I participate in this new program?
- With all the taxes I pay, why do the schools still turn out kids who can't read?
- As a legislator, I'm convinced that this town does not need another shelter for the homeless. Do you think the social workers complain about problems so they can keep their jobs?

11. Myths and Lack of Information About the Human Services

Because the human service field is so broad and the barriers to finding and using help pervasive, the public can understandably be confused.

The public sees many professionals—firefighters, doctors, teachers—doing their jobs; this is not necessarily the case with human service workers. We don't wear uniforms or have any observable symbols or tools of our trade. People usually visualize the human service professional primarily in the role of therapist, counselor, or welfare investigator, working one-on-one to solve individual problems or ferret out wrongdoing. Although these are important roles, they do not show the full dimensions of human service work.

Instead of working in a one-on-one counseling relationship with Kathy, for example, some human service workers tackled the problem of substance use by trying to change the social system that supports it:

- They made speeches about the need for funding substance use education programs.
- They designed training programs for school and private industry personnel to combat substance use.
- They met with legislators to change the laws governing the advertising and sale of addictive substances.
- They conducted research to find out what kinds of prevention programs work best.
- They published newsletters, books, and journal articles that disseminated the wisdom they have gleaned about substance use prevention and treatment.
- They designed computer programs so that information about addiction could be easily retrieved.

These social change activities are just as important as the counseling interventions that the public identifies as the province of human service workers. Yet the media does little to help the public get a well-rounded picture of the varied work of the field. Television programs show the lives of doctors, emergency medical technicians, lawyers, detectives, newspaper reporters, and an occasional teacher, but rarely those of a human service worker.

Worse than the paucity of information about the field are the myths and misinformation projected by the popular media using human service workers as the objects of ridicule: "Hello," says the client. "Hmmm, now what do you really mean by that?" asks the counselor.

A PARADOX

When we consider the barriers strewn along the path to getting help, we should think about them in their current context. When placed in perspective, these barriers reveal a frustrating paradox.

Source: Courtesy of Barbara Schram

Encouraging responsible behavior and reducing the self-defeating cycle of substance use require creative approaches. This wrecked car raises frightening questions about the fate of its once-carefree driver. Change in drinking patterns is painstakingly slow, yet we believe that change is always possible.

Certainly, attitudes toward people with substance use disorders have improved. Thirty years ago, if a police officer had encountered Kathy's dad sleeping off his binge in a public park, he probably would have arrested him, and a judge might have charged him with disorderly conduct, public drunkenness, and the like. But by the time Kathy wrote this paper, many police were most likely aware that addiction is a disease.

So the barriers of inaccessibility and stigma, for example, should be toppling down for families facing the kinds of problems Kathy described. Right? Wrong! Strangely enough, this isn't happening. In this new millennium, there is controversy about whether health insurance plans should require mental health and addiction treatment coverage. At the same time, many citizens as well as those in government are questioning the effectiveness of publically funded social services and the manner in which they are delivered. In later chapters, we will return to these themes to see how they play out as human service workers try to ameliorate social problems in an ever more complex world.

CHOOSING OUR WORK ROLE IN A HUMAN SERVICE NETWORK

From one perspective, this wide range (some might call it a hodgepodge) of human service agencies can seem overwhelming to the those just starting a human service career. On the flip side of the coin, this incredible diversity offers workers a chance to find the particular combination of worker roles, agencies, people, populations, and problems that fits their unique talents.

As you read about Kathy's experiences, reflect on your own struggles to get help, or glance through directories or websites, you will probably be attracted to some human service roles and repelled by others. These are natural reactions. While one person thrives working with youngsters

with cerebral palsy, another might drown in feelings of frustration or hopelessness. That same worker who cannot cope with a child with a physical disability might be able to coolly trade put-downs with the angriest teenager. One worker who can listen patiently and nonjudgmentally all day long to folks like Kathy's dad would be tongue-tied trying to convince the zoning board to let her agency purchase a building to house survivors of domestic violence, when the neighbors have organized to block the sale.

We need to tune in to our instinctive feelings of attraction or repulsion to different human service tasks and roles. But we also need to keep our options open. We often surprise ourselves by discovering that we can do work that we thought we could never tolerate. We can also find ourselves unstimulated by a work role that we always thought we wanted.

Currently many students are being trained to be human service **generalists**. A generalist is knowledgeable about a wide range of resources, strategies, and subgroups, and can operate comfortably in many agency roles. She does not necessarily identify with one human service subspecialty but works with a small number of people in need of services, helping them confront and solve the gamut of life's problems. The generalist is often a team member or an assistant whose daily tasks grow out of a job assignment that complements the role of other helping professionals.

Some students take the reverse path, specializing in a specific role from the start of their careers. Trained to work as addiction counselors or as mental health technicians, they develop depth rather than breadth. Later on they might need to expand their skills as priorities shift or as they move up the career ladder. Whichever direction students take at the start of their career, they will probably continue to do a significant amount of growing as they search for the academic degrees and experiences that suit them best.

Whether returning to school for advanced training or switching jobs, workers need to make choices about (1) the specific problems or populations they want to deal with, (2) the type of agency setting they enjoy, and (3) the strategies of intervention they are best at. These choices will be determined by:

- Personal attributes
- Lifestyles
- Ideologies
- Accessibility of certain occupational roles.

Our Personal Attributes

Many of us have been taught since childhood that talking about our good points is "bragging" or "showing off," but in the human services, we must develop insight into precisely what it is that we do best and what we do not do very well. We need to estimate what our chances of growth or change will be in a specific role.

Although the same values and attitudes are basic to all types of human service work, there are differences between the kinds of people who can do intensive, one-to-one counseling and those who fare best in the rough-and-tumble atmosphere of creating community or policy changes. Some of us are outgoing and articulate; others are more introspective and quiet. Some are comfortable filling a niche in a traditional structure; others like to be in charge or work alone. Each time we try a new field experience, meet clients and workers at different agencies, or read about human service work, we should try to visualize ourselves as full-time workers in that role. We need to figure out how its demands fit our personality and how much we are willing to change.

Our Lifestyles

Even as we start our human service education, we should think about the elements in an environment that bring out the best in us. Some of us, for example, are "night people," so working a 2:00 P.M. to 10:00 P.M. shift in a teen residence or running evening parents' groups would be a good fit. Others are "nine-to-fivers"; perhaps they will choose to work in a school or on the day shift at a hospital or mental health clinic. All jobs require some mix of time, location, and structure, dictated by the sorts of populations the agency serves.

Some people feel strongly about dressing in a certain fashion; however, that desire might not fit a particular setting or subgroup. Others insist on having privacy or a place of their own. Obviously, a live-in job in a residence might not suit them.

Although we need to compromise on certain issues, others are vital and legitimate personal needs. As our lives change, the kind of work that makes sense for us also changes. The choice of a specific role need not be lifelong. Optimally, it should support the other parts of our lives as family members and citizens. The broadness of the human service field offers a unique chance to shift gears as circumstances require.

Our Personal Ideologies

Each of us comes to human service work with a unique set of philosophies, drawn from our religion or a general ethical framework. These beliefs must be compatible with the work we do. If a person has strong religious convictions about war, contraception, suicide, special types of food, or days of rest, these must be taken into account in choosing a place to work. We must not be self-conscious about acknowledging the primacy of these issues in our lives. Usually, we can find jobs that allow their expression. Although our values will come under constant scrutiny in the course of learning about the field and though many values might change, they should never be suppressed. If we try to deny them, they may subtly affect our work.

Likewise, many of us have political beliefs about how society should be organized—our personal visions of utopia. We choose the human service work that seems to be moving the community in that direction. As long as our politics or visions do not engulf our work, they add dimension and intensity to it. Some jobs might make demands that we cannot in our own good conscience fulfill. We need to acknowledge these problems openly. Needless to say, having our own beliefs never means that we insist that our clients agree with us. If we have rigid beliefs, it may turn out that human services is not the right field for us.

Agencies in the Local Community

Throughout this text, we underscore the variety and changing nature of human service work. For example, priorities are not necessarily the same in a rural setting as in an urban center. Priorities might change as the population shifts in age or ethnicity or new inventions or technological advances affect people's lifestyles. Election results might redirect the agendas of local or national government. Some agencies might become obsolete and others expand when, for instance, the country is at war, is experiencing an economic recession, or seeks to establish better supports and programs for veterans, survivors of domestic violence, and other at-risk populations. Funding patterns can change dramatically in short periods. Sometimes the human services help to shape the political climate in the country; more often they are shaped by it.

You might, for example, read about shelters for young mothers who have AIDS. You might decide to work in one, only to discover that your state does not appropriate money for such

Source: Courtesy of Barbara Schram

As our lives evolve through marriage, raising children, caring for older parents, facing an empty nest, or perhaps moving to a new area, our work life needs to accommodate those changes.

shelters. This does not necessarily mean you won't ever work in one. Perhaps you will first have to join with others and use your organizational skills to create a public outcry for such programs. Once successful, you can retool, using your social change skills less and using your counseling or caregiving skills more.

To get a visceral feeling for the highs, lows, and realities of human service work, let's meet Stephanie Lake, a worker whom Kathy might have encountered on her college campus.

INTERVIEW WITH A HUMAN SERVICE WORKER AT WORK

Stephanie Lake, Program Coordinator, Drug and Alcohol Education Project

My work on the Drug and Alcohol Education Project at a large university began while I was a human services student; now I am a staff person. I first met the director of the project when she came to my class as a guest speaker. She was new on campus and looking for students to help get the program off the ground.

Although we have a Department of Student Counseling and a half-time counselor who specializes in helping students struggling with substance use disorders, the administration decided to put more energy into the prevention of substance use. That way, they don't just sit around waiting for the problems to come to them.

I volunteered to help the new Drug and Alcohol Specialist recruit students for a peer-counseling program called Peers Reaching Out, or PRO. We started with nine students. The first thing we did was

a survey of attitudes and behavior. We walked around the student lounge for days with our clipboards. Because they knew their answers were anonymous, kids really opened up to us. We also recruited a few peer counselors that way.

The next thing we did was form a committee. This was made up of university staff from different programs and student leaders. They became a brain trust to come up with ideas about the rules that needed to be changed and make suggestions for programs. I became the secretary to the group and still am.

They suggested that we needed more awareness on campus of the problem of substance use and of the new programs we proposed. The president of the university declared a DRUG-AHOL Awareness Week. Faculty members agreed to invite speakers into their classes, and the resident assistants organized discussions in the dorms. We set up a table in the quad and took turns sitting at it every day for a week. We gave out literature on different aspects of the problem and had a drug board that showed the paraphernalia and effects of drugs and alcohol. We also had drug wheels that you could use to figure out how much alcohol it would take to make you legally drunk.

The idea I was proudest of was the display of a totally wrecked car donated by a junkyard. We had it towed right into the center of the quad. The students could see in gruesome detail what can happen when you drive drunk. They stopped and asked a lot of questions. We also had a video going constantly in the main lobby about the crash involving that car.

After I volunteered for two quarters I was put in charge of DRUG-AHOL Awareness Week, and each one has gotten better since then. At first I was afraid to speak in front of student clubs, but I eventually got over that. I wrote articles for the student newspaper and was interviewed on the student radio station. I also used all my own contacts and was able to recruit a solid group of 45 students. Some of them were in recovery themselves and some of them, like me, had alcohol use in their families. I organized the weekly training sessions, set up speakers, got videos, and stayed in touch with the peers between training sessions.

I think I've also been especially pleased with the development of the campus task force. I've gone from being a student member to being one of the professional staff to whom people turn for suggestions. We had a major problem with our senior "bash." For years it's been a tradition for the seniors to bring champagne onto the quad the last day of classes and just get totally drunk. They would destroy the grass, break the bottles, and have a series of nasty accidents. We needed to stop it, and yet, we recognized the seniors' need to celebrate. Our committee proposed that the university take over the celebration, providing the champagne, soft drinks, and plenty of food. That way, the seniors could have their party and we could help them drink in a responsible way. They grumbled the first year, but we pulled it off.

But this year the university decided we couldn't repeat it. The president felt we couldn't take the ethical or moral risk of providing liquor to students who would later drive home. So they gave them a beautiful, fancy, nonalcoholic party. Of course, the students went to the local bars right after it, but there is only so much you can do.

The other project I work on is a program called INSTEAD. From the student court, we get referrals of residents who have caused damage while drunk or who have been caught with liquor in the dorms. The university used to expel them from the dorms. Now we recognize they have an issue that needs to be addressed. They have to attend a six-session training course and do community service. I think this has helped a lot of them turn around. Some of the INSTEAD members go on to join AA. Some even stay with their volunteer work with neighborhood kids.

I have learned so much about administration and planning in this job. It is ending within the next month because the grant that pays my salary will end. This gives me a chance to explore going back to school for my advanced degree. I think maybe it's time to leave, but it's been great to grow with a program that has so much meaning for students and faculty. I am very pleased I chose to major in human services; it is a common foundation for study in many different fields. Wherever I go, I will take with me the insights I have gained through course and field work.

Summary

1. Three possible routes for a young woman looking for help with her father's alcohol use were described. By following these paths, we encountered 25 different human service roles.
2. A picture of the human service programs in any one particular town can be discovered by calling the town hall or an umbrella funding agency, searching out directories of services, calling hotlines, and searching online.
3. Although services might be available, people in need frequently have difficulty finding and using them. Barriers generated by internal and external pressures clutter the paths. We looked at a variety of these barriers by listening in on the nagging doubts and questions that reflect them.
4. The public often accepts stereotypes about who we are and what we do. People often lack accurate information about the full range of human service work.
5. The complexity inherent in human service problems leads to a proliferation of agencies and professional roles. This diversity can offer much choice to those seeking appropriate services or roles. People choose their work roles in the field by considering their own personal attributes, lifestyle, philosophy or ideology, and available programs.
6. The description of the daily work of a program coordinator for a substance use education and prevention project reveals many important roles in the human service network.
7. Although navigating the maze of the human service system can be complex and frustrating, it is never routine and is often exhilarating.

Discussion Questions

1. Some people believe that substance use is a crime best left to the criminal justice system. Others believe that addiction is a moral failing and thus should be cured by the family and the church. Others assert that it is a problem that should be dealt with by the medical establishment and human service programs networks. What do you think of each of these positions?
2. What is the situation with substance use on your campus? What approaches does the administration appear to be using if there seems to be a problem, and how effective do you think those approaches are?
3. If you were assigned to write the type of helpee paper that Kathy wrote, would you be willing to write about a personal problem? Would you be willing to share your paper with your classmates after you wrote it (if you decided to fulfill the assignment)? To what extent do you think that asking students in a human services class to share personal information with the instructor or with other students is an appropriate learning device? To what extent does it feel like an unjustified invasion of your privacy?
4. What human service workers have you personally met? Which ones do you know about in your community or on your campus? Which of their jobs seem like a set of tasks you might like to try out? Which would you prefer to avoid? When you check out the web site of your community, what human service agencies are listed?
5. Interview a staff person at a human service agency. What is her exact role, and what kind of degree is required for that role? What does the person see as the best part of the work? What does that person see as the frustrations or drawbacks of this role? Is this a role that you can imagine yourself in?

Web Resources for Further Study

Occupational Outlook Handbook, U. S. Department of Labor

https://www.bls.gov/ooh/

U. S. Department of Health and Human Services

https://www.hhs.gov

Hazelden Addiction Treatment Center

https://www.hazelden.org

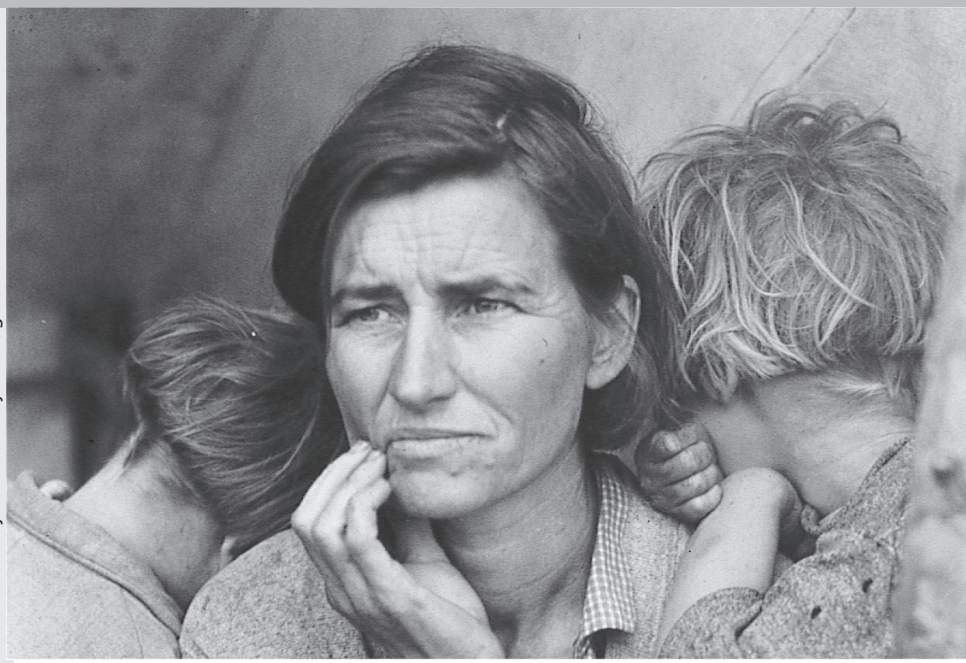
The National Mental Health Consumers' Self-Help Clearinghouse

https://www.mhselfhelp.org

2 The Changing Nature of the Helping Process

Learning Outcomes

- Students will be able to characterize societal attitudes toward people with problems and how the social programs to deal with them have changed through the ages.
- Students will be able to differentiate between means-tested and universal programs and describe how poverty is defined.
- Students will be able to critique cycles of helping in the welfare, mental health, juvenile justice, and criminal justice systems.
- Students will be able to explain the history of human service work and the careers within the field.



Source: Courtesy of the Library of Congress

INTERVIEW WITH MARIE KISSEL, HOMECARE DIRECTOR, ELDER SERVICES OF THE MERRIMACK VALLEY

Marie has worked at Elder Services for over 30 years, and has seen many changes in clients needs, family structures, social issues, government funding, and delivery of services over this period of time.

Elder Services of the Merrimack Valley (ESMV) is a private non-profit agency under contract with the Massachusetts Executive Office of Elder Affairs serving elders and adults with disabilities who reside in northeast Massachusetts. Established in 1974, our mission is to support an individual's desire to make their own decisions, secure their independence, and remain living in the community safely. Elder Services case managers and nurses work with thousands of elders and family members each day to make sure they have the right services, living arrangements, and access to good health care and benefits (www.esmv.org).

Case managers carry a caseload of about 90 people and visit each person a minimum of twice per year as well as maintain contact

Source: Courtesy of Marie Kissel

by phone. The caseload hasn't changed in the 33 years I have been with Elder Services, but the job has gotten more complex. In 1984 the agency offered four programs: Home Care, Protective Services, Nursing Home Ombudsman, and federal Title III programs such as Meals on Wheels. Now we administer 24 programs with over 60 different contracted providers. Each program has its own funding sources, eligibility requirements, paperwork, and computer tracking systems. The biggest change in the agency over the years is that before, we basically coordinated housework, grocery shopping, laundry, and meals so that seniors could live at home independently. Now the focus is on keeping people out of nursing homes and providing the choice to live at home regardless of the complexity of their needs. We have seniors living on their own with dementia, oxygen tanks, or feeding tubes, and many who are bedridden. In the past, these clients would have been placed in a nursing home. Now they have the right to live at home with services. This client-centered approach, combined with hospitals that discharge people before they are well, means that we have to put more services in place to provide a safe environment. While we at times are providing services 24/7, it is not possible unless there is backup support from the family members.

Another way society has changed in the past 30 years, making elder care in the community more complex, is the growing problem of substance use in clients or their family members. More and more frequently we see elders who have criminal backgrounds, often the result of an addiction issue. These elders are unable to secure housing either in housing specifically for elders or in private housing because of this, and may at times be forced to go to an assisted living facility unnecessarily because there is no place else for them to live. There are also more grandparents raising their grandchildren because the parent is deceased, incarcerated, or addicted. Our Protective Services program is there to assist seniors who are being physically, emotionally, or financially abused by someone or who are neglecting themselves. We have seen our referrals to this program grow from 40 or 50 per month to over 250 per month now. Substance use is often a factor in these cases. We had two Protective Services workers when I started at Elder Services; now there are more than 20 outreach workers and interns that assist with the work.

The huge shortage of affordable housing is also a major problem. The waitlists are at least five years long in our area. As noted, clients with criminal records cannot be housed, so they have no choice but to stay in assisted living facilities. We are already beginning to experience the "Grey Tsunami" as the baby boomers become of age and begin to need senior housing and services. As the number of seniors needing services is increasing, we have a shortage in home care workers and case managers. Home care workers provide personal care, cleaning, and shopping services. Our provider agencies have a difficult time retaining home care workers because the positions don't pay well and the work is very challenging. Many of the home care workers are immigrants and may have language barriers, making caring for elders with dementia and/or hearing loss difficult. The pay is often less than working at a fast food restaurant and the work is both physically and emotionally demanding.

There is also a constant demand for case managers, particularly if they are bilingual. The case manager position requires a bachelor degree in Human Service, Social Work, or a related area. We

have a hard time retaining newly hired case managers because there is a lot of competition for workers with the same qualifications. But we also have some case managers who have stayed with us for 10 to 20 years because for them it is a calling and a career rather than just a paycheck. In addition to having strong communication skills, organizational ability, and excellent interpersonal skills, the case managers must also be comfortable with using computer databases. The pay is not great, but there is a great deal of satisfaction in making a difference in an elder's life by enabling them to remain at home and supporting their family caregivers. If you enjoy being the facilitator of many interrelating agencies and services providing care to a consumer, such as the Visiting Nurse Association, mental health providers, and a variety of other agencies, this is a very rewarding job.

When asked what the future holds for elder services, Marie referred to the "elder-friendly communities" movement that aims to make all communities accessible to seniors in their physical design, housing, transportation, and services.

ESMV is already taking bold steps to make communities elder-friendly: We have partnered with a number of housing authorities to build supportive housing and worked with other partners to address the need of elders for fresh food, mental health assistance, basic necessities, and financial management services. We are proud to be one of the first agencies recognized nationally for our work with evidence-based healthy living programs to help people become better health care consumers and manage their chronic health conditions. We were also one of the first agencies in the nation to be awarded funding for a partnership with six area hospitals offering transitional care services for patients being discharged from health care settings.

CHANGES IN SOCIETY SHAPE HELPING BEHAVIOR

Attitudes toward the poor and toward people with physical and mental health issues have changed over time. Changes in attitudes, both positive and negative, are the result of media, research, social movements, and public policy. As social programs and policies evolve, so do the roles of the human service worker. In Europe in the middle ages, people believed God decreed their economic status. There were no programs to help people gain education or better employment if they were in a lower class. In other words, there was no "upward mobility." In America, economic status is tied to the notion of "rugged independence"—the belief that individuals are solely responsible for their economic situation. There is a strong belief in upward mobility, which implies that hard work will lead to opportunity. The flip side of that belief is that poor and troubled people are not working hard enough or have caused their own problems. Because of this deep-rooted belief, America has been a "reluctant" welfare state and there is a stigma to receiving assistance (Jansson, 2001). Human beings are social animals who have always helped each other (and, of course, also hurt each other). The kind of relationship that a society expects from its citizens and the way it organizes its important institutions—the family, and the system of governance and control—can either nurture or stunt people's impulses to give help to relatives, friends, and needy strangers.

If a modern society is to stay intact, it must encourage some form of mutual help. This is what the anthropologist Claude Levi-Strauss (1974) called the **principle of reciprocity**, which he considered the basic glue that holds together a society. That principle points to people's mutual obligations toward each other, based on caring and a sense of justice.

Not only do different cultures vary in their helping behaviors, but our governments, churches, and even private groups have always reacted differently to those in need of help. By

Source: Library of Congress Prints and Photographs Division Washington [LC-USZ62-11203]

Social attitudes about behavior go through cycles. Sometimes they reverse themselves from one era to another. These immigrants to the United States, landing at Ellis Island early in the twentieth century, faced adversity, but their labor was welcomed. Now, the descendants of many such immigrants vote to restrict the entry and social benefits of new waves of hopeful immigrants.

exploring a small part of the history of a few institutions that are supposed to provide help, we see this evolution in concrete form. "But," you might ask, "why must I bother studying the past in order to do my job as a human service worker in the twenty-first century?" Each new view of the way people should be helped, or not helped, has left behind its skeletons. Buildings constructed during one era are still standing many years later; people trained under outmoded theories continue to practice them in their day-to-day work. Lingering myths and misconceptions about crime, mental illness, physical disability, women's rights, multiculturalism, gender identity, and income inequality are almost impossible to stamp out, even in the face of overwhelming scientific evidence proving them wrong.

Changes in Social Attitudes Toward Helping People with Problems

Change is not an upward, linear progression. Rather, changes in social attitudes and treatment methods tend to be cyclical. Yet, although the next spin in the cycle may look familiar, it doesn't come out exactly like the previous one. The philosopher Hegel called change a **dialectical** process. First there is the idea or action (a thesis), which inspires its opposite idea or action (antithesis). Out of the struggle of these two opposites comes a new synthesis. Then the process begins all over again. We find ourselves periodically returning to the same debates about the legitimacy and effectiveness of strategies to deal with such issues as:

- Birth control
- Capital punishment
- Educational methods

- Mental health treatment
- Rehabilitation of people in prison
- Women's rights
- Gender identity issues
- Child raising techniques.

Tracing the overall history of helping in the United States as well as in western Europe reveals a tortured path, starting from the times when people who needed help were viewed as the responsibility of their families alone or perhaps were also given a little help from the church or a benevolent feudal lord, owner, or other master. Along with the shifts between private and public responsibility for helping has come a slowly changing set of social perspectives on people who need help. In feudal times, people were pretty much locked into their social status, and the rulers of society, buttressed by theologians, spread the word that the poor or people in trouble were poor because God willed it. If God willed it, the rulers argued, then it would be sacrilegious to change their status. The rich, however, could assure their own entrance into heaven by giving to the poor (Herlihy, 1973).

Sixteenth-century theologian John Calvin extolled the virtues of thrift, industry, sobriety, and responsibility as essential to the achievement of the reign of God on Earth. The Puritan moralists of New England used his ideas to reinforce the work ethic needed for the newly emerging industrialism of the United States. The moral imperative to be productive made it a stigma to be poor or handicapped.

A powerful influence on the treatment of the poor during the late nineteenth century was the adaptation of the ideas of Charles Darwin. Although Darwin did not draw any sociological conclusions from his work, Herbert Spencer, an English philosopher and one of the first sociologists, used Darwin's work to coin the phrase "survival of the fittest." According to Spencer's interpretation, the fittest people in society were those who were able to make money. Poor people were declared unfit and accorded the same treatment doled out to common criminals. This philosophy is called **Social Darwinism**.

SOCIAL DARWINISM Spencer was one of the first to apply Darwin's theories of evolution to the human sphere. The concept of "survival of the fittest" was used to justify accumulation of wealth and disregard of the needs of the poor.

Darwin actually said that we are programmed to be cooperative and caring, according to one psychologist, Dacher Keltner, director of the Berkeley Social Interaction Laboratory. He wrote the 2009 book *Born to Be Good: The Science of a Meaningful Life*, in which he says, "Our mammalian and hominid evolution have crafted a species—us—with remarkable tendencies toward kindness, play, generosity, reverence, and self-sacrifice, which are vital to the classic tasks of evolution—survival, gene replication, and smooth functioning groups" (Keltner, 2009).

With the decline of feudalism and the rise of industrialism, the responsibility for those people who could not help themselves began to shift more and more to town governments. Official overseers of the poor gradually replaced the church and almsgivers as the primary sources of help outside the family. Eventually, providing help became a task for volunteers or trained professionals.

The beginnings of the industrial age ushered in the view that people with problems were morally depraved, almost as if they had a self-inflicted contagious disease. It was thought that

they deserved punishment or removal from society. William Ryan calls that point of view **victim blaming** (Ryan, 1976). It is a point of view that has sunk roots deep into our society. Some examples of victim blaming:

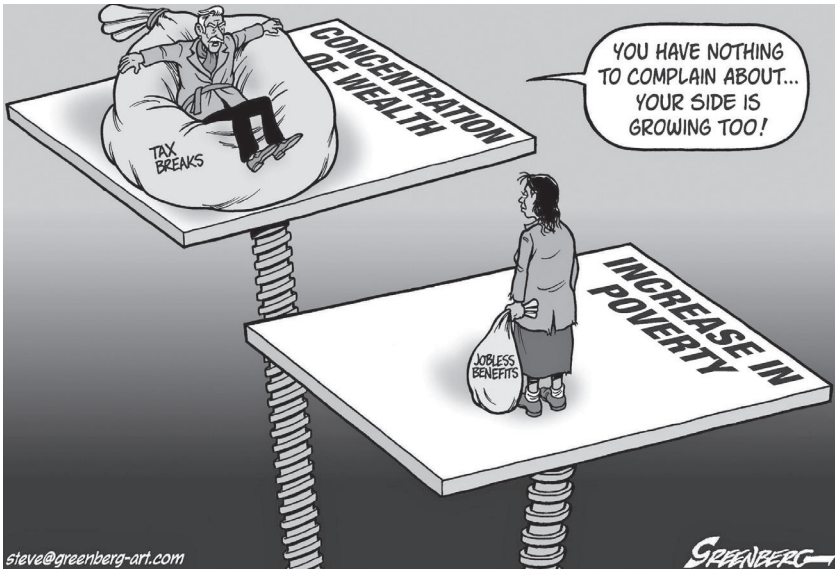
- Women who report rape are blamed for provoking it by the way they dress.
- Single mothers on welfare are blamed for having children to get money from the state.
- People who are homeless are blamed for not managing their money properly.

An opposing point of view, held by the human service profession, is built on providing a counter-perspective to the blaming-the-victim ideology. It defines human problems as a result of interacting personal and social forces, often beyond the control of the individual. It looks at individuals as embedded in families and communities and in economic and political systems that exert a powerful pull on personality development, social status, and life chances. The alternative perspective:

- Women who report rape are courageous to step forward and should receive medical, emotional, and legal assistance for the trauma that they have endured.
- Single mothers receiving cash assistance or other benefits are struggling to take care of their children, often while working or in school, and their strengths should be recognized.
- Persons who are homeless may have a number of reasons for losing a house or apartment, including loss of job, or physical or mental illness.

This point of view, which looks at social systems, asserts that life situations are an inevitable part of the human condition in an industrialized society. Older adults will retire from their jobs; working parents will often need help with child care; everyone gets sick at some time; wage earners who support a family sometimes die or become disabled; women get pregnant and need prenatal care; everyone needs education in order to be a contributing member of society; many workers are injured; some babies are born with crippling diseases or develop them later in life; some people will lose their jobs. Poverty and the stresses of life have long-term health consequences, including more illnesses and shorter life expectancy (Wilkinson & Marmot, 2003). Some governments have developed strong **social safety nets** and others have weak and fragmented programs. These opposing philosophies have resulted in very different approaches to giving help. The blaming-the-victim ideology always sees character defects in individuals. At best, it results in remedial programs to "cure" those defects. At its worst, it punishes people for what it defines as perverse or immoral conduct. Entire groups of people are blamed for their behavior. The poor, for example, are assumed to be poor because they lack initiative and a work ethic. People who are homeless are thought to have brought their condition on themselves through personality defects or lack of careful planning. If you move from one country to another or from one state in the United States to another, you will find great differences in the programs offered and the funding given to social service programs (Urban Institute, March 2016).

The United States, for example, has been called a "reluctant welfare state" in comparison with most other industrialized nations (Jansson, 2001). The United States ranks twenty-fifth among developed countries on social welfare spending (cash and services) but spends considerably more on health care and education than other nations, partly due to tax credits and higher costs in these areas (OECD Social Expenditure Update, November 2014). According to a study in the *Washington Post* (Max Fischer, April 15, 2013), the United States ranks thirty-fourth out of thirty-five developed countries for child poverty rates. For a country with the means to provide a social safety net, it has been unwilling or unable to do so in a way that combats poverty.



Source: © Steve Greenberg

There is a growing inequality of the distribution of wealth in the United States, resulting in the richest Americans having a disproportionate amount of total assets.

MEANS-TESTED VERSUS UNIVERSAL PROGRAMS People who tend to blame the victim sometimes feel superior to those in need. They assume that they could never be in the circumstances that the victim is in. They tend to separate people into "them" and "us, " **deserving versus undeserving**. They often prefer means-tested programs for all people, even those in the most precarious circumstances, and feel that before people receive aid that their financial situations should be fully investigated (Ryan, 1976).

The means-tested approach is often called the **residual philosophy of social welfare** (Zastrow, 2009). Proponents of means-tested programs generally have the opinion that benefits should be made difficult to obtain, that assistance should be tied to work, and that strict measures for determining need should be adhered to (Zastrow, 2014). Applicants must prove that they have so little money and so few assets that they meet the criteria that the agency sets for eligibility. When there are limited funds to support the programs, the means-test has higher thresholds for eligibility, in order to limit the number of people served. For example, in order to secure a shelter bed, a person who is homeless may have to obtain documentation to prove that he has no other assets, has no family members who can take him in, and was not evicted due to his own fault.

Those who look at people as being embedded in a social system, and thus having predictable developmental needs, are more likely to regard social supports as a universal right. That philosophy of social welfare is called the **institutional,** or **developmental, philosophy of social welfare**. Programs subscribing to this philosophy are called **universal programs**. Workers in these programs assume that problems are bound to occur, so they provide for people in need in a way that respects the dignity of the individual. The programs they create—unemployment insurance; workers' compensation; family and children's allowances; pensions for people who are older, who are survivors, and who have disabilities; Medicare—are given as **entitlements**, which do not distinguish between "deserving" and "undeserving." Social security comprised at

least half the income of 69 percent of aged individual beneficiaries, and 48% of the income for married couples (Social Security Administration, 2018). Social security is considered an entitlement program and because beneficiaries pay into it, they often consider it earned income versus welfare even if they collect far more than they pay into the program.

Universal income supports and social services include both the affluent and the poor, and therefore have more public approval. Wealthy people who receive such aid will pay some of the cost through **progressive taxes**, whereby the rich are taxed at a higher rate than the less affluent. Universal programs are much more widely used in European countries than in the United States. For example, most industrialized countries except the United States have what they call a family allowance, which gives a certain amount of money to families for each child they have. France has universal child care for working mothers. Most industrialized countries have a national health insurance system, funded by the government from tax revenue.

Many human service workers tend to prefer universal programs, which they believe show more respect to ordinary people. Others, who view themselves as more conservative, tend to prefer **means-tested programs** (programs in which people must prove great need). People who receive benefits under universal programs are called claimants; people who receive means-tested benefits are called recipients. Claimants are claiming their rights; recipients are receiving whatever someone chooses to give them.

Defining Behaviors as Social Problems

When does a particular kind of personal or social behavior become defined as a "social problem"? Why did social-problems textbooks before the 1970s rarely mention such issues as sexism, domestic violence, incest, sexual harassment, rape, and discrimination against people with disabilities, whereas post-1970s textbooks prominently discuss these as social problems?

Behaviors become social problems when some people and organizations force those issues to the top of the public agenda. Domestic violence, rape, and discrimination based on race or gender identity were widespread before 1970, but they weren't defined as social problems until the feminist, civil rights, and LGBT movements, among others, challenged traditional assumptions (Best, 1989).

More than most other countries in the world, the United States has clung to an individualistic philosophy, believing the Horatio Alger rags-to-riches myth that anyone can make it if she works hard enough. Sociologist C. Wright Mills (1959) distinguished between "private troubles" and "public issues." Troubles happen to individuals and to the relationships between individuals. Issues, on the other hand, transcend one individual and are widespread within the community. Mills gives the following example:

> When, in a city of 100,000, only one man is unemployed, that is his personal trouble, and for its relief we properly look to the character of the man, his skills, and his immediate opportunities. But when in a nation of 50 million employees, 15 million men are unemployed, that is an issue, and we may not hope to find its solution within the range of opportunities open to any one individual. The very structure of opportunities has collapsed. Both the correct statement of the problem and the range of possible solutions require us to consider the economic and political institutions of the society, and not merely the personal situation and character of a scatter of individuals. (Mills, 1959, p. 9)

We know that as unemployment rises, so do substance use, homelessness, child abuse, divorce, domestic violence, crime and delinquency, mental illness, and other issues. The human service worker who treats each case as a personal trouble is doing a disservice to people in need, society, and the profession.

Source: GWImages/Shutterstock

Many individual social behaviors are a result of bigger social issues and problems that need to be addressed on wider basis.

Social issues of the last decade include post-traumatic stress disorder (PTSD) of veterans returning home from war in Afghanistan and Iraq, and the opioid crisis. Significant attention has been paid recently to racially motivated shootings, shootings of police officers, and people with mental disorders and illness as related to school shootings. The social behaviors have impacted an "ordinary" person, which moves the behaviors from individual to social problems. Once something is recognized as a societal problem, public policy and programs begin to respond.

CYCLES OF HELPING

To illustrate the dialectical nature of human service issues, we shall discuss four issues: welfare, mental illness, juvenile justice, and criminal justice.

Cycles in Welfare Reform

We are using the term *welfare* in the way that the public generally understands it. The government's name for the program is Temporary Aid to Needy Families (TANF).* If we called all government financial transfer programs "welfare," then financial aid grants to college students and veterans' benefits, for example, would come under that category. Although the amount spent on the TANF program has been relatively small—less than 1 percent of federal government spending and about 3 percent of state spending—it garners a huge amount of public attention, although

*States have given different names to TANF. In Massachusetts, for example, the program is called Transitional Assistance to Families with Dependent Children (TAFDC).

much larger grants go to the middle class and rich in the form of tax benefits. "Welfare grants" provide a good example of the cycles of reform. Frances Fox Piven and Richard Cloward (2013), two former professors of social work, wrote that welfare expands and contracts in response to changes in the economy and the political climate. Piven and Cloward argued that government officials expand public assistance in times of civil turmoil. When the turmoil dies down, they cut back on welfare. They documented the following cycles of expansion and contraction in welfare:

- Beginning of large-scale federal relief programs during the Great Depression as a response to civil turmoil
- Cutbacks during the 1940s and 1950s after the turmoil of the 1930s subsided. Welfare was often withheld from people in order to force them into low-paid agricultural and factory work.
- Expansion during the 1960s as a response to civil turmoil (and as an attempt to build a new urban base for the Democratic party)
- Cutbacks from the 1970s to the present after the turmoil of the 1960s subsided. During this period, welfare has been withheld to force women out of their homes and into the low-wage labor market (Piven & Cloward, 1993).

As welfare and other safety net programs were cut back, the criminal justice system expanded. The United States has the highest incarceration rate on the planet—five times the world's average. The United States has 5 percent of the world's population, but 25 percent of the world's prison population. There were about 2.24 million people incarcerated in federal, state, and county prisons in 2014 and another 6.8 million under community supervision (Bureau of Justice Statistics, 2014).

THE DOWNWARD SLIDE The upward climb of social welfare expenditures reversed in 1975. Expenditures then took a downward turn for the first time in three decades, beginning with the Ford and Carter administrations, and picking up roller-coaster speed during the 1980s. Congress and the Reagan administration cut means-tested programs for the poor and near-poor. Programs for the middle class suffered also, though entitlement programs such as Social Security and Medicare were safe from cuts (Campagna, 1994; Jansson, 2015). Some states replaced the lost federal funds with state funds, but during periods of economic recession, states tend to cut social welfare and implement punitive measures. Across the nation, state legislators and governors have slashed benefits for people with low incomes. Fourteen of the 30 states with supplemental welfare programs, known as General Assistance, have cut benefits, affecting nearly half a million people.

At the same time that corporations were being restructured, social welfare programs were also being restructured. As wages went down, so did welfare payments—no coincidence. According to a principle known in welfare circles as the **principle of less eligibility**, welfare payments in the United States are almost always kept below the lowest wages in order to encourage people to take any low-wage job rather than go on welfare.

Over 25 years ago, the consumer advocate Ralph Nader warned that many politicians were engaged in a campaign to undermine people's trust in government. The results of the 2016 presidential election seemed to reinforce the idea that voters had lost trust in the government. Voters largely rejected career politicians and supported candidates who were in favor of limiting safety net programs and more strongly controlling immigration. Now we see how farsighted Nader was. When people believe that the government does not have a responsibility to provide social safety nets or to offer social programs that help people in challenging life situations, the fundamental basis of much social policy and practice is impacted. The impact might result in the removal of

the "buffer" that is intended to protect people from situations such as working at a job that does not pay wages that cover basic needs, staying in abusive relationships, or becoming homeless. It seems that we have returned full circle to the 19th century in welfare reform.

Welfare is like society's lightning rod, attracting people's anxieties and ambivalence about dependence and self-reliance—about work, about race, about sex, about our responsibilities toward one another, and about the nature of a just society. It is an increasingly political hot-button issue in the United States (Gilens, 1999). Even though the welfare rolls have declined since the 1996 welfare reform, the perception that welfare dependency is rampant remains in people's minds.

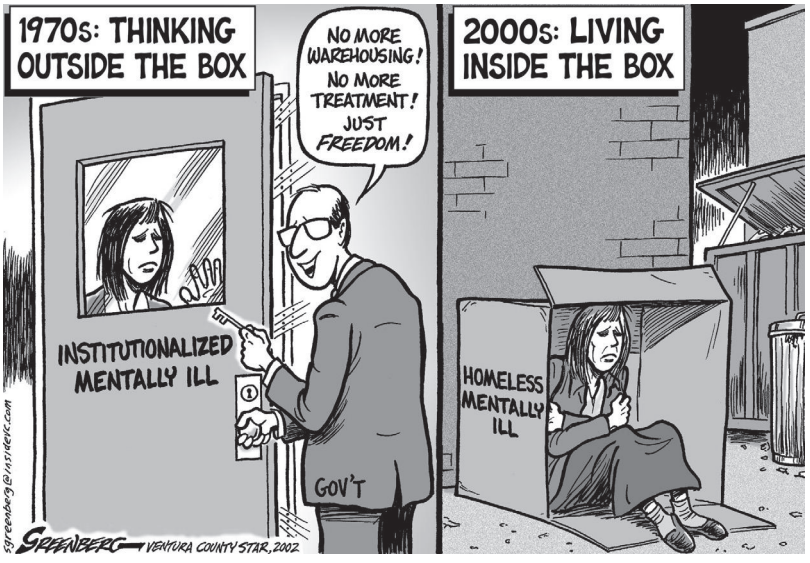
Cycles of Treatment of Mental Health Conditions

The treatment of people with mental health conditions has taken many twists and turns throughout history. Again we see the similarity of present conditions to earlier times. In 1985, the president of the American Psychiatric Association, John A. Talbott, said: "In trying to reform the mental health system, we've gone from atrocious to awful. In colonial times, hordes of mentally ill people wandered from town to town. They lacked food, shelter, and care. That's exactly the situation today: We've come full circle" (Nickerson, 1985, p. 18).

Political philosopher Michel Foucault pointed out that certain behaviors are regarded differently in different cultures and at different historical periods. Foucault said that up until about 1650, "madness was allowed free reign" (1987, p. 67). Society neither exalted it nor tried to control it; in fact, in France in the early seventeenth century, there were famous "madmen" who were a great source of entertainment for the public. But "about the middle of the seventeenth century, a sudden change took place; the world of madness was to become the world of exclusion" (1987, p. 67). Throughout Europe, institutions were built to house many different categories of people. In about the middle of the eighteenth century, Europeans began to protest the widespread internment of people. A goal of the French Revolution of 1789 was to abolish internment as a symbol of ancient oppression, particularly for the poor. But this liberation did not apply to individuals who experienced mental illness and were considered dangerous. "Hence the need to contain them and the penal sanction inflicted on those who allow 'madmen and dangerous animals' to roam freely" (Foucault, 1987, p. 70). Thus, individuals who experienced mental illness were left behind in the old houses of internment.

In the 19th century, madness was thought to be contagious. Because it was thought unfair to criminals to expose them to individuals who experienced mental illness, the latter were separately confined in asylums. The doctor was not the servant of the patient but of the society. Foucault believed that the psychologization of madness that occurred in the nineteenth century was "part of the punitive system in which the madman, reduced to the status of a minor, was treated in every way as a child, and in which madness was associated with guilt and wrongdoing" (1987, p. 73).

While physical conditions are diagnosed using laboratory tests, mental health diagnosis is less precise. Except in the case of organic conditions such as brain tumors, mental illness is primarily diagnosed by observing behavior and through medication trials. For many years in the past, a person could be labelled as "mentally ill," without any diagnosis, and removed from her family and put in a hospital (Szasz, 1961). Lawsuits against hospitalizing people against their will and warehousing so many people with problems finally led to deinstitutionalization. This resulted in the closing of psychiatric hospitals that were supposed to be replaced with small community residences and outpatient treatment.



Source: © Steve Greenberg/Ventura County Star, 2002

Unfortunately, when our society embarks on a positive social reform, the effort is often underfunded or incomplete, leading to new types of problems.

THE PROGRESSIVES AND THE REFORMERS During the early 20th century in the United States, social activists known as **Progressives** were shocked by the oppressiveness of the overcrowded prisons and mental health facilities that helped so few people. They did not, however, want to abolish them; rather, they thought that each person would be cured if professionals could tailor a case-by-case treatment plan.

Modern reformers are closing the mental health facilities and returning the patients to their communities. Indeed, treatment of people with mental illness has come full circle, but now the rationale behind it is different. The colonists of early America believed in the inevitability of problems; modern reformers believe that hospitals institutionalize people but do not heal them. The latter argue for the healing power of kin, community ties, and normal, everyday routines.

INTERVIEW WITH JUDY CHAMBERLIN, MENTAL PATIENTS' LIBERATION FRONT

Judi Chamberlin was one of the founders of the mental patients' liberation movement in the 1970s. She called herself a "psychiatric survivor" of the mental health system. She not only survived but also went on to write a book about her experiences with mental illness and psychiatric hospitals. She also started an alternative service for those who had been treated and released from mental health facilities. Chamberlin was one of the leaders of the Mental Patients' Liberation Front (MPLF), an organization of people who are or have been in psychiatric hospitals and who oppose many established psychiatric practices. MPLF has established support groups and alternative institutions.

In 1988, Judi wrote On Our Own*, a book about her own experience with depression, when she was involuntarily hospitalized. That book became a kind of bible for the mental patients' liberation movement. Judi spoke at conferences all over the nation and the world, and passed away in hospice in 2010.*

When students learn about the mental health system, they only hear the views of the professionals. They seldom empathize with the mentally ill or try to understand how it feels to be on the receiving end. If they want to have an honest dialogue with the mentally ill and ex-patients, service providers have to be prepared to face their anger and mistrust. People who use services have been treated in paternalistic and controlling ways, and this understandably has made them angry.

The attitudes of service providers have caused a split between the Alliance for the Mentally Ill (AMI), a support group for relatives and friends of mentally ill people, and the Mental Patients' Liberation Front (MPLF). Parents in the AMI argue, "We love our sons and daughters and want them to get help. We may trick them if we have to, whether they say they want it or not." The patient may not want to take drugs, but relatives often think they should and complain that patients don't take their medications. (Research has shown that a high percentage of all drugs, not just psychotropics, is not taken according to the doctor's prescription.)

Judi tried to promote dialogue between AMI and MPLF.

Ex-patients and families have one thing in common: They didn't choose to be in the system. Professionals choose to be there. It is important to recognize that families have a valid perspective.

Some people accuse the MPLF of being totally opposed to drugs, but I believe in choice. Patients need to have all the facts, which are often kept from them. The professionals sometimes feel that if they give patients information, they only scare them. I tried drugs but didn't find one that helped me. For me, drugs didn't work, but I wouldn't tell anyone else what to do. The journalist Robert Whitaker wrote the book *Mad in America*. He investigated the statistics of mental illness and found that the number of people diagnosed with mental illness keeps going up and the number of people on disability keeps going up, despite all the claims that drug companies make about medication. A typical anti-psychotic drug causes severe obesity— [a gain of] 100 pounds or more—and diabetes. But it is very profitable for drug companies. The power of drug companies keeps growing. Lots of doctors are getting huge amounts of money from drug companies, and lying about it.

Drug companies and doctors have everyone convinced that the problem is biochemical, but we see it as psychosocial. Poverty is a factor. Life on SSI (Supplemental Security Income) is pretty miserable because the grant is so low. There is a "Ticket to Work" option to encourage people to try working, and to enable them to return to SSI if it doesn't work out. But people are wary of trying that because they know how hard it is to get on SSI, and they fear that they would be left with nothing if they were denied SSI. Researchers have tracked unemployment and hospital admissions, showing that mental illness rises with unemployment. Research about women in mental hospitals indicates that as many as 50 to 80 percent have been sexually abused.

Interestingly, the rate of recovery of mental patients is higher in third-world countries. I believe that is because they have stronger family and community ties. Also, traditional healers, who would be used more in third-world countries, sit with the patient, sometimes for days. In Africa, for example, a native healer spends several days observing the patient. That presence sets up a powerful therapeutic alliance. The healer does not think that it is important to ask questions but that it is important just to be there.

Ours is a strength-based model. It is important to teach people skills, and train people to be advocates and mentors. That changes how people think about themselves. Instead of making sickness his identity and saying, "I'm Joe, I'm schizophrenic," he can see himself as somebody with something to give others. We aim to put people in positions of power over their own lives. When people feel powerless, they are overwhelmed. When everyone is making decisions for them, it is not surprising that they don't have good outcomes.

RECENT DEVELOPMENTS AND PROBLEMS IN TREATING PEOPLE WITH MENTAL HEALTH CONDITIONS

1. **Deinstitutionalization, followed by a lack of funding, has caused increases in both homelessness and incarceration of individuals with mental health issues.** Dorothea Dix, who campaigned in the 19th century to get people with mental illness out of jails and into psychiatric hospitals, would have been vexed to see that the hospitals evolved into substandard and abusive living conditions. Beginning in about 1955, the state psychiatric hospitals began to undergo **deinstitutionalization**. While the intent to deinstitutionalize may have been good, the outcome was that community facilities did not meet the demand, and ultimately most of the patients were "reinstitutionalized" into shelters, nursing homes, rest homes, or prisons. David Wagner (2005) studied this process of "reinstitutionalization" and compared the poorhouses and workhouses with present-day shelters for the homeless. He said, ". . . almshouses and shelters are generally comparable, and the six studied are probably better than most homeless shelters in regard to sleeping areas, waiting lines, food and so on"(Wagner, 2005).

   Most psychiatrists assert that deinstitutionalization was made possible by the discovery of antipsychotic drugs, which allow patients to live a stable life outside the hospital. Although it is true that these medications have helped some people return to mainstream life, Blau (1992) points out that psychiatrists have often relied too heavily on drugs in their eagerness to empty the hospitals. An overreliance on drugs can prolong social dependency and produce neurological damage. The lack of a permanent home and outpatient treatment can also prevent regular use of medication.

   Pharmaceutical companies are spending large sums to get doctors to use their medicines by giving the doctors various perks. Some psychiatrists are lured by this largesse to prescribe medications that they might not otherwise prescribe (CBS News May 13, 2017). One psychiatrist spoke out against this practice, which he himself had been doing. He said, "There's really no nice way to say it. If you're being paid to offer an opinion you're not all that confident that you believe, you're corrupt" (Goldberg, 2007a).

   The failure of deinstitutionalization to live up to its promise is an illustration of a principle that sociologists call the **unintended consequences of reform**. Sometimes a reform can become so perverted in the way it is carried out that its advocates, who held such high hopes for it, feel betrayed.

   In 1955, there was 1 psychiatric bed for every 300 Americans. In 2005, there was 1 psychiatric bed for every 3,000 (Torrey et al., May 2010). Now it is extremely difficult to find beds for people who need them. Most acute in-patient care is now available in general hospitals. Average length of stay has fallen steadily to less than 10 days (Lee, Rothbard, & Noll, 2012). Officially, patients who left the hospitals were supposed to be mainstreamed into the community, where they would receive supports. Some of the patients went home to their families and some went to halfway houses, foster care, or jail. Some were discharged to the streets or to shelters for the homeless. The rest went to nursing homes.

   According to the Substance Abuse and Mental Health Services Administration, 20 to 25 percent of the homeless population in the United States suffers from some form of severe mental illness. In comparison, only 6 percent of all Americans are severely mentally ill (National Institute of Mental Health, 2009). The Mental Retardation Facilities and Community Mental Health Centers Construction Act, signed into law by President

Kennedy in 1963, was supposed to fund 2,000 mental health centers by 1980, but only 789 were ultimately funded (Blau, 1992). Even those did not serve the chronically mentally ill in the way that was originally intended. Mental health professionals found the chronically mentally ill less rewarding to work with than the acutely ill or the neurotic. "Hence, a mere ten years after passage of the act, chronic mental patients had too few places to go, and even in those places, they were not exactly welcome" (Blau, 1992). Far too many people with mental illness wind up in the criminal justice system: An estimated 56 percent of state prisoners, 45 percent of federal prisoners, and 64 percent of jail inmates have a mental health problem (Urban Institute, March 2015). Homeless shelters and permanent affordable housing often require residents to be substance free and will not accept residents with mental illness they feel they cannot handle. The Housing First model is a permanent housing option that accepts the resident first, and then provides opportunities (not requirements) for the individual to address her behavioral and mental health issues. This model can include independent apartments or permanent supportive housing. Permanent supportive housing has proven to be both cost-effective and effective in retention of people with dual diagnosis of substance abuse and mental illness (National Alliance to End Homelessness, April 2016).

2. **Untreated mental illness has gained media attention after mass shootings.** Several bills were introduced following the mass shootings of innocent victims by people with mental illness, such as the Sandy Hook Elementary School shooting, where a 20-year-old man who had been treated for mental illness shot and killed 20 first-grade students and 6 teachers in December 2012. The tragic incident prompted outrage by parents and formation of groups such as Moms Demand Gun Reform. Their efforts resulted in requiring increased background checks in four states that did not have them before and an expansion in seven other states. However, on the federal level, gun rights were expanded with conceal and carry laws across state lines and changing the definition of "fugitives from justice" to allow people on the FBI list to own weapons. (ABC News, December 12, 2017). The tragedy also prompted a look at the mental health system and at the need for prevention services (National Council for Behavioral Health, July 26, 2018).

   The "Helping Families in Mental Health Crisis" and the Mental Health Reform Act bills were introduced in Congress in 2015 to improve prevention and treatment, and to move away from incarcerating persons with mental illness. Under President Barack Obama, the 21st Century Cures Act (Cures Act) was signed into law in December 2016. This Act includes mental health initiatives such as increasing access to behavioral health services and providing treatment before justice involvement (National Council for Behavioral Health, July 26, 2018).

3. **Socioeconomic factors are strongly associated with the prevalence of mental disorders, and women and minorities are disproportionately affected.** There are a now a disproportionate number of people of color and women who are deemed mentally ill. A disproportionate number of women and minorities are poor, and poverty contributes to stress related mental health issues such as anxiety, ADHD, depression, and suicide (Grote, et al., 2007). According to the World Health Organization, "Gender determines the differential power and control men and women have over the socioeconomic determinants of their mental health and lives, their social position, status and treatment in society, and their susceptibility and exposure to specific mental health risks." Where one lives matters when it comes to conditions that impact mental health. Some clinic staff engage in social action