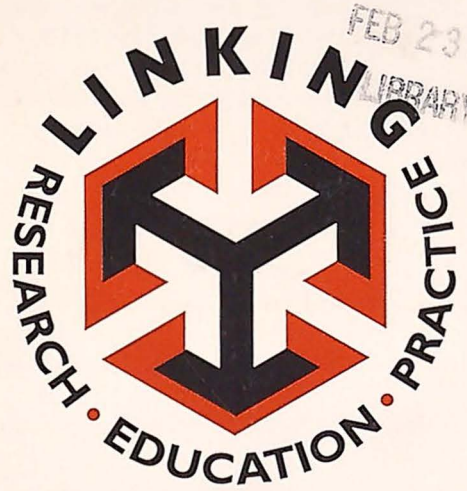
Advances in Social Work



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Advances in Social Work

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CONTENTS

FROM THE EDITOR

In presenting the inaugural issue of ***Advances in Social Work***, the Indiana University School of Social Work proudly joins the rich cadre of peer-reviewed scholarly journals in social work. We unveil the first issue at a time when social work education and human services are undergoing profound changes in both structure and orientation. These revolutionary trends have been precipitated by the convergence of information technology, a changing demography, market oriented universities with its emphasis on customer comfort and satisfaction, greater emphasis on technological proficiency, globalization, a call for increased educational exchange of domestic and foreign students (Hardi, 2000), welfare reform, managed care, privatization of social services, and changes in financing of health and human services guided by capitalist principles of competition and free-enterprise. These trends are further reinforced by greater demand for evidence based practice outcomes and cost-effectiveness in all fields of practice, and new discoveries in biogenetic engineering.

While science and technology are desirable tools to advance the knowledge base, they are not adequate in explaining value-based issues and non-rational elements of human actions such as emotionalism, intuition, beliefs and experiences. Constructivist educators further argue that empirical science is incapable of providing the necessary framework for problem-solving in contemporary context (Papell, 1978; Papell & Skolnik, 1992; Schon, 1982, 1987; Tyson,1992). Suzanne Fields (2000), a noted philosopher and anthropologist, writing in the Los Angeles Times, asserted that classical empirical science has a limited focus, and lacks the free imagination that helps students to think critically and to develop skills in the process of ethical reflection. Recognizing that logical positivism tends to exclude alternative, metaphysical ways of knowing made Joseph Vigilante speculate as early as 1974: "Can science provide a tangible proof about 'truth' or 'reality' when truths in a profession are deeply rooted in values and beliefs?"

As human services increasingly rely on hyper-technology, embrace capitalist ideology, and engage in entrepreneurial model of practice, and as the demand for measurable results escalates, social workers will face new and more complex ethical issues and challenges to preserve humanistic and social dimensions of life in the new millennium. The current Curriculum Policy Statement mandates that social work programs prepare graduates for a commitment to people's well-being and social and economic justice and equality. (CSWE, 1994) However, socio-political and economic forces have produced tensions between the individualistic value orientation and social and familial responsibility which present a complex

dilemma for social work practitioners to resolve. The lead article in this issue by Elaine Congress very appropriately reflects this concern and offers a decision-making model for practitioners when confronted with ethical dilemmas. Congress discusses the use of ethical theory to help practitioners resolve moral dilemmas that arise within the context of contemporary practice.

Because social workers engage in a variety of social service roles, ethical concerns extend beyond the realm of direct practice and include organizational ethics and even ethics in the use of cyberspace. Among the myriad uses of online technology is included the emergence of consortia of state-wide virtual universities that offer courses and even degrees through online instructions (Young, 2000). The Internet is also used for providing therapy to clients, known as WebCounseling. (Morrisey, 1997) While cyberspace offers seemingly unlimited opportunities to gain easy and fast access to information, there is a great potential for misuse of the Internet. A substantial literature shows that cybercheating is endemic on college campuses including social work programs. (Benning, 1998; Cobb, 1994; Guernsey, 1998; Lauer, 1992;Marson, 1998). Cybercheating can take many forms such as plagiarism and "buy-up" term papers. (Gibelman et al. 1999) Realizing the great potential for such abuse, Marson and Bracken in their article lament the fact that there is an "ethical vacuum in cyberspace." They further note that currently there are no legal or ethical norms that govern and regulate the use of online information, nor does the current NASW Code of Ethics provide guidance for legitimate online interactions. The authors emphasize the need for ethical and legal standards that have the support of most computer professionals.

Related to the content on social work ethics in curriculum, is the issue of religion and spirituality that has received sustained attention in both social work practice and education. A growing and substantial literature exists that suggests that spirituality and religiosity play an important role in the treatment of psychological problems that face people and urge social workers to take seriously the religious dimension in the lives of their clients. A growing number of social work students are expressing a desire for content on religious issues and skills to be included in their professional training. (Sheridan & Hemert, 1999) However, the non-sectarian schools of social work, by and large, are still ambivalent toward the idea of incorporating religious content in their programs because some faculty lack comfort in addressing such issues, perceive introduction of spiritual content as a conflict with the NASW Code of Ethics, or their own beliefs, or because they perceive a possible breach in the barrier between church-and-state (Dudley and Helfgott, 1990). This year, presidential politics in which religion has emerged as a salient issue in debates among candidates (The Wall Street Journal, March 9, 2000: A9) is likely to cause a resurgence of interest in religion and spirituality in social work education and practice. In their paper, *"Social Workers' Religiosity and*

Its Impact on Religious Practice Behavior", Mattison, Jayaratne and Croxton join the on-going debate on the subject. In a survey of 1,278 students, the authors found that regardless of race, age, gender or auspices, the social worker's own religious and spiritual beliefs impact their practice with clients. One of the interesting findings is that a significant number of workers had prayed with a client, even when they considered it inappropriate conduct. One of the practice behaviors workers found more appropriate than praying with clients was 'laying on of hands' as a healing technique.

The logo of the Journal underscores its mission that social work practice, research , and social work education are intertwined as each component informs and enriches the other. The integration of the three functions represents the essence of social work as a profession and undergirds its mission for amelioration of poverty and social and economic injustice. We further believe that the concern for effectiveness, accountability and quality of social work practice can be best addressed by the structure of a curriculum designed to integrate three components. Each reinforces the other in this conceptual trinity in ways that connect courses both vertically and horizontally. The application of this tripartite model to curriculum is derived from the framework presented by Meenaghan, Powers and Feld (1978) on curriculum options in pursuit of integrative learning. The variable nature of the problems faced by social workers requires knowledge that emphasizes experiential, theoretical and empirical learning. In order for social work education to contribute to improving practice, it needs to reflect the complexity and demands of the service area.

Appropriate to the Journal mission Sherraden and Sherraden report outcomes of their innovative programs that helped ameliorate poverty among low-income families, especially among women. The authors employed several strategies such as action research, legislative advocacy, education, and program planning to rally state and federal agencies for implementing programs that enabled low-income households to build assets which go beyond mere income maintenance. While income is necessary to sustain daily living of poor people, accumulating assets that involve home ownership, investment in education for children, and the ownership of small businesses moves these families beyond the threshold of poverty. At the Center for Social Development, the George Warren Brown School of Social Work, the authors involved mothers on AFDC and introduced them to two programs: individual development accounts (IDAs) and microenterprise. Using a community development approach, the authors involved multiple sources of matching funds from government and private sectors.

One of the fields of practice that has required the development of new skills on the part of most social workers are services to children and their families. A

growing concern for the failure of the child welfare system to provide adequate safety, permanency, and child and family well-being has provided impetus for the enactment of The Adoption and Safe Families Act (ASFA) in November 1997 (P.L. 105-89) This Act marks the first broad-based child welfare reform legislation since Public Law 96-272 was enacted in 1980. To promote adoption of children from foster homes, ASFA shortens the time limits for reunification work, limits the requirement for an agency to make reasonable efforts, and establishes a time frame for the termination of parental rights. The Act requires states to revise their child welfare laws within the framework of these federal standards and guidelines. Cathleen Graham describes the very laborious and lengthy process experienced in Indiana as it struggled to implement ASFA. She reports that changes to the Indiana child welfare system have resulted in a substantial reduction in the number of children in long-term substitute care. The article raises question whether the changes really serve the best interest of the children who have exited the system. Obviously, a follow-up study of these children is needed to answer this question. Like Graham, there are other experts who argue that this Act might be an ill-considered approach to reforming the foster care delivery system. (See, for example, Holody, 1999).

Working with the elderly is a growing, but neglected area of practice. Because of improved healthcare and the aging of the baby boom generation the proportion of older Americans has been increasing rapidly over the years. By the year 2016 the number of seniors is expected to comprise nearly 16 percent of the population. Thus, they represent one of the most needy populations within the social work practice arena. There is a growing need for skills and services designed specifically for older citizens afflicted with chronic conditions such as mental illness alzheimers, poverty etc. Cummings and Kropf maintain in their paper that there is a serious omission in preparing social work graduates to provide care and services to such vulnerable populations. The authors propose an infusion model whereby content about aging, awareness of mental illness and service needs can find a good fit with the theories of human behavior, and the socio-cultural context taught in HBSE, and the models of assessment, intervention and interviewing taught in the practice sequence.

Poverty and its related problems has always been of primary concern to social workers. Despite affluence and record levels of unemployment, one out of seven Americans is poor. Poverty has a pervasive psychological impact beyond just the lack of income. In the final paper in this issue Pandey and Zhan present data gathered from inner-city Chicago residents including high, medium and low poverty neighborhoods. Among their most salient discoveries was the finding that parents' expectations of their children's educational achievement, and age at which offspring may begin working or marry did not vary by type of neighborhood when parents' demographic characteristics were controlled. While their study refutes the

culture of poverty theory, it does indicate that a parents' educational level is a good predictor of their children's achievement. Accordingly, educated parents expected their children to attain higher levels of education, begin their first job at a later age, delay marriage, and have kids at a later age. The study underscores the importance of investment in education for low-income parents, especially low-income mothers.

I was very pleased and honored to have been asked by the then Dean Roberta Greene to initiate and shepard the development of this new Journal. I was fortunate to have so many talented colleagues to help me in this endeavor. Without their thoughtful and critical input this idea would not have advanced. They deserve my heartfelt appreciation. I would like to extend my deepest gratitude to the distinguished scholars who not only agreed to serve as consulting editors but fulfilled their commitment with promptness and without tears. My special thanks are owed to Dr. Erwin Boschmann, Associate Dean of the Faculties, who not only provided start-up funds for the journal, but also shared his wisdom in shaping the interdisciplinary and national focus of the Journal. I hope we have lived up to his confidence.

It is hoped that this Journal will serve as a forum for exploring a variety of topics that bear on the present and future of the profession as well as on emerging trends that will stimulate debate in our continuing search for knowledge. This introductory issue is a testimony to that commitment.

I undertook the challenge of creating this new Journal two years ago. I have enjoyed the excitement of conceptualizing and developing a foundation for what I hope will prove to be a rewarding new chapter in the school's continuing pursuit of excellence. With the appearance of the first issue, I believe I have completed my obligation. I immensely enjoyed the journey, and to borrow an African proverb I would say: *"We go quickly where we are sent, when we take interest in the journey."* As I move to another university for another assignment, I would say: ***Sayonara,*** my friends! And Good Luck!

I wish all the best for my successor. I am sure the Journal will scale new heights of excellence under the leadership of the new editor.

June 5, 2000 Paul Sachdev, Editor

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MESSAGE FROM THE DEAN

It is a source of great pride for the Indiana University School of Social Work (IUSSW) to present this first issue of its journal *Advances in Social Work.* Our hope in initiating this new publication is that it will provide an opportunity for faculty, student and practice scholars from around the world to disseminate their research findings and conceptual frameworks as they apply to social work practice and for practice experience and wisdom to contribute to hypothesis development and research. *Advances in Social Work* is conceived of as a generic and global journal covering all social work methods and fields of practice. We invite contributions from practitioners, faculty and students.

An important element of the IUSSW research program is the evaluation of agency services and practitioner interventions at individual, organizational and community levels. This research program builds on significant community partnerships and provides for the active interaction between practice and research. The IUSSW research and community involvement have provided the impetus for the development of *Advances in Social Work.*

As with any new enterprise we are grateful to the many people who have contributed to its implementation. My personal thanks is extended to the editor and editorial board who have nurtured the journal from conception to birth and to our support staff for their word processing creativity. Our appreciation is also extended to the contributing editors for their support and able assistance as referees reviewing articles submitted for publication.

The IUSSW was founded in 1911 to provide opportunities for faculty and students to apply theories of human behavior on behalf of the well being of Indianapolis residents. The educational program was influenced by the settlement house movement, family welfare services and hospital and medical programs. Over its nearly nine decade long history the School has taken pride in its role of educating competent, thoughtful, contributing social workers. Its graduate program was first accredited in 1923, its baccalaureate program was accredited in 1975 and in 1994 its doctoral program was approved and initiated. The publication of *Advances in Social Work* is another milestone in the School's history providing an outlet for the dissemination of knowledge.

Sheldon Siegel
Interim Dean
May, 2000

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CEU ARTICLE

What Social Workers Should Know About Ethics: Understanding and Resolving Practice Dilemmas

Elaine P. Congress

ABSTRACT: *Recognizing ethical issues and dilemmas that arise in professional practice is crucial for social work practitioners, educators, and students. After a discussion about the limited, although growing, literature on social work ethics, the ten main tenets from the most current NASW Code of Ethics are presented. These topics include limits to confidentiality, confidentiality and technology, confidentiality in family and group work, managed care, cultural competence, dual relationships, sexual relationships, impairment and incompetence of colleagues, application to administrators and relevance to social work educators. In addition to understanding the Code of Ethics, social workers can use the ETHIC model of decision making for resolving ethical dilemmas. This easy to use five step process includes examining personal, agency, client, and professional values, thinking about ethical standards and relevant laws, hypothesizing about consequences, identifying the most vulnerable, and consulting with supervisors and colleagues. A case example involving confidentiality, HIV/AIDS, and family therapy demonstrates how social workers can use the ETHIC model.*

While the social work profession has always been value-based and ethical practice has long been an educational concern (Pumphrey, 1959), within the last twenty years there has been increasing interest in this topic (Reamer, 1995b). Over the years the ethical focus has shifted from a focus on the morality of the client to the ethical behavior of the practitioner (Reamer, 1995b) and most recently to social work educators (NASW, 1996).

The NASW Code of Ethics provides a standard for ethical practice for social work practitioners and educators. This chapter has two objectives 1. a discussion of what is new about the current Code of Ethics and 2. a proposed model for ethical decision making (ETHIC) that is easy to apply to complex ethical dilemmas. The goal is to improve ethical practice and decision making among practitioners and educators.

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ETHICS AND PRACTICE

The social work value and ethical base for the profession has been reaffirmed in the centennial year of our profession (Reamer, 1998). In addition to generic texts on social work ethics (Lowenberg & Dolgoff, 1996; Reamer, 1995b; Rhodes, 1991), a review of *Social Work Abstracts* for the last decade lists thirty-one (31) professional journal articles on social work values and ethics. Many of these articles have focused on ethical concerns in health care (Abramson, 1990; Beauchamp & Childress, 1994; Callahan, 1994; Congress and Lyons, 1992; Fandetti and Goldmeier, 1988; Joseph and Conrad, 1989; Proctor, Morrow-Howell & Lott, 1993; Roberts, 1989). Other literature relates to different fields of practice including HIV/AIDS (Abramson, 1990), child welfare (Pine, 1987), and school social work (Berman-Rossi & Rossi, 1990; Congress & Lynn, 1994; Garrett, 1994). With the increase in malpractice litigation, more literature has focused on liability and malpractice issues (Houston-Vega, Nuehring, Dagio, 1997; Reamer, 1994). *Controversial Ethical Issues in Social Work* Practice (Gambrill and Pruger, 1996) considers ethical debates in social work practice, while two of the most recent books on social work ethics have focused on the new Code of Ethics (Congress, 1999a; Reamer, 1998).

CODE OF ETHICS

The first Code of Ethics for the National Association of Social Workers contained fourteen abstract statements listed on one page (NASW, 1960). The Code was revised and expanded in 1967, 1979, 1990, 1993, and 1996. Previous codes had been critiqued as not stressing professional standards (Jayaratne, Croxton, & Mattison, 1997). Although the previous code can be applied to social work educators (Lewis, 1987; Congress, 1992) and administrators (Congress, 1996), there were not specific sections referring to administrators (Congress & Gummer, 1996) and educators (Congress, 1992). Another concern was that the code spoke primarily about individual treatment concerns, rather than group work (Dolgoff and Skolnick, 1992). The current 27-page Code addresses many of these issues. Professional standards are presented, as well as sections on educators, administrators, and group workers (NASW, 1996). Included in the code is a description of core values, as well as ethical standards. While some standards are aspirational, others are enforceable guidelines for professional conduct. The Code of Ethics contains standards for social workers in six main areas: 1. responsibilities to clients, 2. responsibilities to colleagues, 3. responsibilities in practice settings, 4. responsibilities as professionals, 5. responsibilities to the social work profession and 6. responsibilities to society. The new Code was developed by a national committee of social work educators and practitioners appointed by the national NASW Board of Directors. This committee solicited input from professionals

around the country before the Code was ratified by the NASW Delegate Assembly in August, 1996.

ETHICS AND SOCIAL WORK EDUCATION

More than forty years ago an early social work educator, Muriel Pumphrey (1959), identified the need to teach students about conflicting values in social work ethics. While ethical dilemmas in supervision have previously been identified (Levy, 1973; Cohen, 1987; Congress, 1992a), ethical challenges for faculty advisors around conflicting duties and responsibilities to school, agency, and student have recently been identified (Congress, 1997). A new area in social work ethics, dual relationships, has been discussed in the context of social work education (Congress, 1996).

The Curriculum Policy statement mandates that social work values and ethics be included in curriculum (CSWE, 1996). How should students learn this content? Should ethics be taught as a discrete course or integrated throughout the curriculum? Research suggests that a discrete course may be more effective in teaching social work students about values and ethics (Joseph, 1991; Joseph and Conrad, 1983; Reamer and Abramson, 1982). A discrete course in ethics can be used to integrate ethics into different areas of required curriculum (Congress, 1993). While in 1989 only 10% of accredited graduate programs offered a separate required or elective course on ethics (Black, Hartley, Whelley, & Kirk-Sharp, 1989), recent research suggests that almost half of graduate programs may offer either a required or elective course on ethics (Congress, 1999).

Students may study social work ethics in a separate course or in many courses. Yet much of ethical behavior is learned through observing their teachers (Congress, 1992b; Congress, 1997; Lewis, 1987). Ethical standards "caught" by students may be more significant than what is taught (Lewis, 1987, p. 3). This speaks to the importance of the social work educator not only knowing the Code of Ethics, but also incorporating ethical standards into educational practice.

NEW PROVISIONS IN CODE OF ETHICS

Preliminary research in this area suggests that even advanced social work practitioners are not that aware of new code provisions (Congress, 1999.) While not exhaustive, the following ten areas focus on new issues in the Code of Ethics:

1. **Limits to confidentiality**

   While the earlier Code of Ethics prevented the disclosure of information only for "compelling professional reasons," the new Code of Ethics spells out what these compelling professional reasons are. (NASW, 1993, p. 4; NASW, 1996, p. 10). Social workers are advised to maintain confidentiality, except when it is necessary to prevent serious, foreseeable, and imminent

harm to a client or other identifiable person. Confidentiality can be breached in reporting child abuse, as the child may be at risk of harm. Also social workers are able to violate confidentiality when a client is suicidal or homicidal. The social worker who suspects child abuse or works with a suicidal client can feel supported by the current Code of Ethics in making a decision to breach confidentiality.

While the 1996 Code originally contained the phrase "when laws or regulations require disclosure without a client's consent" the 1999 Delegate Assembly amended the Code of Ethics to exclude this phrase. There was concern about the growing number of state laws regarding reporting of undocumented people or homosexual couples who want to adopt children. These laws are seen as contrary to our ethical principles that oppose discrimination against people because of legal status or sexual orientation (NASW, 1999).

2. **Confidentiality in technological age**

For the first time, social workers are advised to protect confidentiality in the use of computers, electronic mail, fax machines and telephone answering machines. Disclosure of identifying information should be avoided whenever possible.

While students were previously advised not to leave charts open on their desks when they went to lunch, they now learn to protect confidentiality by computer passwords and firewalls (Rock & Congress, 1999).

Fax machines present new confidentiality challenges to social workers. Often they are not housed in individual offices, but rather in public office areas where they are accessible to all. Faxed reports are often sent to a fax number with limited knowledge of where they arrive. One social worker recently reported that he frequently received hospital discharge summaries as the number of his home fax machine differed only slightly from that of a large nursing home. Despite the use of passwords, telephone voice mails and e-mail do not protect confidentiality, as they can often be accessed by others.

There are no easy answers. With each new technological advance, confidentiality as we know it is changed forever. To provide for minimal standards of confidentiality in an increasingly less private world, social workers may have to delineate differing degrees of sensitive information and provide differentially for the securing of confidential information. (Rock & Congress, 1999).

3. **Confidentiality - family and group work**

While previous codes focused primarily on individual work in clients (Dolgoff and Skolnick, 1992; Dolgoff and Skolnick, 1996), the new code

addresses confidentiality issues in group and family work (NASW, 1996). The inclusion of ethical issues about groups and families is especially relevant as many social workers see clients in groups and families rather than only individually (Ginsberg, 1995). In providing services to groups and families, social workers should seek agreement with all parties about the importance of maintaining confidentiality, but also inform participants that it cannot be guaranteed.

Because other group members as well as family members are usually not professional social workers, the social worker cannot have the expectation that they will maintain confidentiality. Yet the social worker can explain the importance of confidentiality and discuss with the client group or family how the worker will handle confidential information.

4. **Managed care**

While managed care is not cited specifically in the new Code, social workers are advised to inform clients of limits to services because of the requirements of third party payers in sections about informed consent (NASW, 1996, 1.03a, p.7-8) and confidentiality (NASW, 1996, 1.07 d, e, and f, p. 10-11). Although social workers debate about whether managed care threatens client and worker autonomy (Munson, 1996) and confidentiality (Davidson and Davidson, 1996), "managing ethics under managed care" has been seen as possible, although challenging for social workers (Reamer, 1997). Social work practitioners must be alert to when managed care conflicts with social work ethics. Challenges to confidentiality with extensive reporting to managed care companies, as well as limits to service for vulnerable populations, are two main areas of ethical concern. Social work practitioners can be active as client advocates in preserving clients rights in a managed care environment.

5. **Cultural competence**

For the first time, the new Code includes a section on cultural competence and social diversity. Social workers are now expected to understand culture and its function in human behavior with an emphasis on the strengths perspective. Social workers are advised to develop a knowledge base of their clients' culture and demonstrate competence in providing services to people from different cultures. Finally, the current Code mandates social workers to "obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religious, and mental or physical disability" (NASW, 1996, p.9).

A concern about this code provision is how realistic is the expectation that social workers know about all their client cultures, especially in large urban areas with clients from many countries. One social worker who worked in the emergency room of a large public city hospital reported that in the course of the day she had seen clients from twenty different cultural backgrounds. Asking clients about their cultural backgrounds has been seen as a therapeutic and empowering method to use in learning about clients' cultures (Ortiz-Hendricks, 1997).

Another key question is, does learning about characteristics of specific cultures lead to over generalization and stereotyping about cultural characteristics? Self examination is often an important first step in developing cultural and social sensitivity (Aponte, 1991: Ho, 1992; Ortiz-Hendricks, 1997). Also asking clients about specific aspects of their cultural backgrounds and completing a culturagram (Congress, 1994) have been seen as helpful in this area.

6. **Dual relationships**

The current Code of Ethics states that social workers should avoid dual relationships in which there is risk of exploitation or potential harm to clients (NASW, 1996). When the primary relationship is therapeutic, social workers should not enter social, business, or educational relationships with clients. If dual relationships cannot be avoided, the responsibility is on social workers to set appropriate culturally sensitive limits. Dual relationships in agency practice may lead to role reversal (Kagle and Giebelson, 1994), while dual relationships in academia may lead to exploitation of students with limited power (Congress, 1996).

After much debate at the Delegate Assembly, the provision about dual relationships appeared for the first time in the 1993 Code of Ethics. Many social workers, especially in rural areas, indicated that avoiding dual relationships with clients was impossible. In small towns often clients' children went to school with social workers' children. Social workers and their clients often attended the same PTA meetings. Because dual relationships at times cannot be avoided, social workers—not clients—should assess if the relationship is potentially exploitative or harmful to the client.

While almost all social workers report that sexual relationships with current clients are unethical, they are much less certain about friendship and employment relationships with former clients (Borys and Pope, 1989). Discussing the appropriateness of dual relationships with other colleagues and applying the ETHIC model of decision making can strengthen their skills in deciding when dual relationships are unethical and should be avoided.

7. **Sexual relationships, physical contact, and sexual harassment**

The current Code has very extensive prohibitions about sexual relationships with clients.. While the previous code only addressed the avoidance of sexual relationships with current clients, the new Code forbids sexual contact with former clients, future clients, clients relatives, or close friends.

While almost all practitioners believe that sexual contact with current clients is unethical (Borys and Pope, 1989; Gechtman, 1989), there is less consensus about intimate relationships with former clients (Jayartne, Croxton, & Mattison, 1997). Social workers are more likely to condone relationships with former clients if the initial contact has been brief, occurred many years ago, and did not involve psychodynamic therapy. The overwhelming majority (95%) of social work educators believe that sexual contact with current students is unethical, while a much smaller percent (60%) in contrast to practitioners believe that sexual contact with former students (clients) is unethical (Congress, 1999).

The current code prohibits social workers from engaging in physical contact with clients when there is possibility of psychological harm. The responsibility rests with the worker to set appropriate boundaries. While the provision about physical contact with clients arose primarily because of concern about sexual abuse of children, the extent of appropriate physical contact with children is often debated.

A prohibition about sexual harassment with clients and colleagues is also included in the current code. Most agencies, as well as schools, have policies about sexual harassment. Despite institutional policies, however, more than half of the graduate social work programs report one or more incidents of sexual harassment (Singer, 1994). Because cases of sexual harassment often become a school or agency secret, the actual incidence of sexual harassment may be much higher.

8. **Impairment and incompetence of colleagues**

While in the previous 1993 Code a social worker who believed a colleague's impairment due to personal problems, psychosocial distress, substance abuse, or mental health difficulties interfered with practice effectiveness was advised to consult with that colleague, the new Code extends that responsibility. If the colleague refuses to address the issue and seek help for the problem, the social worker is now advised to take action through employers, agencies, NASW, licensing, and regulatory bodies.

Practitioners must assume responsibility for ensuring that social work colleagues not engage in impaired or incompetent practice. Many professional social workers, as well as students, can report occasions on which professional social workers demonstrated poor practice because of substance abuse, burnout, or mental health problems.

At times, substance abuse becomes an agency secret, similar to a family secret about which all know, but rarely speak. Practitioners quite accurately perceive that they have limited power and fear that if they speak to colleagues about substance abuse problems or report impaired behavior to supervisors, then their own occupational progress might be jeopardized. Often NASW can and does provide support to social workers about how to talk with colleagues about substance abuse problems and how to pursue the problem through other channels (Congress and Fewell, 1994).

9. **Application to administrators**

While the earlier NASW Code seemed to apply primarily to direct service practitioners, the new Code includes a section specifically on administration. Social work administrators are advised to advocate for resources in and outside of agencies to meet client needs. They should seek to allocate resources in an open and fair manner. When all clients needs cannot be met, they are required to develop an allocation procedure that is nondiscriminatory. The need to provide adequate staff supervision, as well as a working environment consistent with the Code of Ethics, is also enumerated.

Many direct service practitioners believe that administrators are "above" the Code of Ethics. It is important that practitioners learn that the Code of Ethics applies to administrators who often must struggle with making decisions about the equitable distribution of scant resources (Congress, 1996). Practitioners need to become aware of how ethics affect everyone in an agency (Levy, 1983).

10. **Education and Training**

For the first time the new Code of Ethics specifically addresses issues for educators and trainers. Social work educators are advised to provide instruction only in their areas of competence, and this instruction should be based on the most current knowledge and information. Dual relationships with students should also be avoided when there is a risk of harm or exploitation to the student.. An important new Code provision codified an acknowledged field instruction practice, i.e. that social workers should ensure that clients are informed when students provide services (Feiner and Couch, 1985; NASW, 1996).

In their roles as field instructors, practitioners are required to keep current about social work knowledge and practice skills. This mandate is especially challenging for social work supervisors now with the influx of new knowledge and research in the social sciences. Continuing education for social work supervisors is especially crucial at this time.

ETHICAL DECISION MAKING

Being informed about the current Code of Ethics, however, is only an initial step for social workers, as frequently they encounter ethical dilemmas in which there is a conflict of social work values and/or ethical principles. As Perlman (1975) has written, a social work value has little value unless it can be translated into ethical practice. Only to know about the Code of Ethics does not make one an ethical practitioner.

How social workers resolve ethical dilemmas has been a subject of some concern to the profession. Social workers are often guided by two main principles. The first beneficence (or positive obligations) speaks to providing good, while the second principle nonmalfeasance (or negative obligations) relates to causing no harm (Reamer, 1995b). Both principles affect ethical decision making. Those who favor beneficence would most likely take a proactive stance, while those favoring nonmalfeasance would favor the least intervention. Social workers acting from a nonmalfeasance perspective might decide to take no action and wait for further results.

Although social workers may not be aware of this, they frequently rely on two philosophical models—deontological and teleological—in resolving ethical dilemmas (Reamer, 1995b). Deontological thinkers believe that social work values such as self determination and confidentiality are so absolute and so definitive of the profession that to deny them would lead to distrust of the professional.

Many social workers, however, use a teleological approach that involves examining the consequences of the situation. Deontologists and teleologists, however, do not always find themselves on opposite sides, as two deontological thinkers might argue about the importance of two contradictory absolute principles such as self determination or the protection of society. In a similar way two teleological thinkers might envision two very different consequences of their decisions.

Most social workers use a combination of deontological and teleological thinking. One can argue that the values of the social work profession are deontological in nature, but often social workers use teleological consequential arguments to decide complex ethical dilemmas. Many social workers do not use a philosophical approach at all, but base their decisions on practice wisdom

(Walden, Wolock, Demone, 1990) or the Code of Ethics (Congress, 1992). Although there has been a proliferation of books and articles on ethics over the last twenty years, the number of ethical decision making models are few. Lewis (1984) first developed a model of ethical decision making that incorporates both deontological and teleological thinking but proposes that the deontological approach should prevail. Reamer (1995) proposes a deontological system based on Rawls' theory of justice and Gewirth's rank ordering of conflicting duties. Lowenberg and Dolgoff (1996) use a hierarchical model in which different social work values are ranked to help social workers arrive at the best ethical choice.

Social workers, however, frequently make speedy decisions without much deliberation (Wolock, Walden, Wolock, Demone, 1990). This may be related to limited time in which to make decisions, as well as perceived organizational constraints. Moreover, social work practitioners may approach ethical decision making with dread due to fear of making the wrong decision in a litigious environment. There also is anxiety that the process of ethical decision making will require a consideration of very weighty, abstract principles that may seem very removed from practice realities.

In order to make ethical decision making fast and simple and apply to a variety of ethical dilemmas, the ETHIC model of decision making was developed to help social workers make ethical decisions as quickly and as effectively as possible (Congress, 1999a). The following model includes social work values, the Code of Ethics, and the social work context. Based on an easily remembered acronym, the ETHIC model is presented in Table 1 and described more fully below:

TABLE 1. ETHIC Model of Decision Making

E	**Examine relevant personal, societal, agency, client and professional values.**
T	**Think about what ethical standard of the NASW code of ethics applies, as well as relevant laws and case decisions.**
H	**Hypothesize about possible consequences of different decisions.**
I	**Identify who will benefit and who will be harmed in view of social work's commitment to the most vulnerable**
C	**Consult with supervisor and colleagues about the most ethical choice.**

Examine relevant personal, societal, agency, client and professional values.

Personal, societal, agency, client and professional values all influence ethical decision making. The social worker who relies only on professional values is not likely to have a full understanding of important contextual issues to use in making decisions. An important initial step for social workers is to assess their own personal values if they want to avoid making decisions based on their personal, rather than professional values. Furthermore, an examination of client values is very important, especially with culturally diverse clients whose values may differ from the personal and professional values of many traditional social workers. An example of this occurred when an Anglo social worker became increasingly aware that she was imposing her personal and professional values about self determination on an adolescent client who based his personal educational objectives on family responsibilities.

A discrepancy between agency and professional values can also produce conflict for the social worker. For example, the social worker supported the professional value of confidentiality, yet in an attempt to promote greater efficiency in handling records the agency had introduced a new computer program with inadequate safeguards to protect confidentiality.

Think about what ethical standard of the NASW code of ethics applies, as well as relevant laws and case decisions.

The ethical standards in the NASW Code of Ethics are divided into six sections:

1. Social workers' ethical responsibilities to clients
2. Social workers' ethical responsibilities to colleagues
3. Social workers' ethical responsibilities to practice settings
4. Social workers' ethical responsibilities as professionals
5. Social workers' ethical responsibilities to the profession
6. Social workers' ethical responsibilities to the broader society.

If the ethical dilemma involves an issue about appropriate treatment for clients, the social worker might want to examine the section under responsibilities to clients. Topics in this section include conflicts of interest, self determination, informed consent, confidentiality, access to records, and issues

about payment for service and termination of service. The standards can be viewed as deontological (absolute) principles for the social work profession.

Social workers need to be cognizant of relevant federal, state, and local laws that may affect the ethical dilemmas they encounter. Social work ethics is different from, but often parallels, legal regulations. While laws and social work ethics usually coincide, there may be times when they conflict (Thompson, 1990; Dickson, 1995; Dickson, 1998). The social worker needs to be aware when a law or regulation may be unethical. Discriminatory laws about reporting of undocumented people or homosexual couples may be current examples.

Hypothesize about possible consequences of different decisions.

This step makes use of teleological reasoning to resolve ethical dilemmas. If protecting confidentiality is a concern, the social worker should think about different scenarios, one in which confidentiality is maintained, and the other in which confidentiality is violated. The social worker can list pros and cons about maintaining confidentiality versus breaking confidentiality. Examining possible results helps the social worker decide which is the preferred alternative for the ethical dilemma.

Identify who will benefit and who will be harmed in view of social work's commitment to the most vulnerable

Often social workers must decide between two bad alternatives, rather than one that is clearly right and clearly wrong (Keith-Lucas, 1977). This step may elicit very convincing reasons for or against different courses of action, especially when the Code of Ethics seems to support contradictory decisions.

Social work has had a lengthy tradition of concern for the most vulnerable in our society. The concern for the most vulnerable may distinguish social work from other professions (Lewis, 1972). On a macro level, concern for the most vulnerable has been proposed as a governing principle in regard to downsizing (Reisch & Taylor, 1983). As the current Code proposes that "social workers should act to expand choice and opportunity for all persons, with special regard for vulnerable, disadvantaged, oppressed, and exploited persons and groups" (NASW, 1996, p 27), this step is most important for social workers in resolving ethical dilemmas.

Consult with supervisor and colleagues about the most ethical choice

Although often ethical decision making occurs alone, talking to other colleagues who can suggest alternatives or present new information can be very helpful. A social worker who has a supervisor should use this person as a first resource in ethical decision making. With current cutbacks, more experienced

workers and even beginning workers may have minimal supervision. Social workers are encouraged to bring questions about ethical dilemmas to other colleagues for informal consultation. Sometimes, ethical dilemmas can be presented as part of a case conference and social workers can help the agency develop ethics committees.

The formation of ethics committees may be especially useful in a multi-discipline agency in which the social worker works with other professionals who may not share social work values and ethics (Joseph and Conrad, 1989.) Differences between social workers and doctors (Roberts, 1989) and public school educators (Congress and Lynn, 1994) have been noted. When social workers participate in ethics committees, however, their decisions about ethical dilemmas are often respected by other members (Joseph and Conrad, 1989).

APPLYING THE ETHIC MODEL

Since the first identification of HIV/AIDS as a very serious, but greatly stigmatized health problem in the early 1980's, the social work profession has continued to stress the importance of maintaining confidentiality in working with people with AIDS. Preserving confidentiality has been seen as essential to the establishment and continuation of a helping relationship. (Abramson, 1990).

With the spread of AIDS to the heterosexual population and more specifically to those with no known risk behavior, maintaining of confidentiality surrounding AIDS has been questioned. The development of medications that have transformed AIDS from a terminal to chronic illness has also led to the need to know early who is affected even if confidentiality is at risk.

The new Code of Ethics promises confidentiality except when "disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person" (NASW, 1996, p.10). This principle relates to the Tarasoff Decision in which the courts established a duty to warn an identified victim by stating that "the protective privilege ends when the public peril begins." (Tarasofff 1976: 336-337.) Some have argued that the Tarasoff case is not applicable to the AIDS situation, as often there is not an identifiable victim. Also, violating a client trust may have negative consequences for the client continuing with treatment and/or engaging in safe sexual practices. Others have argued that an HIV-positive individual places an uninformed sexual partner at risk and thus is relevant to the Tarasoff case. The courts as well as ethicists seem to be divided about the correct course of action, but a model of ethical decision making can help the clinician understand more clearly the issues involved and begin to resolve the ethical dilemma of duty to warn with clients who are HIV positive.

The following case example illustrates the application of the ETHIC model in marital therapy when one is HIV-positive.

Marlene, an experienced MSW, was seeing the Smith family for marital therapy. Their conflicts had increased steadily over their four-year marriage. One of their main stressors was financial (Tom had not been able to work steadily, but occasionally found short term construction jobs, while Joan worked full-time as a cashier at a local grocery store). Another involved their futile attempts to start a family. Both came from a large family and wanted many children, but after trying for four years they still did not have any children. Joan's only pregnancy had ended in a miscarriage at three months. Another area of concern was that Tom was increasingly coming home late from construction jobs after stopping off at a local bar to have a few beers with his friends. One afternoon, Marlene received a frantic call from Tom. Recently he had applied and been accepted for a maintenance job at a local hospital and he was completing routine medical tests needed for employment. His test for HIV antibodies had come back positive. He knew there must be some mistake. He was going to have the test repeated, but he had called Marlene because he just needed to talk to someone. Tom felt that he could not tell his wife as she might leave him. She would be sure to blame him for causing his own illness because he had a three-day drinking binge last year when he disappeared from the house and returned not remembering anything that had happened during this period of time. Tom repeatedly asked Marlene not to tell his wife. He reminded Marlene that he had been promised confidentiality when he first began treatment.

In an attempt to resolve this ethical dilemma, Marlene applied the ETHIC model:

Examine relevant personal, social, agency, client and professional values.

Marlene began to look very carefully at her own countertransference reactions to people with AIDS. Many social workers have negative attitudes toward people with AIDS. (Ryan & Rowe, 1988). Marlene realized that although her professional education had taught her otherwise, she felt that a person afflicted with AIDS had almost all the time brought it upon themselves. She thought about homosexuals who were very sexually active, about IV drug users who continued to exchange needles despite the risks. She remembered her family's "black sheep," her second cousin who had been abusing drugs since early adolescence and had died last year of AIDS. She wondered if she blamed

Tom for not pursuing help with his alcohol problem earlier and thus avoiding his three-day binge and infection with the HIV virus.

In terms of her treatment of this couple, Marlene wondered if she was always more supportive of Joan, as trying harder to make the marriage work. She also thought that her identification and greater support of the wife in a marital couple might be related to her interest in feminist issues.

Marlene knew about negative social values regarding people with AIDS. She acknowledged that her own personal values had been in part shaped by societal tendency to blame the victim. Often, people with AIDS are thought to be responsible for their illness because of their behavior either as a member of a stigmatized population of homosexuals or IV drug abusers. Similar to the worthy and unworthy poor concept, Tom would be considered an unworthy AIDS victim as he "brought the illness on himself," while Joan, if she were to contract the disease, would be viewed as a "worthy" AIDS victim as she caught the disease unknowingly as the wife of an infected person.

What were the agency's values about AIDS, about confidentiality? Marlene knew that the mental health agency where she worked did not have any written policies about AIDS, despite a large number of clients who were HIV-positive. She wondered if her agency was similar to many agencies in which not talking about AIDS, maintaining it as a secret, was a way of denying its existence. Her agency did have policies about confidentiality. Most of these policies, however, were written about individual clients, despite the fact that increasingly clients were seen in marital, family or group modalities.

What were the client values? Joan realized that as a marital therapist she must understand the values of both her clients. She knew now that Tom seemed to place a high value on confidentiality, perhaps a lesser value on keeping the relationship together. Marlene was less clear about Joan's values about confidentiality, probably because it had never been challenged. She did know that Joan was very committed to maintaining the marriage, no matter what problems the couple had.

Finally, Marlene examined professional values. She knew that the social work profession believed that people with HIV/AIDS were often stigmatized in society. Maintaining confidentiality was seen as an important way to prevent discrimination. Yet she knew that as a professional, she had a responsibility to both clients. Concerned with ethical issues in regard to working with a couple, she had discussed in the beginning how information should be shared with both people, that she would not maintain "secrets" with one member, yet she never anticipated that the secret would be AIDS, about which there was a strong demand to maintain confidentiality.

Think about which Ethical Standard of the NASW Code of Ethics applies, as well as relevant laws and case decisions.

Marlene looked carefully at the new Code of Ethics in trying to decide what would be the best course of action. She read about clients' "right to privacy (and protecting) the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons" (NASW, 1996, p. 2). She wondered if protection of Joan and a possible child was a "compelling professional reason" for which "disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person." (NASW, 1996, p. 2) The state she lived in supported maintaining strict confidentiality about HIV status. Marlene knew there had been some attempts to apply the Tarasoff case in terms of duty to warn to HIV/AIDS cases, but that the results had been mixed.

Hypothesize about different courses of action and possible consequences.

Marlene tried to think through various courses of action. If she maintained confidentiality, Tom would be pleased. He would continue to come to see her to work with Joan on their marriage. Furthermore, he could receive her support and help in addressing psychological or physical consequences of his HIV/AIDS diagnosis. He could be encouraged to share his health status with his wife at a later time.

On the other hand, there might be serious consequences of not sharing with Joan information about Tom's HIV status. Joan might not be HIV-positive and every day Marlene delayed informing Joan increased the risk of her also being HIV-positive, especially as they were trying to have children. If Joan learned after the fact that Marlene had known about the risk of exposure to AIDS and did not share this information, she could sue Marlene for exposing her to a "clear and imminent danger." Also, by maintaining Tom's confidentiality, Marlene seemed to be promoting Tom's right to confidentiality as more important than Joan's right to well being. When two clients have conflicting positions, Marlene would appear to be siding with one partner, by entering into a collusion around the AIDS secret.

What would be the consequences of violating confidentiality? The best possible scenario is that Joan will be saved from becoming HIV-positive and will be very supportive of Tom. Tom may secretly thank Marlene for telling Joan the secret he could not share. A more negative consequence is that Tom will leave treatment, break up his marriage, or have increasing binges which might increase the possibility of AIDS infection for others. Also, he could charge Marlene with a violation of confidentiality through the NASW Committee on Inquiry, the State Licensing Board, and/or the state court system.

Identify who will benefit and who will be harmed in view of social work's commitment of the most vulnerable.

If Marlene maintained confidentiality, it would seem that Tom would benefit since his HIV status would remain secret. It can be argued, however, that this would only be time limited. Joan would be harmed in that she would remain uniformed about her exposure to the HIV virus, and furthermore, there is a risk to her anticipated child.

If Marlene decides to tell Joan about Tom's HIV status, Joan will benefit in that she can avoid exposure to HIV virus and also the possibility of giving birth to an HIV infected child. One can anticipate, however, that there may be some harm to Tom in terms of a violation of confidentiality and trust in the therapeutic relationship.

The current Code of Ethics speaks of our professional responsibility to vulnerable people and social work literature has repeatedly addressed the fact that the rights of the most vulnerable should prevail (Lewis, 1972; Reisch and Taylor, 1983). One might argue in the above case example that Joan is the more vulnerable and thus the benefit to her should have greater weight than the benefit to Tom.

Tom and Joan's differing rights are in conflict in this case example. While the principle of confidentiality (Tom's right) is certainly a basic principle in social work practice, the principle of preservation of life (Joan's right) seems more important. While conflicting benefits were in question, a hierarchy of rights such as presented by Lowenberg and Dolgoff (1996) may be helpful.

Consult with supervisor and colleagues about the most ethical choice.

At lunch Marlene discussed the dilemma with two of her colleagues and received conflicting advice. One social worker believed that Marlene definitely should call up Joan, as she (Marlene) had the power to avoid another person being affected with AIDS. Also, Joan was her client, too. What was her responsibility to protect Joan? Her other colleague was concerned about the violation of confidentiality. How could Tom or for that matter Joan ever trust Marlene again? What was the effect on developing a trusting relationship with a client if confidentiality could be so easily violated? Did not Marlene realize why the social work profession had stressed that knowledge about HIV/AIDS must be treated with the utmost confidentiality? By violating confidentiality, did Marlene increase the possibility of stigma and discrimination against Tom as well as Joan?

Unlike many graduates with two years experience, Marlene still had the benefit of a supervisor whom she saw regularly. Her supervisor suggested that Marlene think about what she had discussed about confidentiality with her client. Marlene remembered that at the beginning of therapy she had engaged in an extensive discussion about confidentiality with both Tom and Joan. Ironically, Tom had then raised concerns that Joan would be repeatedly calling Marlene with criticisms about him that Joan would not bring up in the joint sessions. They had then made an agreement that whatever was discussed individually would then have to be brought up in the general session and that Marlene as therapist would support and facilitate the process.

Marlene then used the earlier discussion of confidentiality in terms of this new information. She finally encouraged Tom to share with Joan in a joint session about his HIV status and was there to provide continual support for the couple. Ironically, what seemed to be a major stressor—Tom's HIV-positive diagnosis—brought the couple closer together as both Tom and Joan decided to work jointly on coping with this new problem.

The preceeding discussion illustrates the application of the ETHIC model to an ethical dilemma about AIDS and confidentiality. It also demonstrates the importance of establishing confidentiality guidelines early in work with individuals and couples. One can ask if the situation would have been different if Joan had not been a client. Would Marlene have had any responsibility to share HIV status with a nonclient partner? What about nonclient multiple partners? The duty to warn of the Tarasoff decision has not been applied when there are multiple nonspecific victims (Reamer, 1991).

SUMMARY AND IMPLICATIONS

This paper had two purposes 1. to inform practitioners and educators about the main new provisions in the current Code of Ethics and 2. to present an easily applicable model of ethical decision making. In recent years, the number of charges about unethical practice of social workers has grown (Reamer, 1996). We are also most aware that we live in an increasingly litigious time. Furthermore, there is greater complexity surrounding ethical issues because of greater use of technology, managed care, and medical advances. As social work educators, we must strive to educate future social workers about how to identify and resolve professional dilemmas. How we as educators model ethical practice with students, however, is equally if not more important than what we teach students didactically about ethics (Lewis, 1987; Congress, 1994).

As practitioners, we must struggle with increasingly complex ethical dilemmas. The ETHIC model provides an easy to apply model in a work environment that is increasingly demanding. The last step of the ETHIC model—Consult with supervisors and colleagues—may be especially important when facing thorny dilemmas. Unfortunately, supervision has decreased even

for new graduates in the current environment of diminished social service resources.

When there is minimal supervision, both new and experienced social workers must assume primary responsibility for informal consultation with colleagues within and outside the agency. Continuing education programs and NASW can also be resources for professional social workers struggling with complex ethical dilemmas in the new millennium.

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CEU TEST

1. According to Reamer over the years the focus of ethics has shifted from a concern with the _____ of the _____ to the _____ of the _____.

2. Name two authors of books about social work ethics.

3. The first NASW Code of Ethics in _____ was 1 page and contained 14 statements, while the current Code adopted in ____ is 27 pages with 155 provisions.

4. Some of the standards delineated in the current Code are _____, while others are _____ guidelines for professional conduct.

5. The NASW Code delineates ethical responsibilities in the following areas:

   a. _____
   b. _____
   c. _____
   d. _____
   e. _____
   f. _____

6. _____ the first social work educator to focus on social work ethics identified the need to teach students about conflicting values in social work ethics.

7. The _____ of _____ requires the inclusion of content on values and ethics.

8. Ethical conduct that students observe may be more significant than what they are taught.

   True or False

9. Under what circumstances does the NASW Code of Ethics permit breaching confidentiality?

10. There are special challenges to confidentiality in an _____ era.

11. While previously the Code addressed confidentiality only in terms of ____ _____work with clients, the current Code looks at confidentiality with

_____ and _____.

12. Managed care is specifically addressed in the current Code of Ethics.
True or False

13. Cited for the first time in the current Code, the provision about _____ requires social workers to become familiar with the _____ of their clients.

14. Social workers are mandated to avoid dual relationships with _____ or _____ clients when there is risk of _____ or _____.

15. While social workers agree that dual relationships of a _____ nature with current clients is unethical, they are more divided about whether dual relationships of a _____ or _____ nature should be avoided.

16. When a social worker has a colleague whose behavior is impaired because of substance abuse, what is the first step a social worker should take?

17. The current Code of Ethics for the first time speaks specifically about social workers who function as _____ or _____.

18. Most social workers use a specific detailed model of ethical decision making. True or False

19. Congress's ETHIC model includes the following five steps:

    1. _____
    2. _____
    3. _____
    4. _____
    5. _____

20. Maintaining _____ in working with people with _____ has been seen as particularly challenging.

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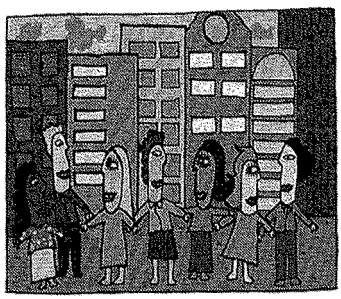

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Ethical Interaction in Cyberspace for Social Work Practice

Stephen M. Marson
Sara B. Brackin

ABSTRACT: *The nature of ethics on the Internet may be confusing to some social workers because of the unique characteristics of client contacts in cyberspace. This article addresses three basic issues/questions that clarify the ethical relationships among clients, other professionals and the Internet. These include: a) What must I do to maintain professional ethical standards on the Internet? b) How do I deal with the unethical interaction of others within cyberspace? c) How do I examine and analyze ethical issues with no clear guidelines?*

Social workers are not alone in noting the complexity of online ethics. Ethical issues equally perplex computer professionals. Laudon (1995:33) states, "There is an ethical vacuum in cyberspace." Stager (1993) shows that there is no clear consensus among computer center directors regarding their legal and ethical obligations. Wood (1993) illustrates that the computer professional's length of experience has little or no influence on understanding computer ethical dilemmas. A computer professional with limited experience can understand the dynamics of ethical decision-making as well as one with 20 years' experience. Neither adequately understands ethics. Wood adds that he does not see any changes in the foreseeable future, and Stager recommends establishing ethical policies at the institutional level

In clarifying the analysis of online ethics, ethical interaction can be divided into two mutually exclusive perspectives. First, some aspects of Internet interaction are so unique that current professional ethical codes cannot provide guidance. These online interactions are unique because they emerged solely from a new technology unfolding new social and ethical norms. Second, some aspects of Internet interaction are *not* unique.

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The medium is new but the interactions and ethical dilemmas can be as old as personkind. Unfortunately, the new medium sometimes muddies one's ability to acknowledge that ethical behaviors face-to-face share common ground with ethical interactions in cyberspace. This article reviews the two perspectives by examining both the online implications of the current professional code of ethics and those of established online guidelines.

The authors believe that the most effective method of summarizing and simplifying the practical application of ethical conduct in cyberspace is found in Figure 1.

Figure 1

Source of Ethical Concern

		Self	**Others**
Level of Commonality Between Real World and Cyberspace	**Common**	Code of Professional Ethics Standards of Practice	Control of Outgoing Information Locking Doors
	Unique	Emoticons Bandwidth Flamewars	Cookies Passwords Encryption

The first step in conceptualizing ethics is to appreciate that ethical conduct in cyberspace has a common bond with activity in the real world, but paradoxically it also has unique features. The second step is to acknowledge that sources of ethical concern in cyberspace must include evaluating self-motivation and assessing one's vulnerability to unscrupulous others. The issues addressed in the cells were introduced in this article, but are clearly incomplete. The matrix helps us unlock the seemingly mysterious nature of cyberspace. Ethical conduct in cyberspace has much commonality with the real world with some deviations. In a sense, studying ethical conduct on the Internet is a study of human diversity and should be approached in the same manner.

Despite the lack of clear ethical guidelines, many professionals are providing "therapy" over the Internet. Morrissey (1997) reports that this practice has prompted many intense debates about the lack of regulation and professionalism. In her article, she reports on concerns that have surfaced about providing ethical guidelines with so many undefined parameters. For example, Morrissey states when a professional organization provides guidelines for cyberspace ethics, it is in effect endorsing this kind of service. Lee (1998) sees Web counseling as counter to the standard therapeutic relationship, but agrees that intervention has merit for the new generation of cyberspace clients. Web counseling would eliminate physical closeness and the ability to observe clients in the environment. Lee expresses optimism about the newly established standards for

the ethical practice of Web counseling published by the National Board of Certified Counselors. Hughes and Ruiz (1998:11) state, "There are undeniable values in Internet technology for counselors. It has great positive potential, yet we need to always be aware of the potential pitfalls."

The act of communicating over the Internet (newsgroups, chat rooms, discussion groups) is a multilevel activity. If a professional organization publishes ethical standards, the court can impose legal sanctions with ease (Legal Research Network, *et al.* 1996). As a result, counseling over the Internet is being scrutinized. Professional Internet communication guidelines for mental health professionals have been noticeably absent and many of the early Web counseling sites reflect questionable professional judgment. Anyone can offer Web counseling and there is no apparent process in place to verify the professional's credentials or ensure client confidentially. For example, the Institute of Transcedendent Analysis (http://www.itai.com) charges $100 for 30 minutes of therapy with a transcendent analyst. There are no names associated with their analysts. The Institute also offers a discount for clients who join ($300 for membership) and a money back guarantee if their overall level of functioning does not improve within the first three sessions. Our review of this and other Web counseling sites suggest that many professionals do not understand that normal ethical protocols (i.e., confidentiality) are *also* applicable to cyberspace intervention.

Bloom (1997) reports on the National Board of Certified Counselors (NBCC) recently approved standards for Web counseling. While not an endorsement of the practice, these standards result from a need to encourage those professionals engaging in online practice to follow ethical guidelines (Morrissey, 1997). However, Bloom questions where ethical responsibility lies. Some mental health professionals have organized and established ethical standards for Web counseling. The following web sites are relevant:

- http://www.metanoia.org/imhs is a consumer's guide to Internet therapy,
- http://www.mhnet.org assesses the quality of Internet therapy sites, and
- http://netpsych.com/web.htm is a clearinghouse for information regarding Internet therapy.

Nationally known professional organizations do not seem to be taking a lead role in assessing the ethical concerns of these therapy sites. The APA (American Psychological Association, 1997) has issued several statements about services by telephone, teleconferencing, and Internet (http:///www.apa/org/ethics/stmnt01.html). At the time of this writing the statement reads:

> In those emerging areas in which generally recognized standards for preparatory training do not exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect patients, clients, students, research participants and others from harm.

In other words, the APA recognizes that the present code of conduct is not specific with regard to Web counseling. The statement concludes that no present code of ethics bars counseling over the Internet and further stresses that psychologists engaged in this type of counseling must consider how service delivery, client confidentially, and all other characteristics are applicable to the present code of ethics.

MAINTAINING ETHICAL STANDARDS

All cyberspace interactions that have ethical implications do not reflect the same level of seriousness. For example, simple courtesies unique to cyberspace or netiquette fall within the realm of online ethical interaction (Shea, 1994). Unlike other ethical transgressions, violations of netiquette do not fall within the realm of legal sanctions, but the repercussions are social sanctions that include serious cyberspace punishment. For example, the law firm of Canter & Siegal posted the following message on thousands of newsgroups:

> Do you want to get a green card for permanent residence in the United States? THE TIME TO START IS NOW!

Over 30,000 users flamed Canter & Siegal, which crashed the firm's computer and led Internet Direct Inc. to terminate their Internet access (Gilpin, 1995). What is confusing about netiquette is that some behavioral standards are unique to cyberspace and do not exist in the real world. On the other hand, many standards of cyberspace behavior are easily recognized from the real world.

NETIQUETTE RULES—UNIQUE TO CYBERSPACE

The most confusing aspect of the code of Internet interaction is that it varies from one location in cyberspace to another. For example, the interactive expectations on a mail list are different from those for a newsgroup. It is common for a particular newsgroup to embrace its own unique code of conduct—different from other newsgroups' code. Serious violations of these codes are dealt with serious social sanctions[1]. Users (either in a newsgroup or a mailing list) attack the offender. How does one learn "how to act?" Shea (1994:60) writes, "Lurk before you leap." Prior to participating, observe and learn how people interact. In this respect, cyberspace applications should be approached in the same manner as any new or unique real social setting. Three

unique characteristics of cyberspace merit special attention because they have no functional equivalent in reality. They include: emoticons, bandwidth issues, and flame wars.

Emoticons

Often joking or sarcasm cannot be clearly articulated in the printed word. Emoticons are critical aspects of communications because they are the functional equivalent of facial expressions or tone of voice in which non-verbal messages are transmitted. Although hundreds are employed, some of the most commonly used can be found in Figure 2:

Figure 2

Most Common Emoticons

Emoticon	**Meaning**	**Emoticon**	**Meaning**
:-)	The smiling face.	:-\	The undecided face.
;-)	The winking face.	:-o	The shocked face.
:-(	The unhappy face.	:-&.	A tongue-tied face
:-t	The cross face.	:-#	Lips are sealed face

Emoticons facilitate clarity of meaning. Although they appear humorous, they are critical for imparting ethical standards to others (Argyle & Shields, 1996).

Bandwidth Issues

Bandwidth refers to the volume of information that hardware and software can handle in a given period of time. In nonacademic settings, bandwidth can create a serious problem. Some commercial vendors have a fee schedule for the space and time utilized by a subscriber. Outside of cyberspace, there is no functional equivalent for this term. Unlike the spoken word, cyberspace communication must be more economical because many users are charged for bandwidth. When we are transmitting to a newsgroup or a discussion group, we must be thoughtful of the bandwidth available to others.

Flame Wars

Deliberately insulting another user may result in numerous emails, each becoming more vicious. These emails can flood a location and crash a system. Some people who enjoy upsetting the balance of a discussion group will send offensive remarks to one or more users. These disrupters remaining anonymous or, impersonating another person, become invisible in cyberspace. This cloak allows them to exercise morally disreputable behavior and avoid detection (Parker, 1995). When users begin to respond to the remarks, a flame war may develop. Flame wars are not intended as lively discussions and by nature are destructive. It is best to avoid them.

NETIQUETTE RULES—A REMINDER OF COMMON COURTESIES

Five general guidelines are shared by both cyberspace and the real world (Shea, 1994). They include:

- Do not use harsh or offensive language
- Be willing to share expert opinions
- Respect others' privacy
- Be forgiving of grammar and spelling slips (first drafts are commonly transmitted)
- Do not exploit one's knowledge of cyberspace toward new cyberspace residents

These guidelines reflect basic human courtesies and are essential components of effectively communicating with others in the real world *and* cyberspace. If one is caught in a flame war or is being personally attached by another user, the best advice is to discontinue further communication with that person or discussion group. When making an important point about a subject that might be interpreted as argumentative, remember to use emoticons. Emoticons clarify one's intent and allow the discussion to remain productive.

Professional Code(s) of Ethics

From an historical perspective, Oz (1993) points out that professional ethical codes for computers technicians and other users generally precede the development of laws governing actions on computers. Thus, awareness of one's professional code of ethics becomes the centerpiece of behavior on the Internet. Reamer (1998) offers an excellent outline and critique of National Association of Social Worker's ethical (NASW, 1996) responsibilities to clients, colleagues, practice settings, and, as a professional, to the profession and society. However, he does not elaborate on the online implications for social work because the Code does not explicitly articulate online issues.

Unlike the APA or NBCC, NASW[2] does not explicitly articulate ethical guidelines for online practice. As a result, an individual social worker must extrapolate meaning from the NASW Code of Ethics. This requires more interpretation on the part of the social worker versus those required by counselor or psychologist. However, the process of applying ethics to online activity is not complex. Figure 3 illustrates a selective commentary on the technological interpretation of the NASW Code of Ethics. It is an example of what a professional must do if no specific online guidelines are written by one's professional organization.

Figure 3
Technological Interpretation of the NASW Code of Ethics

- Social workers are required to be knowledgeable about all practice tools including new technologies. Social workers are expected to pursue appropriate education, training, consultation, research and supervision to ensure the protection of clients (standard 1.04 a-c).

- To the extent that is available, social workers should base their learning about online technologies from recognized experts and empirical based research (standard 4.01 b, c).

- Valid and informed consent must be given to cyberspace clients. Social workers must articulate on the web page and in understandable language: 1) purpose of services; 2) cost; 3) alternative treatments; 4) the right to refuse treatment or withdraw consent; 5) time frame of consent; 6) an opportunity to email questions; and 7) the risk and limitations of obtaining treatment via cyberspace (standard 1.03 a, b, c, e).

- Social workers must not only be sensitive to cultural and ethnic issues within the client's experience, but also must be cognizant of the social norms and values held in cyberspace (standard 1.05 b, c).

  Social Workers must not exploit clients with their knowledge of cyberspace (standard 1.06 b).

- On their web sites, social workers must clearly represent their qualifications, credentials, education, competence, affiliations, services provided, results to be achieved from their services and other dimensions of practice that testify to the quality of service (standard 4.04, 4.06 c). Cyberspace services have a

clear advantage over treatment available in the real world in that the ethics can be available on the web page without having to verbally repeat it to each new client.

- Social workers may not use derogatory language in cyberspace and must be respectful of clients (standard 1.12).

- Once the process of service begins, the social worker must make an effort to assure technological problems do not interrupt treatment (standard 1.15).

- Social workers must have a system (adapted for cyberspace) by which he/she can determine if and when services are no longer required. In addition, social workers are expected to have a reasonable alternative or backup plan that would prevent a client from feeling abandoned (standard 1.16 a, b).

- When the social worker does not have the competence to address the client's problem situation, the social worker must refer to another professional. Such a referral includes employing cyberspace to locate a competent professional -- assuming that the client specifically desires cyberspace intervention (standard 2.06).

- If for any reason, the social worker anticipates an interruption or termination with treatment incomplete, the social worker is obligated to assure that the client receives email explaining the situation. The social worker is obligated to offer alternative treatment - in cyberspace if desired by client (standard 1.16 e).

- Fees and payment method must be clearly spelled out on the social worker's web page. Fee transfer must be completed in a manner that insures confidentiality and secures private financial transactions (i.e., security for credit card numbers) (standard 1.13).

- Social workers must apply cutting edge standards of security in the computer storage of client records (standard 3.04 a-c).

- Social workers must articulate legal limits of confidentiality. This is especially complex because of difference in state

Figure 3 continued...

> statutes. The client and social worker are likely to be located in different states or even countries (standard 1.07).
>
> - Social workers must conduct relevant research and evaluation to assess the impact of online services (standard 5.02 a-c).

Every professional is legally bound to adhere to his or her code of ethics. In cyberspace intervention, this means one must search the code and from it extrapolate the context for cyberspace practice.

DEALING WITH UNETHICAL INTERACTIONS WITH OTHERS

From an ethical perspective, the best analogy for cyberspace is the "Wild West." Without law enforcement, everyone must become self-protective. Cyberspace is a new frontier. As in the Wild West, cyberspace inhabitants must consider the ethical transgressions of others. Major concerns in cyberspace are password protection, encryption, and defense against viruses and worms.

Password Protection

The password is the first line of defense in protecting client confidentiality. Social workers have an especially important responsibility to protect their computer passwords. Crackers,[3] knowing that many cyberspace practitioners do not understand the concept behind the password, have a long history cracking passwords. Disregarding standards for password selection can put a client in serious jeopardy (Rock & Congress, 1999). Stoll (1990) vividly demonstrates the sanctity of passwords. Stoll lays out a story of how spies were able to break into a large number of university computer systems. As a result, the spies (or crackers) were eventually able to tap information from the United States Defense Department.

The accepted standard for password selection can be found in any basic computer article or reference book (Marson, *et al.,* 1994; Raymond, 1996; Santa Cruz Operation, 1995). Guidelines in selection are critical for any cyberspace practitioner housing confidential computer files. If a service provider is found in non-compliance of standard password security measures, a client has solid grounds for a malpractice suit (Legal Research Network, Inc *et al.*, 1996; Sheldon *et al.*, 1999). When selecting a password one must understand how passwords are broken.

The typical methods employed to break passwords include:

- A caller representing himself/herself as being from the computer department asks the secretary to provide the logon ID and other information necessary to get into an account.

- Getting someone's account by watching keystrokes when the password is inputted is extremely common. Some crackers are adept enough at this to be able to do it from across a room.

- Most people adopt a password that is fairly obvious to them—typically the name of their pet, their husband or some other close everyday item that is a favorite of theirs. "Crack" dictionaries exist that will successively attempt to login to an account using all the words in that dictionary.

Counter measures that foil attempts to break a password include:

- Do not share a password with anyone. Instruct your staff not to share one, either.

- Never invoke a password with someone present in your office. This is the functional equivalent of talking about a client in a hallway.

- Never use a password that can be found in any database. Memorize a password and never write it down. Use a mixture of numbers, letters, symbols, and punctuation. Use both upper and lower case letters.

- Change your password at least once every three months.

Encryption

Encryption is the translation of data into a code called cipher text. Only persons with a password or secret key can decode the encrypted data. Encryption is the best method for complying with ethical standards of confidentiality. If we apply the existing standards of NASW, APA, and NBCC concerning a client's right to confidentially, then encryption is a necessity for *all* cyberspace therapy. NBCC's (1997) standards for the ethical practice of web counseling states: "Inform Web clients of encryption methods being used to help ensure that security of client/counselor/supervisor communications." *Any* encryption code can be broken (Electronic Frontier Foundation, 1998) and this is an important point to stress to a client. Almost all web sites boast of secure communications and encryption methods. It is the responsibility of the counselor or therapist to

ensure that methods being used are adequate to protect the clients' confidentially. A good example of how encryption and confidentially can be used can be seen by visiting one of the following web sites:

http://www.flash.net/~wmartin/confidentiality.htm
http://www.flash.net/~wmartin/privacy.htm

Defense Against Viruses and Worms

It is impossible to *completely* protect an Internet connected computer from viruses and worms. Software programs can protect a system from being infected, but these programs are vulnerable to unknown viruses and worms. Johnson (1994) defines virus as any unwanted code, specialty machine code, that will attach itself to another program. When this code is activated, the virus is executed and spread. A virus can delete data files and system files rendering the computer useless. A worm is similar and can be as destructive as a virus. A worm is an independent program that may be running at several different locations. Worms can be used to gather and send information and to infiltrate a system for the purpose of copying information that can be used to break into the systems. The people responsible for these destructive acts are called crackers. Johnson (1994) reports that crackers' mentality is that all information is free without regard to the type of information. Crackers believe they are serving an important role by showing others where the leaks and flaws exist in their systems.

The best protection against virus and worm infections includes:

- Constantly update virus protection software.
- Follow the guidelines for password protection.
- Beware that anything downloaded from the Internet may be infected.
- Beware that any file or program uploaded floppy or CDROM may be infected.
- Email from unknown persons or sources may be infected. Delete the entire email.
- Do not open any unknown executable program sent to you or attached to email. Delete the entire email.
- Be aware that files can contain macros or embedded programs. These programs may execute when the file is open.

- Do not copy pirated software. It is often infected.

The precautions above may seem overly harsh. They are not. A Web page that advertises secure transmission or encryption presents a challenge for an unscrupulous cracker. The challenge of breaking into or destroying a computer system is the underlying motivation for a cracker.

Examining and Analyzing Ethical Issues

Two methods can be employed to address ethical dilemmas that surface but do not appear to be articulated implicitly or explicitly in a standard ethical code: 1) use ethical theories; 2) self questions.

Ethical Theories

Spinello (1997) and Van Den Hoven (1998) provide excellent illustrations of how and why ethical theories are necessary in the computer age. Spinello (1997) reviews Utilitarianism, Kant's moral philosophy, W.D. Ross's moral philosophy, and Rawl's Theory of Justice. He provides a contrast among them by stating (p. 44):

> Despite these differences, each approach represents a unique perspective from which one can assess and deliberate over moral issues. All of these theories seek to elevate the level of moral discourse from preoccupation with "feelings" or gut reaction to a reasoned and thoughtful consideration of the right course of action. Reliance on these theoretical frameworks therefore will surely improve the clarity and substance of ethical decision-making.

Every ethical theory has a flaw, but Spinello (1997)insists that the theories provide the best basis for making decisions regarding situations that are not clearly addressed in a code of ethics.

Van Den Hoven (1998) is much more practical in his analysis of ethical theories. He reviews the general tenets of ethical theories and concludes that the most effective theoretical approach to resolving ethical dilemmas created by computer technology is John Rawl's "Method of Wide Reflective Equilibrium" (WRE). He states:

> WRE incorporates the best of both the universalist and the particularist worlds. It allows for appeals to considered judgments and intuitions concerning particular cases and

> acknowledges the appropriateness of appeals to general principles that transcend particular cases. (p. 242)

In brief summary form, Van Den Hoven (1998) notes that WRE is composed of a set of three beliefs. These include: a) considered moral judgments, b) moral principles, and c) relevant background theories. The disciplined WRE user resolves moral dilemmas by intellectually shifting among sets of beliefs.

Self-Questions

The works of Spinello (1997) and Van Den Hoven (1998) were primarily written for engineers, computer programmers, and computer consultants. Thus, their intent has to be stretched to have meaning for social workers. After explaining that each ethical theory has good points and bad; and that ethical theories have fundamental and unresolvable conflicts, Spinello (1997; page 45) synthesizes the "best" of all theories by developing a question/answer framework. This framework, reproduced below, is translated (and is significantly changed) into a social work context. When one is facing an ethical dilemma that is not articulated in a standard code of ethics, one should ask the following questions on a case-by-case basis:

1. What is the ethical issue? Is this issue considered in state or federal statutes? If yes, is there a conflict between law and morality?

2. What was your first (intuitive) reaction to this dilemma? To what do you attribute the feeling of embarking on a moral or immoral course of action?

3. Does the analysis of various ethical theories facilitate a clearer course of action? If not, what ethical principle should take precedence? Although Spinello (1997) and Van Den Hoven (1998) do a splendid job of summarizing the major ethical theories, social workers will find the work of Bloom (1990) and Jansson (1990) clearer. Bloom and Jansson discuss ethical theories in the context of social work, while Spinello and Van Den Hoven focus on engineers and computer personnel.

4. What should be your agency's course of action? What should be your course of action?

5. What are the macro or policy implications? In this case, should norms of behavior be prescribed through legislation or regulation?

Ethical issues can be taxing when there is no clear course of action. Professional standards are based on benefiting our clients, students, and others and doing no harm. With this in mind, one should decide an ethical issue after answering all of the above questions, consulting with a colleague, and then making a decision based on agreement.

CONCLUSIONS AND SUMMARY

Based on our review of online ethics, several recommendations can be made:

- Because cyberspace is a relatively new medium of communication, ethical standards may be confusing to some. However, it is imperative to acknowledge that when ethical standards in the real world are applicable to cyberspace, social and legal norms can be applied in full force.

- When real world ethical standards are not applicable to cyberspace, one must rely on two different sources. First, ethical theories provide a sound basis for making decisions that avoid legal and social sanctions. Second, each type of Internet service (e.g., newsgroups, discussion groups, Local Area Networks) has its unique standards of cyberspace interaction. Users must learn these standards by "lurking." Sadly, these unique standards are rarely provided in writing. Role modeling is the path for learning how to behave in cyberspace.

- The analogy of the "Wild West" is applicable in cyberspace. Residents of cyberspace must be cautious of the unscrupulous interaction of others. The precautions include compliance to password standards, security for incoming email and programs, and virus and worm protection.

As advances continue to open new dimensions within areas of communication, the shifting paradigm cannot change the basis tenets of ethics. As social workers, we must continue to be accountable for our behaviors. Cyberspace will reflect our attitudes (listserves), emotions (emoticons), and interaction (netiquette) for the public to view. The public will decide if we are worthy of their trust. Cyberspace interaction that does not elicit public trust is in effect operating against our code of ethics. Cyberspace is testing our ability to incorporate accepted standards without jeopardizing our public trust.

NOTES

1. For example, after being cautioned, a Rural Social Work Caucus listserv subscriber continued to violate basic netiquette rules. The manager removed

him from the listserv. Subscribers requested that the manager post a formal netiquette statement. This formal statement is located on the Rural Social Work caucus web page and can be found at: http://www.uncp.edu/ sw/rural/group. html#Netiquette.

2. The 5th edition of NASW's *Social Work Speaks* is likely to include technology policy statement.

3. "Cracker" is a technical term meaning, one who successfully breaks into a secured computer system. Cracking is generally not associated with technological brilliance, but "rather persistence and the dogged repetition of a handful of fairly well-known tricks and exploiting common weaknesses in the security of target systems" (Raymond, 1996, page 130).

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Social Workers' Religiosity and Its Impact On Religious Practice Behaviors

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ABSTRACT: *This study explores the impact of the social work practitioner's religiosity on religious practice behaviors. A random sample of 1,278 social workers who possessed M.S.W. degrees, who provided direct services to clients and were members of NASW were surveyed regarding their personal religiosity. They were also asked about their views on the appropriateness of six Religion and Prayer in Practice behaviors. Variations in Religion and Prayer Practice behaviors were analyzed in relationship to the worker's religiosity, race, gender and employing agency auspice. Regardless of all other factors, the more religious a worker is, the more likely a worker is to view religious and prayer activities in practice as appropriate professional behavior. Implications and recommendations regarding the integration of religion and spirituality in social work education and practice are discussed.*

The social work profession has long struggled with varying opinions on the appropriateness of the integration of religion and spiritual beliefs into social work practice. Spencer (1957) presented a paper entitled "Religious and Spiritual Values in Social Casework Practice" at several professional social work meetings. She noted that "anyone who attempts to discuss this subject is faced with many hurdles," but goes on to say that "despite the difficulties involved in considering the place of religious and spiritual values in human life, there are evidences of a desire on the part of large numbers of people for help in this area and of thoughtful, though still tentative approaches to the problem by leaders in many professions" (p. 519). She further cites the consistent popularity of books on the topic of spirituality and religion among the general public as further evidence to "attest to the search for sources of security and for something to give meaning to life" (Spencer, 1957:519). Spencer's comments seem equally relevant and timely today as we are witnessing an apparent increased interest in religion and spirituality.

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Dozens of best selling books seem to validate that many are looking for ways to integrate physics, philosophy, science, spirituality and religion into their daily lives (Chopra, 1994; Frankl, 1968; Moore, 1992; Myss, 1996; Weil, 1995).

Although forty-three years have passed since Spencer's address, the social work profession and other mental health professions continue to struggle with the appropriate place of religion in social work practice. Responses among practitioners range from embracing full integration of religion into practice to ambivalence, skepticism and outright opposition based on the perception that it's inappropriate, irrelevant and unnecessary (Lukoff, Turner & Lu, 1992; Russell, 1998; Sermabeikian, 1994).

A review of both the historical connections between the social work profession and religious institutions and values, as well as the sources of ambivalence and opposition to these connections, may be useful in understanding the current lack of consensus.

HISTORICAL CONNECTIONS

The social work profession has been connected to religion historically and philosophically. Much of early social work practice in the United States originated within the context of Judeo-Christian religious principles and the philanthropic efforts of religious groups. Often, it was based on a sense of spiritual and religious mission (Leiby, 1977; Russell, 1998; Siporin, 1986; Canda, 1988). Religious concepts regarding love for God and concern for the welfare of others were translated into a moral responsibility for social service, leading to the development of charity organizations in the 19th century (Leiby, 1985). For example, Jane Addams founded Hull House and led the settlement movement using her religious orientation and affiliation as an inspiration and focus for her seminal work with the poor (Stroup, 1986). While she distinguished Hull House as being different from other settlement houses that were missions in the religious sense, the integration of the spiritual and religious can clearly be seen:

> These men were so serious in their demand for religious fellowship, and several young clergyman were so ready to respond to the appeal, that various meetings were arranged at Hull House in which a group of people met together to consider the social question, not in the spirit of discussion, but in prayer and meditation. (p. 190)

Throughout the history of social welfare and continuing into present day practice, sectarian organizations such as Jewish Social Services, Catholic Charities and Lutheran Social Services have played an integral role in the delivery of social work services. Ressler (1998) predicts this trend will not only continue, but that there will be an increase in religion-based social services as government sponsored

programs shift to the private sector. In addition to providing social services, religious organizations have also historically made large charitable contributions to other social service providers (Bullis, 1996; Ortiz, 1991).

Philosophically, social work and religious schools of thought have common values. They both advocate compassion for others and human dignity, and both desire to ease the pain of suffering and to address the needs of the most forgotten and vulnerable in society (Bullis, 1996). There was some acknowledgment of this relationship in early social work education, which addressed religious and spiritual issues in the first Council on Social Work Education (CSWE) Curriculum Policy Statement in 1953. This statement included "spiritual influences" on individual development as a dimension to be considered despite disagreement on whether the term "social" sufficiently addressed the area of religion (Spencer, 1961).

AMBIVALENCE

Ortiz (1991) identifies the crucial question regarding social work and religion not as one of compatibility regarding values and principles, but what causes the tension between them?

Although the social work profession promoted a holistic view of the person, there was a hesitancy to see religious issues as a part of the social work domain. Some viewed religion as an inappropriate part of social work and have advocated for a separation of religious and secular matters involving clients. This was based on a societal bias toward privacy regarding religious matters and a separation of church and state (Joseph, 1987). The reluctance may also have been based on fear of the misuse of religion in social work practice in order to proselytize, fear of violation of client self determination, and a belief that social workers have little or no training to address religious and spiritual issues (Constable, 1990; Millison & Dudley, 1990; O'Neill, 1999; Ortiz, 1991). Debates about such issues as abortion, homosexuality, divorce and euthanasia illustrate the societal context in which these concerns arise.

Despite these concerns, others viewed the assessment of religion and spirituality as essential to understanding both the supports and the barriers to healthy functioning that these beliefs and values may provide (Logan, 1990; O'Brien, 1992; Sheridan & Bullis, 1991; Sheridan, et al, 1992).

As the social work profession worked to establish its identity and credibility, both secularization and professionalization occurred, resulting in a rift from its religious roots (Loewenberg, 1988; Russell, 1998). The desire to emulate the medical model, along with a high value placed on empiricism, raised concern that a focus on religion may decrease the scientifically based credibility of the profession. Spirituality and religious concepts were considered "soft" and unsophisticated by some and even pathological by others (Millison & Dudley, 1990; Richards &

Bergin, 1997; Russell, 1998). This move toward empiricism and a scientific base also led to changes in curriculum policy statements within the CSWE. References to spirituality and religion included by the CSWE in previous Curriculum Policy Statements were missing in guidelines issued in 1970 and 1984 (Russell, 1998).

Although it appears the great majority of the population has some type of religious belief, including 94% who express a belief in God (Gallup, 1985, 1990), mental health professionals in general tend to place far less personal importance on religion than does the general public (Lukoff, Turner & Lu, 1992). Amid this "religiosity gap," professional training focuses on the biological, psychological and community, with less attention given to the spiritual. This may also contribute to a hesitancy to address religious issues with clients. Thus, though social work was largely born out of sectarian organizations, the secular and scientific, rather than the religious and spiritual, has dominated practice throughout much of recent history.

EMERGING PRACTICE TRENDS

Recently, the mental health profession's response to spiritual and religious issues has begun shifting. The DSM- IV recognizes religious and spiritual issues as an assessment criterion and divides associated problems into categories of psychoreligous and spiritual (American Psychiatric Association, 1994). In addition, concepts of spirituality and religion have been reintroduced more recently into the CSWE Curriculum Guidelines with religion identified as an element of client diversity that should be addressed in the curriculum (Russell, 1998).

While previous versions of the National Association of Social Workers (NASW) Code of Ethics (1960-1993) refer to religion only in the context of one of the areas in which discrimination should be avoided, the revised NASW Code of Ethics (1996) expands the social worker's ethical responsibilities to clients to "obtain education about and to seek to understand the nature of social diversity...." with respect to a number of social domains including religion (1.05). The Code also encourages social workers to treat colleagues with respect and to avoid "unwarranted negative criticism" and "demeaning comments" regarding individual attributes that include one's religion (2.01).

However, it is noteworthy that the words "religion" and "spirituality" are not referenced in the code index.

A historical review of a number of influential practice texts reveals no references to religion or spirituality in social work practice (Dorfman, 1988; Epstein, 1977; Hamilton, 1951; Hollis, 1972; Parad, 1958; Perlman, 1957; Reid and Stream, 1978; Turner, 1995). Where references do exist, they are only brief and seemingly stated in passing as in Hollis (1972) who notes that "religion and psychiatry have the same goals; the only question is how to achieve them." (p.129) or Biestek (1957) who briefly notes that:

> The caseworker, especially when his is of a different religion than the client, must respect the conscience of the client and help the client make choices and decisions which are within the boundaries of that conscience. If the client violates the moral law and acts contrary to his conscience, he does spiritual harm to himself. This not only produces psychological difficulties for the client such as guilt feelings, but it also does spiritual damage. The caseworker needs to have a real conviction about the ontological reality of spiritual values. The caseworker is not promoting the total welfare of the client if he helps the client to solve a social or emotional problem by means which are contrary to the client's philosophy of life. (p.116)

More recently, however, the literature reflects a renewed professional interest in religion and spirituality. A featured article in the *NASW News* (September, 1999) entitled "Social Work Turns Back to the Spiritual" indicates that the concepts of religion and spirituality are being re-examined in both social work education and practice and that integration of these concepts may be becoming more mainstream. Several reasons are cited for this renewed interest including: 1) the profession's emulation of the medical model which now has some research indicating the efficacy of spiritual and religious interventions (Cooper, 1995; Dossey, 1993; 1996; Larson & Larsen, 1994; Matthews & Clark, 1998;); 2) 1995 CSWE Curriculum Guidelines that have increased interest in the subject and 3) the increased interest of the American public in topics related to religion and spirituality (O'Neill, 1999). In the same article, O'Neill cites results from a nationwide survey of spiritual beliefs and practices conducted by Furman indicating that social workers are indeed using religious and spiritual language and concepts in their practice.

While a number of previous studies have noted that many practitioners consider religious issues important in working with clients, there has been a lack of emphasis on religion and spirituality in graduate social work education (Derezotes, 1995; Joseph, 1988; Sheridan, et al., 1992). However, a growing acceptance of religion and spirituality as an appropriate area for study in the academic world seems to be emerging. Kilpatrick & Puchalski (1999) surveyed the top 56 social work schools ranked by *U.S. News and World Report* in 1998 and found that 25 (46.6%) of these programs reported having a separate elective course in the curriculum that dealt with religion or spirituality, and 75% reported having courses that included spirituality or religion in the curriculum. Sheridan, Wilmer & Atcheson (1994) reported that 82.5% of 280 full-time social work educators from 25 schools of social work supported inclusion of a specialized, elective course on religion and spirituality. Current estimates are that between 17 and 30 master's degree programs in social work now have elective courses related to religion and spirituality (O'Neill, 1999; Russell, 1998).

If the profession is "getting more religious," then it is important to examine the impact of workers' beliefs and religiosity on clients. While a number of studies previously cited have looked at social worker's attitudes toward religion in practice and education, none explores the impact of the social work practitioner's religiosity on religion and prayer practice behaviors. This paper examines worker religiosity as it relates to religious practice behaviors within the context of race, gender and agency auspice. Implications and recommendations regarding the integration of religion and spirituality in social work education and practice are discussed within the context of study findings.

METHODOLOGY

The sample for this study was drawn from eligible members of the National Association of Social Workers. Only those members who identified themselves in the NASW membership directory as being in "direct practice" were deemed eligible, resulting in a sampling frame of 58,056 members. A simple random sample of 1,200 was drawn from this population, and after exclusion of bad addresses, retirees, etc., the sample size was reduced to 1,143.

Excluding those drawn as part of the random sample, we identified African American, Asian American, and Hispanic social workers in the remainder of the sampling frame. From this pool of minority social workers, we drew additional random samples of 478 of African American, Asian American, Hispanic/Latino workers respectively, excluding those selected in the original random sample.

A 10-page questionnaire with a cover letter, commitment postcard, and return envelope were mailed to all respondents. If the commitment postcard was not returned within three weeks, a second questionnaire, cover letter, and return envelope was mailed to the respondents. We received 654 responses back from the original random sample for a response rate of 57.2%. The response rates within the African American sample was 48.7% (n=233), Asian American 41.2% (n=197), and Hispanic/Latino 44.8% (n=214). For the purpose of this paper, however, we combined the minority workers in the original random sample with those in the minority samples, resulting in 255 African Americans, 207 Asian Americans, 230 Hispanic/Latinos, and 591 Whites, for a total of 1,283 respondents.

Study Variables

The primary variables employed in this study are the scales on Religiosity and religion and Prayer in Practice. The Religiosity scale consists of the two items "*How often do you attend religious services?*" and, "*How important is religion in*

your life?" These two items are correlated (r = .73), and have a score range 2-8 with higher scores indicating greater levels of religiosity. This scale has been used in numerous prior studies (see, for example, Taylor, 1993; 1986), and measures the degree to which individuals consider themselves to be religious. The scale on *Religion and Prayer in Practice* was created in this study by combining six items (see Table 3), and has an alpha coefficient of .80. Two versions of the scale were used. The first measures the extent to which an individual is likely to consider "appropriate" practice behaviors, which at face value, have a religious component. The scale has a score range from 1-5, with higher scores indicating perceptions of greater inappropriateness for the practice behaviors in question. The second asked the respondents the extent to which they actually engaged in the behaviors. The response range for this scale was from "never" to "five times or more."

TABLE 1. Demographic Characteristics of Study Population*

	African American	Asian American	Hispanic/ Latino	White	Total
	(n=255)	(n=207)	(n=230)	(n=591)	(n = 1283)
Marital Status					
Married	123 (48.6%)	142 (68.9%)	141 (61.8%)	403 (68.8%)	809 (63.6%)
Religion					
Christian	231 (90.9%)	123 (59.4%)	165 (72.7%)	322 (54.9%)	841 (66.0%)
Jewish	1 (0.4%)	3 (1.4%)	6 (2.6%)	121 (20.6%)	131 (10.3%)
None	15 (5.9%)	47 (22.7%)	41 (18.1%)	103 (17.6%)	206 (16.2%)
Other	7 (2.8%)	34 (16.4%)	16 (6.6%)	40 (6.8%)	96 (7.5%)
Gender					
Male	43 (16.9%)	46 (22.4%)	60 (26.4%)	113 (19.2%)	262 (20.5%)
Female	212 (83.1%)	159 (77.6%)	167 (73.6%)	475 (80.8%)	1013 (79.5%)
Age					
Mean age	46.68	44.20	43.63	45.92	45.31
Work auspices					
Public	149 (61.6%)	91 (44.4%)	92 (40.4%)	154 (26.5%)	486 (38.7%)
Private Practice	23 (9.5%)	20 (9.8%)	43 (18.9%)	169 (29.1%)	255 (20.3%)
Private for profit	15 (6.2%)	16 (7.8%)	30 (13.2%)	59 (10.2%)	120 (9.6%)
Non-profit (sectarian)	20 (8.3%)	20 (9.8%)	17 (7.5%)	51 (8.8%)	108 (8.6%)
Non-profit (non-sectarian)	35 (14.5%)	58 (28.3%)	46 (20.2%)	148 (25.5%)	287 (22.9%)

*Note that the N's may differ depending on missing data

RESULTS

Table 1 presents the demographic characteristics of the sample by race. While abo two-thirds (66.0%) of the total sample consider themselves Christian, a substantiall larger proportion of African Americans (90.9%) and Hispanic/Latino responden (72.7%) identify themselves as Christian. The largest proportions of those declaring r

religious preference or identifying with another religion are found in the Asian American group. In the total sample, 16.2% report no religious preference.

Also as presented in Table 1, a larger proportion (61.6%) of the African American workers are employed in the public sector compared to their colleagues, and these workers are also on the average somewhat older.

As noted earlier, the Religiosity scale consisted of two items. In response to one of these items, "*How often do you attend religious services?*", 15.4% indicated never, 34.0% said rarely, 17.7% said once or twice a month, and 32.9% stated they attend religious services once a week or more. In response to the second item in the scale, "*How important is religion in your life?*", 14.0% said not important, 23.1% said slightly important, 24.1% said pretty important, and 38.8% stated that religion was very important in their life.

When we compared Religiosity by race, age, gender and auspices (sectarian and non-sectarian), we found race and auspices to be the distinguishing factors (see Table 2). African-American social workers scored significantly higher on Religiosity compared to the other groups. While neither age nor gender appeared to make a difference, practitioners associated with sectarian agencies score significantly higher on Religiosity than their colleagues in non-sectarian agencies did.

TABLE 2. A Comparison of Religiosity by Race, Age, Gender and Auspices

	N*	Mean	st. dev.		
Race					
African American	250	6.69	1.64	F = 37.514	p<.0001
Asian American	204	5.35	2.04		
Hispanic/Latina	223	5.50	2.01		
White	586	5.16	1.98		
Age					
< or equal to 45-years	672	5.61	1.99	t = 0.872	ns
More than 45 years	658	5.51	2.94		

Table 2 continued...

Gender					
Male	273	5.49	1.96	t = -0.643	ns
Female	1045	5.58	2.03		
Auspices**					
Sectarian agencies	107	6.03	1.90	3.407	p <.001
Non-sectarian agencies	685	5.32	2.01		

* Note that the N's may differ depending on missing data.

**For the purpose of this analysis, we combined all non-sectarian agencies and private practitioners into one group, and compared them with workers in sectarian agencies.

TABLE 3. Distribution of Religion and Prayer in Practice in the Study Sample

	African Amn.	Asian Amn.	Hispanic Latino	White	Total
	(n= 255)	(n=207)	(n=230)	(n=591)	(n=1283)*
Discuss your religious beliefs with client					
appropriate	10.1%	12.3%	14.7%	17.6%	14.3%
not sure	29.0%	23.2	25.4%	24.7%	25.6%
done (at least once)	44.2%	39.3%	43.8%	46.8%	44.7%
Pray with client at client's request					
appropriate	28.5%	30.5%	22.8%	21.2%	24.5%
not sure	26.9%	23.6%	27.2%	30.1%	30.9%
done (at least once)	25.3%	26.7%	22.9%	19.2%	22.5%
Request client to pray with you					
Appropriate	3.3%	4.9%	2.2%	3.3%	3.3%
not sure	6.9%	3.9%	7.2%	6.9%	6.5%
done (at least once)	3.2%	4.4%	3.5%	2.5%	3.1%

Table 3 continued...

Use serenity prayer					
appropriate	35.8%	21.1%	32.6%	39.2%	34.3%
not sure	31.3%	36.7%	26.2%	30.7%	30.9%
done (at least once)	35.5%	18.9%	33.6%	38.1%	33.4%
Initiate laying of hands as a technique					
appropriate	4.8%	5.0%	3.6%	5.4%	4.7%
not sure	9.7%	16.4%	12.1%	11.5%	12.4%
done (at least once)	3.2%	5.3%	4.4%	4.6%	4.3%
Recommend religious form of healing					
appropriate	7.1%	10.8%	6.7%	9.2%	8.5%
not sure	16.3%	15.8%	11.7%	16.9%	15.6%
done (at least once)	9.7%	13.5%	13.7%	13.9%	12.7%

*Note that the N's may differ depending on missing data

We then examined the two scales on Religion and Prayer in Practice, one referencing "appropriateness" and the other actual "doing" of the behaviors in question. Table 3 presents the distribution by race on the six questions, which constitute the scale. On the one hand, over a third of the sample consider the use of the "serenity prayer" appropriate (34.3%) and over a third (33.4%) have actually used the serenity prayer in practice. On the other hand, nearly a third (30.9%) are unsure about its appropriateness. Interestingly, while a relatively small percentage (14.3%) of respondents consider it appropriate to discuss one's religious beliefs with the client, 44.7% of the sample indicates they have engaged in this behavior. Once again, a relatively large percentage (25.6%) is unsure about the appropriateness of this behavior. It is interesting to note that a significant number of workers have engaged in a behavior they deem inappropriate or at best uncertain. Nearly a quarter of our respondents (24.5%) consider it appropriate to pray with a client at the client's request while 30.9% are unsure as to whether this is appropriate professional conduct. At the same time, 22.5% of the practitioners in our sample have engaged in this practice at least once. A critical feature of these data is the degree of uncertainty expressed by these professional social workers about appropriateness of the various religious and prayer practices. While there are small differences by race on these questions, these differences are not significant and there are no noticeable trends.

We then performed a series of regression analyses within the different racial groups. Here, we regressed age, gender, sectarian or non-sectarian agency, and religiosity on the Religion and Prayer in Practice (Appropriateness) Scale (see table 4 below). Although the analysis suggests that age and gender may have an effect within some of the groups, the data clearly point out that within each racial group, the strongest and most consistent predictor of religious and prayer practices in work with clients is the religiosity of the worker. Worker auspices within a sectarian agency does not have any effect at all within this relative predictive model. Thus, regardless of other factors in the model, the more religious the worker, the more likely that worker is to view the conduct of religious and prayer activities in practice as appropriate professional behaviors.

TABLE 4. Regression Analyses on Religion and Prayer in Practice Scale

	Beta	t-value	Sig.	F-value	Sig.
African American (n= 255)				6.113	.0001
Constant		11.367	.0001		
Age	.078	1.239	ns		
Gender	.017	0.268	ns		
Religiosity	-.273	-4.304	.0001		
Sectarian agency	-.107	-1.704	ns		
Asian American (n=207)				2.702	.05
Constant		9.800	.0001		
Age	.143	2.008	.05		
Gender	.017	0.241	ns		
Religiosity	-.191	-2.700	.01		
Sectarian agency	0.061	0.859	ns		
Hispanic/Latino (n=230)				3.582	.01
Constant		11.823	.0001		
Age	.038	0.558	ns		
Gender	-.137	-2.030	.05		
Religiosity	-.158	-2.329	.05		
Sectarian agency	-.123	-1.808	ns		
White (n=591)				14.364	.0001
Constant		16.664	.0001		
Age	.027	0.679	ns		
Gender	.096	2.400	.05		
Religiosity	-.293	-7.203	.0001		
Sectarian agency	.034	0.838	ns		

DISCUSSION

While particular racial groups may score significantly higher on religious practice behaviors, it is not race that appears to account for the differences seen on the Religion and Prayer in Practice Scale. For example, although African Americans both in the literature (Taylor, et al, 1996) and in this study had the highest religiosity scores of all groups, they were no more or no less likely than any other group to feel that the religious and prayer behaviors were appropriate nor to engage in these behaviors. What is clear is that the social worker's religiosity affects practice behaviors regardless of race, age, gender or auspices.

Much of the current attention of the social work profession's interest in religion and spirituality focuses on the practitioner's ability to learn, respect, understand and value the client's religious and spiritual beliefs. However, this research clearly points to the need for practitioners to identify, understand and clarify their own religious and spiritual beliefs and values as they impact practice with clients. The practitioner's religiosity affects both what is done and what is *not* done with clients. The profession has appropriately guarded against proselytizing or imposing one's own religious beliefs on clients. However, it is also problematic to ignore or fail to adequately address clients' religious and spiritual needs because they are viewed as unimportant or irrelevant. This lack of attention to religion and spiritual issues may result in both an inadequate or incomplete assessment and the loss of potentially useful intervention options. Sheridan and Bullis (1991) note that the receptivity of the practitioner to religious and or spiritual issues may determine whether or not the client raises these issues. Therefore, what we believe and value regarding spirituality and religion can directly affect the therapeutic relationship as well as the effectiveness of our work with clients.

It is interesting to note what is considered most appropriate among the religion and prayer practice behaviors. Across all groups, the use of the serenity prayer received broad approval, which may be attributed to the integration of spiritual and religious values in the widely used 12-step programs (Ellis & Schoenfeld, 1990; Nowinski, 1999). When we look closer at the other behaviors related to prayer, another theme emerges. More respondents felt that it is appropriate "to pray with clients during a session at their request" than felt it is appropriate "to discuss their (the worker's) religious beliefs with the client." This seems to illustrate that who initiates a behavior may influence the worker's view of appropriateness. The client's initiation of a request for prayer may be more acceptable than the worker's initiation of a sharing of his or her own religious beliefs without the client's request. This may be based on the repeated emphasis in professional training to guard against imposing one's own values or beliefs on clients.

To further explore this issue of who initiates a religious issue, it is interesting to note that more respondents felt it is appropriate to "initiate or recommend the

'laying on of hands' as a healing technique" than felt it is appropriate to "request a client pray with them during a treatment session." Both of these behaviors are initiated by the worker, but it is the worker's request for the client to pray that appears to be the most unacceptable behavior, even more unacceptable than a physical contact behavior. One could argue that this particular reservation about prayer is founded on the concept of the separation of church and state. There is reluctance to cross this Constitutional barrier, as illustrated in the extensive legal precedence regarding the use of prayer in a variety of contexts (Alley, 1994; Fenwick, 1989; Ravitch, F., 1999). Alternatively, one could also argue that these workers perceive that the laying on of hands is a legitimate intervention. These societal values, combined with socialization to the social work profession's values, may also account for the lack of differences in practice behaviors related to race previously discussed.

There appears to be a growing interest in the areas of religion and spirituality as we follow the interests expressed both by the general public and by the medical field. There is an increasing awareness and openness to acknowledge the religious and spiritual dimension as an important component in taking a holistic approach with clients that acknowledges and respects diversity in a broader sense than was previously defined. Considering the social work profession's historic links to religious organizations and the substantive challenges and dialogue raised by some social work practitioners for almost 50 years, one could ask why we are following rather than leading in this area. The challenges and questions raised by Spencer in 1957 remain.

The social work profession is being challenged *again* to expand personal and professional awareness of religious and spiritual beliefs as they directly affect our work with clients. The reported results of this study raise significant questions regarding the large numbers of practitioners who responded that they were uncertain about what is appropriate professional behavior with regard to religion and prayer. The lack of specificity in the NASW Code of Ethics along with lack of training in this area leave many without an ethical or theoretical basis on which to make professional practice decisions. The profession needs to explore issues of whether or not assessment of religion and spirituality need to be areas of routine client assessment. Standards regarding both assessments and interventions need to be established , as well as whether or not the practitioner should initiate these discussions or wait for clients to raise them. The predicted increase in provision of social work services in sectarian agencies raises important questions for the profession regarding what types of services and intervention strategies with clients will be sanctioned and "allowed" by virtue of particular religious beliefs and values of the service provider.

Finally, we need to address the question of to what degree the profession should incorporate religion and spirituality into professional training. The *NASW Code of Ethics* (1996) states, "social workers should provide services and represent

themselves as competent only within the boundaries of their education, training..." (1.04). Religion-based interventions are being practiced by social workers that have only recently begun to be reported in the literature, but for which there are no specific guidelines and presumably no formal training. Questions regarding professional competence and integration of religion and spirituality into curricula and empirically based practice must be more specifically addressed.

There are indeed many hurdles and difficulties in addressing this subject, but the challenge can no longer be ignored. The choice for the social work profession can be to use its rich tradition and experience not to *follow* but to take the *lead* in this important and developing area.

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Asset Building: Integrating Research, Education, and Practice

Michael Sherraden
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ABSTRACT: *Asset building is an emerging concept in anti-poverty work in economically advanced nations. In the past, welfare states have defined poverty primarily in terms of income. While income is necessary to maintain consumption, saving and investment is also necessary if families and communities are to progress out of poverty over the long term. Asset building is a broad idea with many possible applications, including homeownership, microenterprise, and individual development accounts (IDAs). IDAs are matched savings accounts for low-wealth families. In this paper, the authors 1) describe asset building as a policy and practice innovation; 2) discuss results from two research projects, one on IDAs and a second on microenterprise; and 3) illustrate a strategy for education and advocacy. This work may serve as an example of simultaneous advances in research, education, and practice, wherein each aspect of the work is enriched by and contributes to the others. The strongest advances in social work proceed not by the separation of ideas, study, and application, but by their integration and mutual reinforcement.*

INTEGRATION, THE ESSENCE OF SOCIAL WORK

Social work seeks to build a knowledge base that can guide professional and public education on social issues, and at the same time serve as a guide to policy and practice. The integration of research, education and practice is the essence of social work both as a profession and as a field of study. Indeed, this overlap in functions is highly desirable in social work, whereas it might be viewed as detrimental in a purely academic field of study. Social workers were among the first to combine systematically all three functions in efforts to improve conditions for the poor.

The charity organization societies of the late nineteenth century and early twentieth century systematically collected information in their delivery of services to individuals, known as "friendly visiting" (Stuart, 1999), and in the process debunked common misperceptions:

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> In addition to gathering specific information on the real causes of poverty and dependency and fostering new concepts of treating them, organized charity agents contributed to the development of a technique of social service and research – casework – and with it, the growth of a profession. . . . By the turn of the century, the organized charities were establishing training schools for charity workers (Trattner, 1999, p. 102-103).

The settlement house movement that developed somewhat later, led by Jane Addams and the residents at Hull House, continued to conduct research, practice, and educate, although the focus of their work was on community and policy reform:

> Jane Addams and the women of Hull House – Julia Lathrop, Florence Kelly, Mary Kenny, Alice Hamilton, Sophinisba Breckenridge, Grace and Edith Abbott, Ellen Gates Starr, and others – were committed to making their neighborhood a better place, and at the same time using it as a laboratory for social intervention. They were applied intellectuals. They read and discussed constantly; they collected data on social ills; they published reports; and they initiated changes in local affairs and public policy (Sherraden, 1998a, p. 18).

Both the charity organization and settlement movements integrated practice with scientific methods of the day, and each helped to spawn a professional school of social work. It is important to note that, notwithstanding the strong emphasis on knowledge building, the research of these pioneering social workers was aimed at practice and education, rather than the building of scientific knowledge for its own sake.

Today, as in the early days of the social work profession and social work scholarship, the challenge is to integrate key functions. Fortunately, the new journal *Advances in Social Work* invites papers with a theme of integration. In doing so, it charts a direction that has proven to be effective in the past and in all likelihood will be effective in the future. Our goal in this paper is to offer one example of integration of research, education, and practice.

WHY NOT ASSET BUILDING FOR THE POOR?

The topic is asset building, which refers to key investments in assets such as home ownership, education, and small business, for low-income, low-wealth families.[1] Elsewhere, we have shown that the non-poor benefit from asset building policy, primarily in the form of tax expenditures (Sherraden, 1991). The typical U.S. household has assets in home and retirement accounts, but little else; and both home ownership and retirement accounts are heavily subsidized

by tax expenditures. Sometimes this is called "hidden" public policy (Howard, 1997), but it has nonetheless been very effective.

In the mid-1980s when this work began, there was very little applied or academic discussion about asset building by the poor in policy and community development. At the time (and still largely today), the policy emphasis was on income support. To be sure, some social science researchers had been focusing on asset distributions (among them Wolff, e.g., 1987; Oliver & Shapiro, 1990, 1995). There had been creative proposals for capital accounts in lump sum payments, usually for youth, (Tobin, 1968; Haveman, 1988; Sawhill, 1989).[2] Community organizations emphasized home ownership for the poor, but this was not common. Some community innovators had been promoting microenterprise and its investment qualities (e.g., Friedman, 1988), but there were no proposals for asset building as an overall direction in anti-poverty policy and community development. At the time, income-for-consumption was largely taken for granted as the main theme of anti-poverty policy. Today, asset building as a policy strategy for the poor is emerging in the context of growing questioning of income maintenance as a singular strategy. A mechanism through which this is occurring is individual development accounts (IDAs), matched savings accounts for the poor, to be used for home ownership, education, small business capitalization, or other development purposes (Sherraden, 1988, 1991).

Policy Innovation

Following discussions with mothers who were receiving Aid to Families with Dependent Children (AFDC or "welfare') in the mid-1980's, Sherraden (1988) developed the idea of IDAs. IDAs are 1) special savings accounts, 2) started as early as birth, 3) with savings matched for the poor, 4) to be used for education, job training, home ownership, small business, or other development purposes, 5) with multiple sources of matching deposits: governments, corporations, foundations, community groups, individual donors. Thus, IDAs are a simple but flexible tool, adaptable to many different policy and community development applications. The Center for Social Development (CSD) at the George Warren Brown School of Social Work, Washington University, undertakes research and policy development on IDAs.

In 1989-90, discussions were initiated with Bob Friedman at the Corporation for Enterprise Development (CFED) and Will Marshall at the Progressive Policy Institute, and both organizations published policy reports on asset-building and IDAs. The CFED report was the subject of several columns by William Raspberry in the *Washington Post*, and following this we had inquiries from a number of congressional offices and committees. One of these was the House Select Committee on Hunger, chaired by Tony Hall. Ray Boshara, now the Capitol Hill strategist for CFED, was a staffer on the committee and he brought IDAs to Hall's attention. Friedman and Sherraden worked with Boshara to draft

the first legislation. A companion bill was later introduced in the Senate by Bill Bradley.

At the same time, the executive branch became interested in asset building. Jack Kemp, Secretary of Housing and Urban Development, initiated several White House meetings in 1991-92, leading to a provision by President Bush in his 1992 budget proposal to raise welfare asset limits from $1,000 to $10,000. This was a bold proposal at the time and substantially influenced the discussion on changing welfare asset limits. Today, as mentioned below, almost every state has increased asset limits in means-tested programs. This in itself has been an important policy shift.

Meanwhile, CFED and CSD worked in virtually all of the states that are developing or have an IDA policy, and provided technical assistance of some type to most of the community IDA programs. CFED has assumed responsibility for spearheading federal and state policy changes, with noteworthy successes. For example, CFED began an initiative called the State Human Investment Policy (SHIP) to work on IDAs in Iowa and Oregon in 1991-92. The Joyce Foundation in Chicago funded the first three major IDA projects in 1994. CFED initiated an IDA listserve on the Internet and organized three national conferences on IDAs between 1995 and 1999. CSD created an *IDA Evaluation Handbook* (Sherraden, et al., 1995) to facilitate research on early IDA programs.

Bill Clinton supported IDAs in his 1992 campaign, and they were included in the President's 1994 "welfare reform" proposal. CFED and CSD worked with Bruce Reed, Co-Chair of the White House welfare reform task force to include IDAs as a state option in the 1996 federal welfare reform act, which replaced AFDC with Temporary Assistance to Needy Families (TANF). This act has two important provisions regarding IDAs. First, if TANF participants accumulate assets in an IDA, these funds are exempt from asset limits for all federal means-tested programs (in other words, the welfare poor can save without penalty in IDAs). Second, states are permitted to use TANF funds to match savings in IDAs. Although not widely-recognized at the time, these asset-building provisions in TANF marked the first time in a federal anti-poverty policy that asset-building was no longer discouraged, and in fact could be subsidized with federal funds. In 1999, another federal ruling specified that IDA participation, including matching funds, would not be defined as "assistance" under TANF and thus would not run a participant's "clock" of eligibility for TANF support. This ruling removed a major concern and impediment to inclusion of IDAs in welfare reform in the states.

Another federal IDA initiative, the *Assets for Independence Act* (a legislative descendent of the first IDA bill in 1991), was passed by Congress in 1998 with bipartisan support, and signed by the President. The bill was sponsored in the House by Hall and John Kasich, and in the Senate by Dan Coats and Tom Harkin. The *Assets for Independence Act* provides $125 million in federal

funding for IDA demonstrations over five years. At this writing, CSD is working with Abt Associates on evaluation strategies for this law.

Almost all states now have raised asset limits in welfare, and at least 30 states have included IDAs in their welfare reform plans. Some states plan to use federal TANF dollars to fund IDAs. Several states have committed state general funds for IDAs, and legislation is active in many other states.[3] Fortunately, none of the state-funded IDA programs is limited to TANF participants; IDAs are not a welfare reform program, but a household and community development program that might be utilized by any low-wealth household. IDA legislation in the states typically has broad bipartisan support, and a key reason for this support is inclusion of the working poor.

Universal Savings Accounts (USAs) were proposed by President Clinton in his 1999 State of the Union Address in January and spelled out in greater detail in a White House presentation in April. This proposal grew directly out of early experience with IDA programs and CSD's data on IDAs influenced policy design.[4] Clinton proposed using 11 or 12 percent of the budget surplus, an estimated $38 billion per year at the outset, rising with the rate of inflation, to create a progressive system of accounts for retirement. The federal government would make annual deposits plus matching deposits into accounts of low and middle-income workers, taking in most of the working population, on a progressive basis, i.e., the largest subsidies would be at the bottom. Some have described this as a 401(k) available to all workers. It would be the largest anti-poverty initiative since the Earned Income Tax Credit. In sum, the primary purposes of IDAs and USAs are threefold: 1) to demonstrate that low-income and low-wealth households can save and accumulate assets if they have the same opportunities and incentives that are available to the non-poor; 2) to document that public and private funders of asset building for the poor are making a good investment; and 3) to model a progressive asset-based policy that can be taken to scale.

RESEARCH ON IDAs

In this section, we discuss early results of the main research program focusing on IDAs, the "American Dream Demonstration" (ADD). This 13-site IDA demonstration, one of the largest policy demonstrations currently underway outside of welfare reform, is scheduled to last four years (1997-2001). The evaluation research is multi-method and will extend two additional years (to 2003). Methods include implementation assessment, program and participant monitoring, experimental design survey, in-depth interviews to supplement the survey, community level evaluation, and a benefit-cost analysis. We report here on monitoring data as of June 30, 1998.

CSD created and pre-tested a monitoring instrument in 1996.

During 1997, the monitoring instrument was adapted to user-friendly software, and again pre-tested. Known as the management information system for individual development accounts (MIS IDA), the software is designed to record basic program information on design, match rates, and so on, and information on participant characteristics, patterns of savings, and uses of savings. These data are not the impact data that will come from the experimental design survey, but they shed light on how well IDAs are working and for whom. As far as we know, this is the first time that a policy demonstration, at the outset, has created unique software for an management information system (Johnson & Hinterlong, 1998).

At the program level, five ADD sites are in community development organizations, three in social service agencies, two in credit unions, two are collaborations among multiple sites, and one is in a housing organization. Looking at funding partners, eleven programs have non-profit funders; six have for-profit funders; seven have public funders; and two have individual funders. Partner contributions range from $5,000 to $300,000. Match rates for accounts vary from 1:1 to 6:1. Eight programs have annual deposit limits, ranging from $180 to $3,000; and six programs have lifetime deposit limits, ranging from $1,800 to $8,000. Regarding depository institutions, eight programs are using a bank or savings and loan; four are using a credit union; and one is using both. Eleven programs provide monthly statements, and two provide quarterly reports. All programs offer interest-bearing accounts, and in three programs IDA deposits can be earned.

Looking at intended uses of accounts, 51% of participants intend to purchase a home, 13% microenterprise, 12% post-secondary education, 8% home repair; 6% retirement, and 1% job training. The strong interest in home ownership is somewhat surprising, given that only one of the 13 IDA sites in ADD is a housing organization.

As of June 30, 1998, 440 participants had made deposits into their accounts. Most of these had just started (over half within the preceding three months). At that stage, most of the IDA participants were saving at or near the monthly maximum. The participants had a median savings balance of $80, and total savings balance of $56,349 for all participants. The median IDA balance (including matching funds) was $224, with a total of $166,380 for all participants.

There were no statistically significant differences in savings or IDA balances by gender, urban/rural residence, educational attainment, employment status, marital status, or income (See Table 1). The only significant differences in these early IDA data were by age (older participants saved more) and ethnicity ("others" saved more than whites or blacks – these are mostly Latinos and mostly at one site; we have checked to see if this is a program effect and it does not appear to be). In discussing the age differences, IDA program staff offered a

TABLE 1. Savings Balance by Participant Characteristics: Start-Up Data from Individual Development Account (IDA) Demonstration

	Number	Mean
Gender		
Female	329	$125
Male	109	$139
Age		
40 or below	294	$115
Above 40	144	$154*
Residence		
Urban/suburban	343	$132
Small town/rural	95	$117
Ethnicity		
Caucasian	225	$121
African American	140	$117
Other	73	$173*
Education		
Below high school	48	$115
High school grad	108	$128
Attended college	167	$135
College grad	92	$121
Employment Status		
Employed full-time	263	$127
Employ part-time	105	$127
Others	61	$132
Marital Status		
Always Single	174	$119
Married	133	$133
Others	130	$137
Monthly income:		
Below $1,000	134	$137
$1,000 to $2,000	238	$123
Above $2,000	66	$130

Savings balance includes participant savings plus interest but does not include IDA matching funds.
* t-test, $p < .05$
Source: Sherraden, Page-Adams, and Johnson (1999).

number of reasons why this might be so, including not having young children to support and being "more responsible" and forward-looking with increasing age. The early finding that Latinos save more is less definite and may be a start-up pattern that is not maintained over time. Also, it seems quite possible that other differences in total savings, especially by income, education, and employment, are likely to emerge over time. As data come in, we will pay particular attention

to income and savings, and it will be appropriate to look at differences in savings as a proportion of income. In the early data, poorer people are saving a far higher proportion of income in IDA programs, but this may not continue.

RESEARCH ON MICROENTERPRISE

Microenterprise programs are another example of policy initiatives that aim to increase assets of the poor, and at the same time provide a new stream of household income (Boshara, Friedman & Anderson, 1997). While microenterprise developed in the context of third world development (Otero & Rhyne, 1994), it has gained attention in the United States as an anti-poverty strategy, especially for women (Balkin, 1989; Clark & Huston, 1991). First introduced in the United States in the 1970s, there are now several hundred microenterprise development programs (Severens & Kays, 1997), lending and providing training and technical assistance to thousands of owners of very small businesses.

Microenterprises are usually sole proprietorships, partnerships, or family businesses with fewer than five employees (Severens & Kays, 1997). Typically, they are capitalized with very small loans of several hundred to a few thousand dollars, too small to interest commercial banks. In the early years, U.S. microenterprise programs closely paralleled third world programs in lending to small peer groups. Over time, programs in the U.S. context have moved to mostly individual lending, while using small groups for education, training, and support.

In order to develop greater understanding of the impacts of microenterprise, we conducted interviews with business owners aimed at understanding the experience of opening and operating a microenterprise from the perspective of the owners (Rubin & Rubin, 1995; Sherraden, Sanders, & Sherraden, 1998). These in-depth interviews were conducted as part of a longitudinal study of microenterprise by the Self-Employment Learning Project of the Aspen Institute.[5] In-depth interviews were conducted with 86 participants whose household incomes were below 150% of poverty in 1991.

The relatively few evaluations of microenterprise in the United States suggest that families make modest income and assets gains, although the evidence is not conclusive. For example, some studies show considerable impact on household income (e.g., Clark & Kays, et al., 1999), while others – including the only experimental design study – show little increase (e.g., Benus, et al., 1994). Qualitative data from our study suggest that goals and outcomes of microenterprise can be thought of in broader terms than just financial. These include impacts on 1) personal growth and learning, 2) standard of living, 3) autonomy and ownership, 4) families and children, 5) work levels and stress, and 6) civic involvement (Table 2).

TABLE 2. Outcomes Reported by Microentrepreneurs
(N=86)

Personal growth and learning		
Positive	39	(45%)
Positive & negative mixed	2	(2%)
No mention	45	(52%)
Financial condition/standard of living		
A lot	11	(13%)
Some or a little	28	(33%)
None or lost money	16	(19%)
No mention	31	(36%)
Autonomy and ownership		
Positive	34	(40%)
No mention	52	(60%)
Family and children		
Positive	27	(31%)
Positive & negative mixed	9	(10%)
Negative	8	(9%)
No mention	42	(49%)
Civic participation		
Positive	11	(13%)
No mention	75	(87%)
Stress and long hours		
Stressful but worth it	5	(6%)
Very stressful	18	(21%)
No mention	63	(73%)

This table summarizes outcomes reported in open-ended interviews.
Respondents brought up these topics without prompting and not everyone mentioned all outcomes.
Percentages may not add to 100 due to rounding.
Source: Sherraden & Sanders (1999).

The outcome most often mentioned when asked about the impact of the business on their lives, was personal growth and learning. Among those, many reported that creating and operating a microenterprise boosted their self-esteem and self-confidence. For example, one respondent said that people treat her

differently as a business owner. After being involved in an abusive relationship, a divorce, and having to seek welfare assistance, she said the business "*boosts my self esteem. It makes me feel good to be a business owner. A lot of people have a lot of respect for me* [now]." Several respondents also said that the experience of owning a microenterprise gave them the confidence and skills to think about future businesses and jobs. One respondent said that the confidence gained from operating a business helped her secure a new job: "*I felt like I had enough self-esteem built up from owning my own business that when I interviewed they were impressed with my initiative.*"

Respondents reported mixed impact on their families' standard of living and financial well being. On one hand, 39 entrepreneurs believed that the business made at least a small contribution to their families' living standard, and in some cases a substantial contribution. For example, one respondent, who ran a daycare business in her home, articulated the financial boost that many women felt from their small businesses: "*[I] didn't feel like I had to be on welfare forever. I saw a spark of light at the end of the tunnel. I can make a difference for my family, buy a VCR, get some bills paid.*" On the other hand, 16 respondents said operating a business did not increase family income or was a net loss, such as this respondent who pointed out: "*There wasn't any future in it. There was too much worry for me and my family. Everything was too uncertain.*"

A substantial number (34) said they felt like they gained control over their lives by operating a business. Control over working hours made self-employment much better than working in a job (especially a low wage job) and made up for lack of earnings. In this regard, one respondent's comments echoed those of several others: "*...having my own business, I am able to make my own hours. If I want to work late, it's my choice. I put a lot of time in, but I don't mind doing that.*"

Half of the respondents talked about the impact of their business on their families or children. Most (27) said the effects on their families were positive. For women particularly – although not exclusively – self-employment offered flexible work hours and the option of working at home or taking children along to work. Microenterprise also offered parents an opportunity to be a proper role model, or, in one woman's words, "*to teach my children how to work.*" In contrast, 17 said that the effects on family were mixed or negative. For example, one business owner said that "*if you fall flat on your face there you are with a child and you gotta pick yourself up and try to still feed that child and provide for that child.*"

Accompanying the independence and autonomy of self-employment, come long hours, hard work, worry, and stress. A quarter of the respondents pointed out the difficult workload and high level of stress. For example, one respondent decided she was "*spending time but not seeing the profit . . . I didn't want to*

spend the rest of my life living like this. I didn't want to suffer like this." Finally, she decided to return to school for more job training.

Eleven respondents observed that business ownership increased their commitment to and interest in civic affairs. Specifically, some found themselves assuming a higher profile in the community, while others said that owning a business made them more civic-minded, more conscious about buying products from local businesses, or more involved in volunteer work.

Although policy makers generally have viewed microenterprise as a way to get additional income into the hands of low-income families, entrepreneurs themselves see multiple outcomes of microenterprise. On the positive side, most of the respondents viewed microenterprise as an opportunity for personal growth, additional income and assets, autonomy, family development, and greater involvement in the community. On the negative side, a minority reported the financial costs of running a business and the stress on themselves and their families. On the whole, however, the positives outweighed the negatives. At least five years after opening a business, over half (47) said they still preferred self-employment compared to 11 who definitely preferred a job, and 27 who said that it would depend on the specific situation.

EDUCATION AND ADVOCACY

The concept of asset building can be applied to state level public education and advocacy as well. Community economic development (CED) links development of economic capital – including human capital and financial assets – and social capital in communities (Midgley & Livermore, 1998; Sherraden & Ninacs, 1998). In Missouri, asset building strategies have been pursued by the Community Economic Development (CED) project of the Missouri Association for Social Welfare (MASW), a 100-year old social welfare advocacy organization. The CED Project was founded with the understanding that revitalization of poor communities involves local initiative and resources, as well as leadership and resources from the larger public and private sectors (Sherraden & Slosar, et al., 1999). In other words, while poor communities bring many resources to the table, they have long been victims of disinvestment by both public and private institutions and require considerable external resources (Halpern, 1993). From the CED Project perspective, the state's involvement in providing resources for "human-sized" CED is one key to successful development, especially in an era of diminishing federal involvement.

Formed amidst momentous changes in federal and state welfare policy, the CED project brought together people from across the state in 1994 to focus on community-based economic development. Participants included consumers and professionals from the public, non-profit, and private sectors, including community development agencies, human service agencies, universities, state agencies, and banks. The group adopted goals including home ownership, microenterprise, and IDAs, and methods for advocacy including education, data

gathering and dissemination, network development, legislative initiatives, and policy implementation.

Public education activities included semi-annual statewide conferences on CED topics (e.g., asset building, microenterprise, IDAs, and community development corporations), regional educational forums around the state, educational materials, a legislative alert system utilizing fax and e-mail weekly updates, and occasional news articles and radio interviews. Data gathering involved collecting information from research centers and programs in other states, researching model legislation, and conducting a survey of CED programs in the state. The data from the survey will be used to inform state policy and implementation strategies, and at the same time, provide the basis for applied research.

Legislative initiatives included a community economic development demonstration bill, which would have provided resources for pilot neighborhood level CED initiatives. Although this bill was popular with some legislators, it ultimately failed. A second bill initiated by the project was a Family Development Accounts (FDA) bill that would set up mechanisms to provide $4 million per year for tax credits to fund FDAs (i.e., IDAs) for low- and moderate-income families. Introduced in 1997, this bill was introduced and barely made it to the House floor for debate. In 1998, it was more visible and earned broad bi-partisan support, due in large measure to social work students who educated legislators about its aims. It would have passed were it not for political maneuvering of a powerful special interest group that attempted to amend it in a way that would have changed its intent. At that point, the main sponsor killed the bill. In 1999, FDAs received unanimous support in the House and in Senate Committee, but the same amendment that killed it in 1998 threatened it once more. With a great deal of maneuvering by legislators, the governor's office, state agencies, and the CED coalition, the bills' sponsors passed the FDA bill on the last day of the 1999 legislative session.

Project participants also worked directly with state agencies responsible for implementing economic development policies. For example, CED committee members worked extensively with officials in the Missouri Department of Economic Development (DED) to implement legislation and fund CED projects on a pilot basis.

Social workers from a broad range of settings played key roles in the CED Project's activities (Sherraden & Slosar, et al., 1999). Faculty participated through teaching, research, and service. Social work students were involved through their classes and internships. Agency social workers identified local issues and worked in coalitions. Finally, advocates worked directly with state officials to change and implement policies.

The work of social work students deserves special attention. They integrated their academic studies with field practice, developing skills and preparing them

for professional social work roles (Sweitzer & King, 1999). Between 1996 and 1999, five students spearheaded the legislative work of the CED project. Students gathered information and model legislation, helped recruit sponsors for several bills, worked with sponsors and their aides on the legislative details, helped legislative writers work out the bills' language, kept the CED constituent groups informed of bills' progress, and monitored and mobilized resources and support when the bills' sponsors needed assistance along the way. Such research, legislative advocacy, and program planning prepares a new generation of social workers to carry on the tradition of activism in the social work field (Specht & Courtney, 1994).

CONCLUSION

Thoughtful proposals for asset building policy and programs are becoming more common. For example, as one of eight strategies for policy action in the twenty-first century, Steuerle, Gramlich, Heclo, and Nightengale (1998) include a proposal to "increase everyone's chances to build financial security" by:

> . . . creating opportunities to accumulate assets for financial security, especially among those facing the greatest disadvantages. In this way, society can give everyone a greater stake in the future and the common good. Much of twentieth century social policy, ranging from welfare to social security, created a safety net by redistributing income. Without abandoning those redistributive aims, we must recognize the limits to this approach and how it can reduce incentives to create wealth. We should look to the twenty first century as a time to move beyond simple redistributive policy toward "cumulative" policy. The aim is to strike a new kind of balance between security and opportunity. (pp. 7-8)

We are pleased to see this call for "cumulative" policy as a complement to income maintenance, but the challenge will be to change the policy structure so that it includes the whole population. In this effort, there will be important roles for research, education, and practice, not as rigidly separate activities, but as integrated aspects of the same body of work.

NOTES

1. Portions of this paper are based on: Sherraden, Michael (1998b), Asset Building Policy and Programs for the Poor, invited paper at a Symposium on Benefits and Mechanisms for Spreading Asset Opportunity in the United States, New York University, December; and Sherraden, Margaret S. and Cynthia K. Sanders (1999), Social Work in Microenterprise Practice, paper presented at the Third Annual Conference of the Society for Social Work Research, Austin Texas, January. The research described in this paper is carried out at the Center

for Social Development, George Warren Brown School of Social Work, Washington University, where Michael Sherraden is director and Margaret Sherraden is a faculty associate.

2. The emphasis in proposals for capital accounts has been on providing lump sum resources for welfare and consumption choices at age 18 or 21. A more recent version has been offered in 1999 by two law professors (Ackerman & Allstot, 1999) who do not seem to be entirely aware of the prior work of economists on this concept. However, this lump sum idea may not be good policy. A study of lottery winners finds that those who win about $15,000 per year considerably reduce the amount held in retirement accounts, in bonds and mutual funds, and in general savings (Imbens, Rubin, & Sacerdote, 1999). Instead of lump sum deposits, a better approach may be long-term and systematic asset accumulation in Individual Development Accounts with deposits at birth and throughout the growing up years (Sherraden, 1991). In another version of this, Lindsey (1994) proposes a Child Social Security Account, wherein assets would build over time by government and private contributions. Lindsey points to the likely positive changes that would result from the experience of saving and investing.

3. For summaries of state IDA policies, see CSD's web site at gwbweb.wustl.edu/Users/csd/stateIDAprofiles/html

4. The concept and name USAs has been presented by CFED and CSD over the past several years. Early experience with IDAs was highly influential in the White House decision to propose USAs. In designing USAs, the Treasury Department has asked CSD for early data from the "American Dream Demonstration" showing that, with matching funds, some of the poor will be able to save. At the time of the President's State of the Union Address, CFED and CSD were meeting in Washington on Universal Savings Accounts, with policy experts who form a Growing Wealth Working Group, co-chaired by Friedman, Boshara, and Sherraden.

5. In-depth interviews were the fourth wave of the five-year study (1991-1996) of seven pioneering microenterprise programs in the United States conducted by the Self Employment Learning Project (SELP) of the Aspen Institute. The other four waves of data collection were annual surveys conducted with 405 micro-entrepreneurs in hour-long telephone interviews. Out of the original 405, there were 138 who were low income (under 150% of poverty). Of these, we located and interviewed 86 respondents in Wave 4. Interviews lasted between 1.5 and 3 hours, and were conducted by telephone. They were transcribed and analyzed using Folio Views qualitative analysis software.

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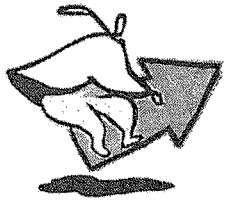

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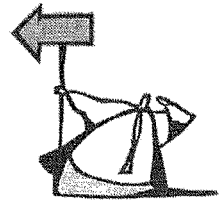

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Implementation of the Adoption and Safe Families Act of 1997: The Indiana Experience

Cathleen S. Graham

ABSTRACT: *The Adoption and Safe Families Act of 1997 (ASFA) is expected to have a profound impact on children and families the child welfare system serves. This article provides information about Indiana's experience in implementing ASFA, including policy decisions made by the legislative and executive branches of government and the involvement of the judiciary. A multi-disciplinary task force addressed training and program needs for positive implementation. Initial outcomes for Indiana children and remaining challenges are discussed.*

President Bill Clinton signed the federal Adoption and Safe Families Act (ASFA) on November 19, 1997. This article highlights the changes required by ASFA and the experience of one State, Indiana, in implementing the resultant child welfare system reforms. ASFA was an attempt by the United States Congress to address growing concerns about the number of children dying as a result of child abuse and neglect, and the length of time that abused or neglected children who had been removed from their homes remained in the child welfare system without a permanent home.

A number of states had experienced deaths of foster children who had been returned to parents who further abused and killed their children. The resultant media attention led to public outrage over the failure of the child welfare system to adequately protect and make decisions for the children entrusted to it. Congress had also heard from persons who wanted to adopt foster children and faced barriers to such adoptions, including the ongoing need to make "reasonable efforts" to reunite children with their parents and the difficulty of terminating a parent's rights to his or her child. The number of foster children in the nation had grown to 486,000, an increase of 74% from 1986 to 1995 (Petit & Curtis, 1997: 72). The Adoption Assistance and Child Welfare Act of 1980,

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also known as P.L. 96-272, was to have ended "foster care drift" through a system of case planning and case reviews designed to give children permanency with a family, either their birth family or an adoptive one. P.L. 96-272 provided for "reasonable efforts" to be made to prevent placement of children out of their own homes and to reunify children with their families. Many child advocates have noted that Congress never fully funded the services necessary under Title IV-B to provide these services to families in a timely manner. Instead, after an initial decline in the number of foster children, the child welfare system again was faced with increasing numbers of children, many of whom stayed in the foster care system until they reached age 18.

The U.S. General Accounting Office, in its report on the foster care system, found that more than 30 states were operating with some sort of judicial oversight through consent decrees and class action lawsuits (U.S. General Accounting Office, 1995). It appeared that States needed some impetus to move children more quickly to a permanent family from the foster care system. President Clinton had issued his Adoption 2002 goals to double the number of children adopted or permanently placed by the year 2002, to move children more rapidly from foster care to permanent homes, to increase public awareness about children waiting for adoption and to encourage Americans to consider adoption (*C. W. Williams, personal communication, December 27, 1996*). Members of a House of Representatives subcommittee had heard testimony regarding the length of time that children who are free for adoption wait for families. Almost half were waiting two or more years for an adoptive home (Congressional Research Service, 1997).

These concerns led to the enactment of the Adoption and Safe Families Act, a compromise between the House and Senate versions of child welfare reform legislation. The legislation contained significant steps to improve decisions and the timeliness of action in order to keep children safe and in permanent families. The legislation was to balance the multiple priorities of child safety, parental rights to time-limited reunification services, expedited permanency for children and system accountability on the part of the states.

THE LEGISLATIVE EXPERIENCE

The Indiana Family and Social Services Administration (FSSA), which administers public child welfare services in Indiana through its Division of Family and Children (DFC), reviewed the changes contained in ASFA and the potential impact on Indiana's child welfare system. There were over twenty changes to the federal law. Each provision required an assessment of the need for subsequent changes to 1) Indiana law, or 2) the State Plan for Title IV-E or IV-B or 3) other administrative changes, for example, to the state's automated child welfare information system. Indiana's sister states were simultaneously going through this same analysis to determine what steps needed to be taken to retain federal compliance and federal funding under Titles IV-E (Foster Care

and Adoption Assistance) and IV-B (Child Welfare Services) of the Social Security Act. In addition, ASFA required that states that needed to enact legislation would have to comply within three months of the adjournment of their next regular legislative session in order to retain their federal funding.

Indiana and other states found that ASFA compliance would require legislative action by the state's legislature. The major provisions requiring such action were:

1. Reasonable effort determinations by courts were to keep the health and safety of the child as the paramount concern.
2. Foster parents, prospective adoptive parents and significant others were to be given the right to notice of court hearings and an opportunity to be heard in court.
3. Children who were found to be abandoned infants, or whose parents had committed certain crimes or whose parents had had their parental rights involuntarily terminated by a court, were to be granted expedited permanency under certain conditions.
4. Permanency hearings were to be held at 12 months following the child's removal from his or her home, with a permanency plan to be presented to the court for approval at that time.
5. Children who had been removed from their homes for at least 15 of the most recent 22 months under the State's supervision were to have a petition filed to terminate their parents' rights, unless there was a compelling reason to believe that such termination would not be in the child's best interests or if the child was placed with a relative, or if the parents had not received services necessary to have their child returned safely to their home.
6. Reasonable efforts were required to be made to place the child according to the child's permanency plan.

Indiana Governor Frank O'Bannon, a Democrat, was very interested in expediting the adoption process for Indiana children. In 1996, he had campaigned with a slogan of "Putting Hoosier Families First" with an emphasis on the needs of children and families (*C. V. Williams, personal communication, September 30, 1999*). Governor O'Bannon became more interested in expediting the adoption process after he learned that an abandoned infant could not be quickly adopted under Indiana law. "Clay Moses" was a newborn infant abandoned in a pit toilet in a community park in August 1997. Local DFC staff estimated that it would take 12 months to finalize an adoption of the child due to the need to search for the child's parents and to wait the statutory six months to file a petition to terminate the parent-child relationship. Governor O'Bannon was also aware of the length of time that it was taking Indiana courts to hear petitions that had been filed to terminate parent-child relationships. A survey of courts through the Court Improvement Project of the Indiana Judicial Center showed that in 43% to 69% of contested cases, it took 91 days or more from the

filing of the petition to the termination (Indiana Supreme Court, 1997, p. 13). In September 1997, 337 of the 9,665 Indiana children in foster care were awaiting either a court hearing or a court decision on the termination of their parents' rights.

Governor O'Bannon was concerned that children have safe and permanent families. In instances where it was not possible to reunify a child with the child's family, he wanted to shorten the child's time in foster care by minimizing barriers to adoption (*Office of the Governor, personal communication, September 24, 1999*). Given these priorities, the Governor made passage of the Adoption and Safe Families Act in Indiana a part of his legislative agenda for the 1998 session of the General Assembly.

Working with the Governor's Office, the DFC prioritized five areas in the legislation: 1) the health and safety of the child as a paramount concern; 2) expedited permanency for abandoned infants and children whose parents had committed certain crimes; 3) timeliness of services to children and families preparing for reunification; 4) expedited hearings to terminate the parent-child relationship in cases where reunification is not possible after 15 months of foster care; and 5) input from the child's foster parents/caretakers through a notice and opportunity to be heard in court.

These priorities were determined with input from the county offices of the DFC and from judges. As the legislation was being drafted, the DFC Deputy Director with responsibility for child welfare programs met with a group of judges with juvenile jurisdiction to advise them of the upcoming legislation and listen to their concerns and priorities for the legislation. The judges were very concerned about the time that it was taking to process children's cases, the heavy workload of most courts, the failure on the part of some DFC case managers to file petitions to terminate parental rights and the likelihood of conflicts in the courtroom if the child's caretakers and prospective adoptive parents were present and in disagreement over what was best for the child. These discussions led to further refinements in the bill draft.

From these discussions and a review of the federal requirements, the proposed mechanism to terminate the parent-child relationship after the child had been in care for at least 15 of the most recent 22 months was the required filing of a petition to terminate the parent-child relationship. The legislation was drafted so that all parties would have the right to file a motion to dismiss such a petition on one of four grounds: 1) the child was placed with a relative; 2) to terminate the parent-child relationship was not in the best interests of the child; 3) the parents were receiving services to reunite the family under a case plan, and the case plan had not yet expired; or 4) the family needed substantial services to reunite the family that the DFC had failed to provide. This provision was a more drastic measure than what the federal legislation required; ASFA

required *only documentation in the case plan* that the parental rights should not be terminated due to one of the above reasons.

However, the DFC and its partners who drafted the legislation were particularly mindful of the concern of the juvenile court judges that some case managers were reluctant to file petitions to terminate parental rights, even in cases in which that appeared to be in the child's best interests. As a result, some children were denied an opportunity to be freed for adoption. Therefore, this mechanism was designed to put the decision-making process in the hands of the court and to let the court determine whether to proceed with the termination of parental rights based on the evidence presented. In addition, to address the findings of the Court Improvement Project survey, the proposed legislation would require courts to hear petitions to terminate the parent-child relationship within 90 days of the petition's filing, in order to speed the process further toward permanency. The major concern was for those children awaiting a decision regarding termination of their parents' rights. These children were truly in limbo, since the court had determined that the children could not be safely returned to their parents; yet, the children were not free to be adopted by others.

A review of data for December 1996 from the state's child welfare information system showed that 7,254 children had been in foster care longer than 15 months. Further analysis of Indiana's data showed that 3,038 children who had been in care for at least 15 months were 14 years of age or older.

TABLE 1. Number of Children in Indiana's Child Welfare System (1996 and 1999)

	As of 12-31-96	As of 10-1-99
Number of Children in Need of Services (CHINS)	12,580	12,897
Number of CHINS in substitute care	9,665	8,267
Number of children in care longer than 15 months	7,254	4,309
Number of children in care longer than 15 months who are 14 or more years of age	3,038	1,511
Number of children in care longer than 15 months who are younger than age 14	4,216	2,798

Source: The Indiana Family and Social Services Administration, Division of Family and Children, October 1999.

(According to Indiana Code 31-19-9-1, a child over the age of 14 years has the right to consent to his or her own adoption.) The remaining 4,216 children were under the age of 14 years and had been in care for longer than 15 months. (See Table 1.) These children were the focus of the State's attention for this legislation. About 25% of the State's children were placed with relatives, a circumstance that might lead to an exception to the filing of a petition to terminate parental rights, particularly if the child's relative caretaker was unable or unwilling to adopt the child. Given this information, the full implementation of ASFA was estimated to affect 3,150 to 4,216 children already in foster care and their families. Each year, an additional 5,000 children were placed in emergency foster care and were expected to be affected by the provisions effective November 19, 1997, for time-limited reunification and expedited permanency under ASFA.

Implementation of the legislation was estimated to cost the Indiana and the federal governments $4.6 million in the first two years of implementation. The costs of implementation were administrative (case management and attorney staff time) and programmatic (adoption subsidies and other benefits). The costs were to be offset by an estimated savings of $8.7 million in foster care costs in the second year of implementation, due largely to the anticipated exodus of children from the system.

At the same time that the DFC was drafting legislation, Senator J. Murray Clark, R-Indianapolis, was working on his own child welfare reform legislation. The O'Bannon administration saw some benefit in combining efforts to promote one strategic piece of legislation. Senator Clark's major concerns about child welfare were the length of time that children stayed in the system, a lack of accountability on the part of DFC staff for the timeliness of services and respect for parental rights and the length of time that prospective adoptive families had to wait for children to be freed for adoption. "At times we lose sight of what I think should be the priority–what's in the best interest of the child. Allowing children to float through the foster care system for years is terrible for kids," he said (McBride, 1998: B1, B6).

In agreeing to author the legislation, Senator Clark added to the proposed legislation a "rebuttable presumption" that the state's jurisdiction would end after a child had been in foster care for 12 months. At the 12-month permanency hearing, the court would have to determine whether the state had successfully rebutted the presumption and could continue jurisdiction with a permanency plan for the child. If the state failed to rebut the presumption, the child would be returned to the parent(s) or a petition filed to terminate the parents' rights, at the discretion of the court.

In reviewing the chances for the proposed legislation to succeed, it is important to note that the Indiana Senate was dominated by the Republican Party, and the House was split evenly among Democrats and Republicans.

In such an atmosphere, the need to collaborate became critical to the successful passage of the legislation. A series of meetings with child advocacy organizations, public and private agency administrators, mental health service providers, and foster parent representatives led to further discussion of the proposed state legislation and specific concerns. Those in favor of the legislation spoke for the expedited permanency process, the expected increase in the number of adoptions of foster children and the emphasis on the health and safety of children in decision-making for children. Opponents of the legislation said that the rights of parents were not being given proper weight, while others said that the requirement for all children who had been in foster care for 15 of the most recent 22 months to have a petition filed to terminate their parents' rights was too extreme and would be detrimental to some foster children who would be left with no legal family under these conditions.

By the time the bill got to the floor of the second chamber, it was being branded a "bad bill" by some members of both parties. Right-wing groups were circulating literature that the bill invoked "sanctions and penalties against parents but none against the welfare system," that there was a "bounty" being placed on children whose parents would have their rights terminated, and that parents who were unable to afford an attorney would be at risk (D. Kruse, personal communication, February 18, 1998). The term "bounty" referred to the adoption incentive funds that states would receive under ASFA if they exceeded their baseline number of adoptions of foster children. Each foster child's adoption was worth up to $4,000 in additional federal funds, with special needs children's adoption being worth up to $6,000. Meant to be a performance-based incentive, the bonus was being used by these right-wing groups to imply that the state would be rewarded for taking more children from their parents.

Meanwhile, on the left, there were concerns by parents' advocates about the limited access to legal representation by parents in poverty and about the lack of notice to parents of the consequences of their failure to improve their parenting skills to the court's satisfaction within the first 15 months of the child's time in foster care. In addition, the organization representing court-appointed special advocates for children continued to be concerned that some children would be harmed by the provisions for automatic filing of petitions to terminate parental rights at 15 of 22 months in foster care.

The bill passed the second chamber but was referred to a conference committee to resolve these differences. The conference committee took testimony from judges, child advocates and parents' rights advocates. Their committee report reflected the following major changes:

> Parents would be advised of their rights and the possibility of termination of their parental rights either at the time of the child being taken into custody (for new cases) or at the time of the next court review (for children already in foster care).

- The detention period for a child prior to the first court hearing was reduced from 72 hours to 48 hours, to be more consistent with the child's sense of time and to be fairer to parents who may be able to safely care for their child.
- It was clarified that reasonable efforts to return a child safely to the parent should be made as soon as possible.
- It was clarified that **the court** must approve the out-of-home placement of a child consistent with the permanency plan for the child.
- The parent may continue to seek to enhance their ability to fulfill their parental obligations and to receive family services even when the permanency plan for a child may be adoption or other plan that is not reunification. The local DFC office would not have to continue to make reasonable efforts to return the child to the parent or to place the child in close proximity to the parents' home.
- The procedure for the filing of a motion to dismiss a petition to terminate the parent-child relationship when the child had been in care for 15 of the most recent 22 months was clarified and amended.

In recommending passage of the legislation to her colleagues, Representative Sheila Klinker, D-Lafayette, said, "We have had a lot of input; we got all the players together and listened to their concerns...The focus is still to reunify the child with the parents, but free the child for adoption if the child cannot be safely returned home...We should not be keeping children in permanent foster care." (*S. Klinker, personal communication, February 28, 1998*). The Conference Committee report was accepted in the Senate by a vote of 48-0 and in the House by a vote of 97-2. Governor O'Bannon signed the legislation into law on March 11, 1998. With such apparent agreement, it was hoped that implementation of the new law would progress smoothly.

IMPLEMENTATION

Following the passage of any significant piece of legislation, there is always the challenge of "getting the word out" in a timely manner. Some of the provisions of Indiana's ASFA legislation became effective July 1, 1998, while others became effective July 1, 1999. Because this legislation had such far-reaching consequences for children, families, and the child welfare system itself, a work group was formed to assist the DFC in implementing ASFA. The work group included attorneys, judicial representatives, foster and adoptive parent representatives, a school of social work representative, public and private child welfare agency representatives from throughout the state, and a court appointed special advocate. The impetus for the formation of the work group was a regional conference regarding the ASFA provisions hosted by the Administration for Children and Families, Department of Health and Human Services (DHHS), in Chicago.

Themes presented at the conference were the increased focus on the needs of the child, timeliness in service and decision-making on behalf of children and their families, the importance of considering cultural issues in determining permanency options and how "permanency" is defined for children, the readiness of the system itself to change, the need for courts to have critical information in order to make the best decisions for children and the importance of attending to the progress in each child's case. The definition of "permanency" in particular was proving a challenge for participants in that, for many children, the child welfare system had become their "permanent" caretaker. Brissett-Chapman (1998) defined permanency for children as "an affectionate bond that endures through space and time emotionally and psychologically." For the children who had been in foster care for years, permanency with a family and an exit from the child welfare system would prove a challenge, no matter whether the children lived with a relative, a long-term foster parent, an institution or other caretaker.

The most immediate concerns identified by the Indiana work group were the challenges of meeting the time lines for termination of parental rights associated with the 15 of 22 months that children were in care, the question of medical coverage for adopted children who were not eligible for Title IV-E benefits and Medicaid, the ability to provide financial assistance to relatives as a permanency option for children, the need to include case conferencing as a strategy to come to consensus on recommendations to the court, and the need for comprehensive, coordinated training across the various parts of the delivery system. The group spent considerable time discussing various interpretations of the new law and trying to reach consensus on how ASFA should be implemented.

The O'Bannon administration had continued an effort begun in 1996 by then-Governor Evan Bayh to increase the number of adoptions of special needs children by increasing recruitment of prospective adoptive families, improving family preparation for special needs adoption and providing more post-adoption services through contracts with private agencies. Because of this public-private partnership, Indiana had seen an increase in placements of special needs children for adoption, from 327 for 1995 to 700 for 1997 (*Indiana Family and Social Services Administration, 1997*). However, in spite of this effort to move children to permanency, a number of barriers remained.

Among those barriers that the work group identified was the difficulty of achieving adoption for some children placed with relatives or in "long-term" foster care. These were children who had more emotional and physical disabilities or who were older and did not particularly want to be adopted. For some families, there was a cultural bias against the termination of parental rights of one family member in order to allow another family member to adopt the child. At the same time, these children were often in fairly stable homes, with either a kinship family or a committed foster family.

In some cases, there were safety issues associated with continued contact by the child's parent or parents while the child was placed with a relative.

The group began to focus its energies and expertise in developing options that would include medical coverage and some sort of subsidy for these kinship and foster families to achieve permanency for the children. Indiana had implemented a Child Welfare Demonstration Project under a Title IV-E waiver in January 1998. Indiana's waiver was to include flexible use of the federal IV-E foster care funds and the ability to provide services in the child's home. Two of the State's 92 counties, Marion (Indianapolis) and Allen (Fort Wayne), were developing guidelines to use these flexible funds for permanency for older children in the foster care system through use of assisted guardianships. Allen County was looking at the same benefits for children age 14 and older. Through the efforts of the work group and those who were developing these two pilot projects, a statewide assisted guardianship program is targeted to begin in July 2000 (*C. V. Williams, personal communication, October 19, 1999*). It is important to note that all those involved in developing this program believed that adoption should continue to be the first and most legally secure option for children who cannot return safely to their parents. The rules for assisted guardianships will therefore require that adoption be ruled out as an option for the child prior to the child being eligible for an assisted guardianship.

In addition to this effort, the work group was instrumental in the extension of Medicaid under the state's plan for special needs children who are receiving an adoption subsidy under the state's program, but who are not eligible for the federal IV-E Adoption Assistance program. This new health care entitlement was effective July 7, 1999.

One of the issues that kept coming to the forefront was the possibility of ASFA implementation creating "legal orphans" who would not be able to be adopted due to age and other special needs. The work group continued to be somewhat divided in their opinions about the automatic filing of a petition to terminate parental rights when a child had been in care for 15 of 22 months. Some felt that the case manager should have been able to make the decision regarding a "compelling reason" to avoid the filing of a petition to terminate parental rights and to document that in the case plan. There was much discussion about what degree of discretion judges had to dismiss such petitions, particularly if the child was placed with a relative. In addition, some group members felt that foster family care was being painted in an unfavorable light as undesirable for children due to ASFA's emphasis on other options for permanency. However, work group member Clara Anderson of the Children's Bureau of Indianapolis, called the group to task by saying "A child is already an orphan if the parent cannot be depended on or is absent. Don't deny the child an opportunity to be adopted" (*C. Anderson, personal communication, October 1, 1999*).

The work group was also instrumental in the coordination of training efforts that began as early as May 1998. The first groups to receive training were the attorneys who participate in court hearings on behalf of the local DFC offices and court-appointed special advocates who represent children in court. In June 1998, the judges with juvenile court jurisdiction received training regarding the ASFA provisions; and the DFC trained over 700 case managers and supervisors. More questions emerged as the various groups began to realize the implications of ASFA not only for the children and families, but also for themselves and how they would complete their work.

One of the counties with the greatest challenges was Lake (Gary). There were over 3,000 children in foster care in Lake County, many of whom had been in care for 30 months or longer. There were also hundreds of petitions to terminate parental rights pending on the court's docket. Through the commitment of the Juvenile Court Judge, the Honorable Mary Beth Bonaventura, and with some Title IV-E funding from the State Court Improvement Project, additional court magistrates were added to hear these petitions. The DFC also began to contract for additional attorney time and to allow additional overtime pay for case managers to expedite the court hearings and decision-making process for these children. As of December 1998, there were over 500 petitions to terminate parental rights being processed by the court in Lake County. Case managers who had been so committed to family reunification that they could not understand the need to terminate parental rights began to see benefits for the children in permanency through adoption. Many of these case managers had to experience the failure of attempted reunifications of children with parents before they realized that reunification is not always the answer for some children and some parents.

Efforts to provide training for foster parents and for private child welfare agencies have been sporadic. Foster parents have received some training through local foster parent support groups and conferences sponsored by the Indiana Foster Care and Adoption Association. Many of the State's private foster care agencies have taken particular interest in the provisions of ASFA and have been active in promoting training through their membership organization, IARCCA–an Association of Children & Family Services. IARCCA has developed resource materials that explain ASFA provisions and the court process as well as a parental rights booklet that can be used with parents by agency social workers (Graham & Hill, 2000). Training efforts have focused on the permanency provisions of ASFA, the emphasis on the health and safety of the child as the paramount concern, the need to work collaboratively across disciplines to make recommendations to the court in the child's best interest, the accountability measures through the required time lines for permanency and termination of parental rights, and the rights of foster parents and others to notice of court hearings and the opportunity to be heard in court. Even with these efforts, cross-disciplinary training remains a need for those who are working in the child welfare system.

Subsequent ASFA legislation in the 1999 Indiana General Assembly included mandatory criminal record checks for all prospective adoptive parents (State law already required such checks for foster parents), establishment of statutory requirements for therapeutic and special needs foster parents, and clarification that the court has discretion to terminate the parent-child relationship in a case in which the child is placed with a relative if to do so is in the best interests of the child.

The implementation process for ASFA continues. For the year 2000, DFC has identified several goals related to the ASFA themes of permanency, safety, and timeliness of services:

- Prevent and reduce child fatalities by 15%.
- Increase adoptions by 10%.
- Increase number of children receiving independent living services by 10%.
- Reduce average length of out-of-home placements by 20%.
- Increase "community-based" services expenditures by 10%.
- Decrease the number of child abuse and neglect investigations open for more than 90 days by 33%.
- Decrease the number of children in out-of-home placements by 10%.

DFC Director James M. Hmurovich stated his commitment to the achievement of these goals: "All the laws and policies do not matter if operations are not accountable to make the changes happen. We improve that which we measure." (*J. M. Hmurovich, personal communication, October 14, 1999*). DFC's strategy to meet implementation goals includes not only the measurement and tracking of accomplishments, but also strengthening the process of recruiting adoptive families for children through more aggressive contracts with private agencies. In addition, the role of foster parents and the engagement of foster parents as members of the case management team and as permanency resources for children have been re-emphasized.

OUTCOMES

The most important outcomes are for the children involved in the child welfare system. It can be said with certainty that more children are exiting the system since the number of children in foster care, especially those in care for more than 15 months, has decreased. (See Table 1.) This can be directly attributed to the efforts of the DFC offices, the courts, and child advocates to achieve permanency for children in the system. As further evidence of Indiana's success in moving children to permanency, on September 24, 1999, Indiana received the sixth highest award in the nation as an adoption incentive bonus for its 54% increase in the number of foster children adopted in federal fiscal year 1998 (954 children) over the baseline years of FY 1995-97.

Outcomes for families are more difficult to ascertain than the numbers would indicate. Carlis Williams of Governor O'Bannon's Office, who served on the DHHS Task Force on Outcome Measures required under ASFA, wants to be sure that parents receive the services that they need and that the DFC has enough people to provide the services for reunification and follow-up so that children are safe. In serving on the Outcomes Measures Task Force, Ms. Williams reported that she was most moved by the perspective of juvenile and family court judges who felt the need for greater communication and information prior to making their decisions regarding children. Ms. Williams, an adoptive parent of foster children, is also concerned that adoptive parents are adequately prepared for the rigorous emotional and physical demands that adoption of special needs children brings and that they have adequate post-adoption support services (*C. V. Williams, personal communication, September 30, 1999).*

For the child welfare system, the changes have been slow but profound. The increased number of children who are moving more quickly to permanency is evidenced in Table 1. For those with experience working in the child welfare system, the question remains, "Are these children going to experience a better life or are they going to return to the system through failed reunifications, adoptions, or guardianships?" Service provider Clara Anderson noted that the child welfare system has to move to provide more supports for adoptive families. "The infant model of adoption is that you 'say goodbye' after the adoption is finalized. With special needs adoption, you keep the door open." (*C. Anderson, personal communication, October 1, 1999*). The family is more likely to experience crises and need intervention strategies that support and preserve the family.

CONCLUSION

In order to more adequately assure that ASFA is being implemented in a manner that promotes the safety and well-being of children, states must continue to provide interdisciplinary training that is focused on best practices, which at the same time educates those working in the child welfare system about the requirements of the law. The recently published federal regulations for Titles IV-E and IV-B include the ASFA provisions and outline penalties for noncompliance with the federal requirements.

The "best interests" of each child should continue to be the driving principle behind the work of public agency case managers, private agencies, the court, child advocates and attorneys. In all the efforts to meet timelines and assure accountability, one must not forget that decisions are being made that affect each child's life. Outcomes should not only be assessed in the aggregate, but also for each child touched by the child welfare system. Children who come into foster care have already experienced the failure of their families. The system cannot afford to fail them, too. Well-trained staff and judges and well-coordinated services, offered in a timely manner, to families (whether birth,

kinship or adoptive) provide the best hope for these children to realize the promises of safety and permanency offered by the Adoption and Safe Families Act.

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An Infusion Model for Including Content On Elders with Chronic Mental Illness In the Curriculum

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ABSTRACT: *Older people with chronic mental illness (CMI) are experiencing longer life expectancies that parallel those of the general population. Due to their experience of having CMI, these older adults present unique issues that affect service delivery and care provision. Content on this population is often omitted in the curriculum, which leaves students unprepared to practice with these clients. This article proposes an infusion model that can be used in baccalaureate or graduate foundation courses to increase exposure to elders with CMI.*

People with lifelong disabilities have experienced increased longevity along with the aging of the general population. Individuals with chronic mental illness previously lived shorter and more restricted lives. With increased lifespans and changes in service systems from institutional to community-based care, however, greater numbers of people with psychiatric disabilities are living into late life. Although estimates of the prevalence of elders with chronic mental illness (ECMI) vary, a NIMH study indicates a minimum of four million older persons with a mental disorder (Aiken, 1990). Chronic mental disorders experienced by the elderly include schizophrenia and other psychotic disorders, bipolar disorder, depression, anxiety disorders and personality disorders. Elders with CMI, therefore, are increasingly coming to the attention of service providers in health, gerontological and mental health related fields.

For many adults, a psychiatric diagnosis is a chronic disability that affects their adulthood and late life stages. The experiences of a person with CMI can have a dramatic impact upon health and resources in later life. Such issues include the functionality of the person's social support system, the effects of extended psychotropic drug usage and other health related changes, a lack of appropriate community resources and family dynamics involved in providing care for an older member with CMI.

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Demographic forecasts herald the explosion of the elderly population and point to the increasingly large number of elders who will make up social workers' caseloads in the 21st century. The need for additional social workers who have expertise in gerontology has been well documented (Kropf, Schneider, & Stahlman, 1993; Lubben, Damron-Rodriguez & Beck, 1992; Peterson, 1990; Solomon & Mellor; 1992). Particularly, there is an omission in educating students about the unique needs and experiences of groups of vulnerable older adults, such as elders with lifelong disabilities (Kelly & Kropf, 1995; Kropf, 1996; Turk, & Overeynder, 1993). The importance of focusing on elders with CMI is highlighted by the fact that mental health has long been a major field of practice for social work practitioners and currently represents social workers' primary area of practice (Gibelman & Schervich, 1993). The high level of social work involvement in the mental health arena coupled with the rapid growth of the elderly population will result in an increased number of elders with CMI who seek the assistance of knowledgeable social workers. The strategy that is advocated here to address this reality is to promote awareness of ECMI through the infusion of content into the foundation sequence of the social work curriculum. An infusion strategy is advocated over a discrete course offering since this method provides all students with some exposure to this older population. In addition, the curriculum in many schools may not provide enough flexibility to mount an elective focused on this content. An infusion model is presented to provide faculty with content that can be included in undergraduate or graduate foundation courses.

AN INFUSION MODEL FOR ECMI CONTENT

Infusion of content about ECMI provides students with an opportunity to learn more about how aging and mental health issues intersect to affect service provision. ECMI clients have a high level of service contact through health, psychiatric, aging and legal services. Unfortunately, practitioners in these service settings are often unaware of the cumulative impact that aging and mental illness have on individuals and their families, and on service needs, options and resources. By including information concerning elders with CMI throughout the curriculum, students will gain knowledge about the needs of and issues related to ECMI on various system levels. Therefore, infusing content related to ECMI can prepare students for the multi-dimensional challenges that are involved in practice with this vulnerable older client group.

Human behavior in the social environment (HBSE)

The HBSE sequence addresses theories and knowledge of human development from a biopsychosocial perspective and includes information concerning how social forces and cultural systems affect individual functioning and well-being. In this sequence, the experience of living with a chronic mental illness, the associated experiences of stigma and discrimination, and the impact of CMI on family developmental stages should be addressed.

Many elders with CMI first became ill when they were in their 20's or 30's. Therefore, these individuals have lived the majority of their adult years with a psychiatric disability. This type of disability often leads to abnormal experiences of early and middle adult years, which then differentially shape their experiences in later years (Cohler & Beeler, 1996; Quam, 1986). Poor communication skills, problematic behaviors and difficulty maintaining stable relationships are common among those with CMI. For this reason, males with CMI are less likely to marry and CMI females have a higher incidence of divorce. Those with mental illness who do marry, in general have fewer children and more childless marriages (Clayton, 1994; Winocur, 1994). The relationships that mentally ill persons have with their spouses and children often become seriously strained over time. Research suggests that many family members eventually burn out after years of caring for a mentally ill relative (Cutrona, Schutte, Suhr & Russel, 1991). Difficulties maintaining stable relationships also result in smaller friendship and social support networks. In addition, those with CMI often have a lower occupational status and broken or non-existent employment histories (Clayton, 1994; Goodwin & Jamison, 1990; Winocur, 1994).

The combination of these factors can lead to the amplification of common challenges faced by the elderly. Smaller family and social support networks are associated with aging due to the death or incapacitation of family members and friends. In addition, elders often have more difficulty taking advantage of existing supports because of mobility problems. For an elder with CMI, the loss of a key relative or friend may seriously attenuate or even destroy a fragile social support system. Available financial resources also typically shrink with advancing years due to retirement, increased health related expenditures and widowhood. For elders with CMI, a history of low status, low paying and short-term jobs often results in a lack of financial security such as limited or no pension plans. Those individuals whose mental status negated the possibility of paid employment, must rely on meager SSI payments (Goodwin & Jamison, 1990; Winocur, 1994). Therefore, many ECMI face their later years with seriously diminished social and financial resources.

The majority of ECMIs alive today were first hospitalized in the 1930's and 1940's when institutionalization was a common experience for those with florid psychiatric symptoms (Sherrell, Anderson & Buckwalter, 1998). Many ECMI have histories of repeated institutionalizations and treatment with more primitive forms of electroconvulsive therapy (ECT) and with early psychotropic medications. As a result, many elders with CMI are very distrustful of the mental health system and of the hospital environment. These perceptions may compromise both their ability to work effectively with mental and medical health care providers and their willingness to follow through on health care recommendations. Long-term use of neurolyptic medications, commonly used to treat schizophrenia, carries a high risk of serious side effects such as tardive dyskinesia (TD), involuntary and repetitious movements

of face, trunk and limbs. While TD is inconvenient and uncomfortable for younger persons, this condition can pose serious threats to elders who may already be at an increased risk for falls (Jeste & Wyatt, 1987).

Issues related to the impact of CMI on family development and on the functioning of late-life families are also highly relevant. The onset of CMI can disrupt normative patterns of family development. Young adult children typically move away from home, start to accept emotional and financial responsibility for themselves and begin to form lasting relationships (Jordan & Franklin, 1995). This trajectory, however, is disrupted for those whose psychiatric symptoms emerge in early adulthood. Those whose symptoms emerge later, however, may marry and begin a family. A mental disorder at this stage of a family's development can result in severe strain in or the dissolution of a marriage. Parenting may be erratic due to recurrent mood swings or psychotic episodes. At times, children are asked to prematurely assume adult roles such as caretaking for an ill parent and younger siblings (Lefley, 1991). As a result, children may grow up experiencing a mixture of emotions including shame, guilt, confusion, fear, and love, which they carry with them into their adult years (Johnson, 1990). These dynamics can have serious implications when a person with CMI becomes frail in later years and requires additional assistance. Many times spouses are no longer involved with the CMI elder. While some adult children are very willing to assume caregiving responsibilities, others may be reluctant to re-engage with their ill parent and take on this role. Thus, the disruption to family functioning that begins early in the CMI person's life often continues and poses serious challenges to the operation of later-life families.

Practice methods

Foundation practice classes provide a theoretical framework for direct practice which informs students' development of assessment and intervention skills. This practice content, according to the CSWE guidelines, is also to include techniques and skills for practice with clients from at-risk populations (CSWE, 1994). ECMI are an example of a largely overlooked at-risk population that can benefit from assessment and intervention grounded in the ecological perspective. In order to effectively practice with ECMI, special attention must be paid to relationship development, illness and treatment history, special family dynamics and distinctive resource needs.

The relationship building tools of "tuning in," active listening, empathy and non-judgmental acceptance, are particularly important when working with ECMI. These elders, who struggle with the dual stigma of mental illness and age, are often used to being discounted. In addition, they may have some difficulty expressing themselves, describing their experiences, and fully understanding questions due to the combined effect of mental illness and age-related factors (e.g., hearing impairment or expressive aphasia). Future practitioners should understand the importance of eliciting these elders' perception of their situation and of validating

their emotional responses in order to gain valuable information and build trust and rapport. Equally important is the skill of obtaining a thorough illness and treatment history. Elders with CMI have varying experiences of treatment by the mental health community. While some elders' experiences may have been positive, others have had negative encounters with mental health services. Such information will provide important clues to the elder's potential level of trust, cooperation and follow-through and to possible barriers that may exist.

To understand the meaning of the symptoms that the elder presents, the symptom history should be explored. It should not be assumed that current symptoms represent the typical pattern of illness recurrence. While this may be true, new symptoms or patterns of symptoms can emerge as the elder's illness evolves over time (Goodwin & Jamison, 1990; Winocur, 1994). Such a change can have serious repercussions. On the other hand, new symptoms may not be related to the chronic mental illness at all but, rather, to physical or cognitive factors such as infection, medical disease, functional impairment or dementia. A wide range of medical illnesses and conditions can cause or exacerbate psychiatric symptoms. Unfortunately, medical problems that produce psychiatric symptoms are often undiagnosed in mentally ill elders (Schmidt, 1986).

Because family support is so crucial, it is necessary that assessment and involvement of the family is always considered. A necessary first step is an evaluation of the family history and dynamics. At times, children or spouses are angry or have conflicted feelings about the elder with CMI. A history in which neglect, abandonment or abuse by the elder occurred during the active phases of their disease may have left scars on family members that need to be addressed before increased involvement is possible (Patterson, Semple, Shaw, Grant, & Jeste, 1996). Family members who have a long history of involvement with the elder may require education about the impact that aging is having on their ill relative. Family members, for example, often confuse symptoms related to a medical condition or dementia with the symptoms of mental illness. As a result, the effects of medical or cognitive deterioration are often misunderstood and, at times, ignored. Family members with past experience dealing with the mental health system may adopt an adversarial role if their past experiences with the system were negative. Affirming the value of their knowledge and their input into the treatment of their relative can be critical. Educating family members about agency operations and about treatment processes and methods can be critical in relieving family distrust and securing their involvement.

A variety of resources and community services may be required in order to promote optimal functioning of an elderly person with CMI. A focus on ECMI provides students with an excellent example of the importance of the referral specialist, broker and advocate roles in securing needed resources for vulnerable clients. ECMI represent a social work constituency that requires an extensive knowledge by the professional of two separate service sectors and of how these

service sectors intersect. Often an information exchange does not exist between aging and mental health-related agencies. Social workers dealing with ECMI, therefore, must pro-actively seek out and link such agencies to develop adequate and coordinated service delivery. Many mental health agencies assist younger clients with vocational rehabilitation, housing and recreational opportunities. Such services may not meet the needs of elders with CMI. Other mental health agencies whose services do benefit elders may have physical barriers, such as stairways, which prohibit elders' participation. Such cases exemplify the need for students to move beyond the referral specialist role and become a broker, defined as an intermediary who actively works to connect people with needed resources (Hepworth, Rooney, & Larsen, 1997). To perform a broker role, a thorough knowledge of community resources, including solid working relationships with key contact people, is necessary.

Social welfare policy

The foundation social welfare policy course focuses on the history and current patterns of social welfare policies and programs and highlights how these may promote or hinder optimal functioning and well-being. The history of mental health and aging policy clearly demonstrates how governmental policies reflect prevailing culture, values and knowledge and how such policies positively or negatively affect the lives of vulnerable members of our society.

In the early part of this country's history, the family was seen as the system with primary responsibility for meeting the needs of the disabled, including the elderly and mentally ill. Federal and state monies were not directed toward the provision of services to support families in the care of their mentally ill or frail elderly relatives. In the early part of the 19th century, sentiment began to change about the government's role in addressing the basic needs of the most vulnerable citizens. Local governments assumed greater responsibility for the indigent elderly through the development of poorhouses, while state-operated asylums addressed the needs of the mentally ill. While some mentally ill elders were admitted to the state-run asylums, most indigent elders, regardless of their condition, were placed in local poorhouses. Although the poorhouses represented an improvement over the neglect that ECMI previously had experienced, no psychiatric or medical treatment was provided. In the beginning of the 20th century, however, an emphasis on the medical model to treat both the elderly and the mentally ill resulted in a change in this system. The passage of the State Care Act at the turn of the century shifted responsibility for insane and demented elders to the states (Goldman & Frank, 1990). Local communities, which were interested in reducing their own financial burdens, readily sent elders and the mentally ill to the state-run mental hospitals.

The housing of dependent elders and the mentally ill in state-run institutions continued until the middle of the century. During the late 1950's, the introduction of psychotropic medications as a method to treat chronic mental illness, combined

with a service emphasis on treating persons in the "least restrictive environments" created the impetus for the de-institutionalization movement, shifting care for the mentally ill back to the local community. Insufficient planning and funding, however, resulted in a dearth of adequate resources to meet the needs of de-institutionalized patients. As a result, families have once again become the primary caregivers of persons with CMI. Today, 50% - 73% of the mentally ill live with family members (Johnson, 1990).

The introduction of Medicaid in 1965, which funded nursing home residence for indigent elders, enabled the "trans-institutionalization" of older persons with CMI from state-run mental hospitals to nursing homes where the federal government shared the financial burden for their care (Sherrell, Anderson & Buckwalter, 1998). Just as de-institutionalization did not translate into the adequate provision of community-based services for younger persons with CMI, inadequate arrangements existed for the treatment of ECMI within the nursing home environment. Research indicates that while trans-institutionalized elders did receive psychotropic medications to treat psychotic symptoms, less than 10% received any type of psychosocial therapy (Aiken, 1990). As time went on, concerns about increased federal spending led to the passage of the 1987 Omnibus Budget Reconciliation Act (OBRA). This act requires that persons with mental illness only be admitted to Medicaid-funded nursing home beds if they also have a medical illness or disability that necessitates nursing home care. Therefore, elders who require a structured living environment and supervision due to a mental illness alone cannot be admitted to a federally supported nursing home. At the time the act was passed, elder nursing home residents who had a chronic mental illness but lacked a medical illness or disability were discharged from their nursing homes. Unfortunately, few housing and service alternatives for mentally ill elders have been developed by local or state governments. While community-based services for younger persons with CMI are widely recognized as inadequate and many states are experimenting with new service delivery systems, little attention has been focused on the paucity of services for ECMI.

Medicare, which was introduced in 1965 along with the Medicaid program, greatly increased elders' access to affordable health care services and significantly decreased the number of elders forced into poverty by health care bills (Hooyman & Kiyak, 1996). Medicare, however, focuses on services to meet elders' acute care needs. Funding is not provided for continuing care services to address chronic conditions, such as schizophrenia. Additionally, while Medicare covers 80% of elders' outpatient medical costs, it only funds 50% of their outpatient mental health costs (Aiken, 1990). Such a system can act as a deterrent to elders who seek mental health care treatment. Lack of adequate insurance coverage and a dearth of appropriate programs contribute to the high numbers of elders with mental health needs who do not receive services. Studies estimate that between 37% and 60% of elders with mental health care needs do not receive treatment (Wetle & Mark, 1990).

Social welfare policies have considerably improved the treatment and living conditions of elders with CMI. However, many gaps in services still exist. Currently, there is no one comprehensive policy covering geriatric mental health care. The existing system of finance for psychiatric services is fragmented and confusing. Current congressional discussions on the future shape of Medicare reflect societal concerns about the rapid growth of the elderly population, the size of the federal budget and generational equity. The future shape of both Medicare and Medicaid will inevitably affect elders with CMI. A classroom examination of how values, priorities and beliefs have influenced the development of policies that impact ECMI and how these policies have been translated into programs could provide students with a deeper understanding of why and how social welfare policies are developed and implemented.

Research methods

The foundation social work research course teaches students to understand, appreciate, and use diverse research methods in order to conduct ethical, efficacious and accountable practice. Additionally, students are taught to understand and avoid potential biases in research with minority and disadvantaged groups. Information about ECMI can be infused into this content to demonstrate issues related to the adequate definition of study populations, appropriate measurement selection and study design.

Prevalence studies on chronic mental illness among elders face many challenges and have resulted in widely varying estimates of the current number of EMCI and the projected number of such elders as the baby boomers age (Nordhus, Nielsen & Kvale, 1998). These challenges include varying definitions of key terms. Students should be advised that when investigating community-dwelling elders with chronic mental illness, several terms must be carefully defined. First, a decision must be made regarding the term "elderly". The required age for Social Security partial benefits (62 years) or full benefits (65 years) could be selected. Some researchers choose a younger age, such as 50 or 55 years, especially when studying persons, such as those with CMI or developmental disabilities, whose conditions and resultant lifestyle may lead to early disability and illness (Cohen, 1991; Seltzer, 1992). Next, the term "mental illness" must be considered. Some researchers include all DSM-IV axis I diagnoses, including substance abuse and dementia, while others exclude the latter two diagnoses. Still others include Axis II personality disorders (Neugebauer, 1980). The term "chronic" may refer to ongoing illness that began in younger years and persists into later life. Alternately, "chronic" could apply to late-onset mental disorders which then continue throughout the later years. Lastly, the term "community-dwelling" could be used to mean only those ECMI who live alone or with their families, or may also include those dwelling in assisted living facilities or in nursing homes.

Students need to understand the implications of operational concepts when designing or evaluating a research study involving elderly with CMI.

Once the study population has been suitably defined, issues related to data collection arise. A wide variety of instruments has been developed to measure various aspects of mental health and functioning. Many of these instruments, however, were originally designed for younger populations and, therefore, may lack validity with the elderly (Schulz & Visintainer, 1991). When designing a research study of elders with CMI, students should carefully examine potential instruments and determine the populations on which the instruments were used. The appropriate source of the data to be collected must also be carefully considered. Although, at first glance, the natural data source may appear to be the persons with CMI, when the subjects are elderly the possibility of cognitive impairment must be considered. Cognitive deficits that compromise the reliability of self-reports may exist in some subjects. In such cases a primary caregiver or surrogate may be asked to provide the needed information. Issues regarding the accuracy of information provided by proxies must be taken into consideration, however. Research suggests that information obtained from proxied responses may be systematically biased (Allen & Mor, 1997).

Many studies of community-dwelling persons with CMI and of their family members have been conducted since the introduction of de-institutionalization. There is increasing research on both the chronically mentally ill and on the elderly. However, very little research has focused on ECMI. Additionally, studies that examine the impact of caregiving among family members of older persons with CMI are scarce (Abramson, Quam, & Wasow, 1986; Patterson, Semple, Shaw, Grant, & Jeste, 1996). Students should be cautioned about applying the results of studies about CMI to the elderly population. Similarly, the results of studies focusing on elders with dementia or late-onset psychiatric disorders should not be applied to ECMI. Students may be helped to appreciate the reality of such threats to external validity by considering the following questions: In what ways are ECMI and their families similar to or different from younger persons with CMI and their family members? In what ways are ECMI and their families similar to or different from other elderly populations, such as those with Alzheimer's Disease, and their caregivers?

LEARNING ACTIVITIES AND RESOURCES

In addition to including content in social work courses, learning activities can increase students' awareness of the complexity in working with older adults with CMI and heighten their sensitivity to the impact of chronic mental illness on elders' experiences, relationships and resources. In-class exercises contrasting case management situations for older and younger adults with chronic mental illness serve to highlight the differential impact that CMI has on young vs. older adults and on the resources that are (or are not) available in the community for these two

populations. Case studies focused on the experience of family members of an elder with CMI can help sensitize students to the personal and practical challenges that families encounter as they struggle to secure needed services and supports for older members with complex and multifaceted needs. Class assignments that encourage students' interaction with professionals in the mental health field who serve older clients can help sharpen the students' understanding of the special skills needed to work with this client population.[1] In practice and human behavior classes, these types of activities can refine assessment skills, and highlight the developmental issues for the individuals' and the family. In a policy class, the activity can highlight fragmentation between various service sectors (e.g. mental health, health, aging). The research classes can use these exercises to develop a needs assessment for the community. Instructors including ECMI content in their courses can find additional information and resources at the National Alliance for the Mentally Ill website (www.nami.org)

CONCLUSION

This model provides an infusion strategy to assist faculty in including more content about a vulnerable segment of the older population–elders with chronic mental illness. For teaching content on ECMI, this framework exposes students to the multi-level issues in service provision, including how the aging process effects the older person with mental illness, family dynamics that affect care provision, interfaces within the service system and various methods of understanding and treating mental illness in the current cohort of older adults.

This model cannot exhaustively cover all of the material that is relevant to providing service to ECMI. However, it does provide a foundation for including content on this population that is traditionally omitted in the curriculum. As advances in health and mental health fields continue to extend the life expectancy rates, social workers will continue to see increased numbers of ECMI in various service settings. Social workers who receive foundational information about salient issues facing this population will be better prepared to offer quality service. The infusion model presented here provides faculty with relevant content on ECMI to include in case examples, lecture content or experiential activities.

NOTE:

[1] Contact the primary author for copies of case studies and exercises

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Effect of Urban Poverty on Parents' Expectation of Their Children's Achievement

Shanta Pandey
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ABSTRACT: *In this study we examine if parents' expectation of their children's success in life varies by type of urban neighborhood. Do parents' expectations of their children's educational achievement and age at which their offspring may start their first job, marry and have children vary by the type of urban neighborhood in which they reside? Analysis of data taken from inner city Chicago indicates that residents in urban neighborhoods varied in their demography, ethnic status, marital status, labor force participation, earnings ability, welfare dependency and asset holdings. Parental expectation of their offspring's educational achievement and age at which offspring may begin working or marry, however, did not vary by type of neighborhood. Expected age at which their children may have kids, however, did vary by type of neighborhood. Actual first child's success indicators were also similar across types of neighborhood. This study shows that parents' expectations for their children's achievement are largely independent of the poverty level of the urban neighborhood in which they reside. The findings also challenge the validity of the culture of poverty theory.*

Concentration of poverty in urban neighborhoods has negative social and economic effects on those who reside in these neighborhoods. A neighborhood effect that has intergenerational consequences is parents' expectations of their children's achievement. None of the existing studies have assessed if place of residence or level of neighborhood poverty makes a difference in parents' expectations of their children's success. Now there is data available that allow us to test if and how living in poor urban neighborhoods affect parents' expectation of their children's achievement. The Urban Poverty and Family Life Survey project has a range of data on inner-city residents in Chicago (Wilson et al., 1987). This study examined neighborhood effects on parental expectations of children's achievement after controlling for some of the family level factors that are known to have an effect on parental expectations. This paper highlights and differentiates neighborhood effects from individual or

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family level effects on parental expectations of their children's success. We divided Chicago's inner city neighborhoods by their poverty levels into high, moderate and low poverty areas and examined if parents' expectations of their children's success varied by these neighborhoods, even after controlling for parents' demographic characteristics, employment status, income status and asset holding. More specifically, we examined the following questions: 1) What are the consequences of neighborhood poverty on parents' expectation of their children's success? 2) Do parents from low, moderate and high poverty neighborhoods hold different views of their neighborhoods? 3) How does their perception of their neighborhoods as places to live affect their expectation of their children's success in life? and 4) Does parental expectation of their children's achievement correspond with actual outcomes by type of neighborhood?

BACKGROUND

Oscar Lewis (1959) popularized the culture of poverty theory by implying that the poor hold values different from those of the mainstream and these values are transferred across generations. Ricketts and Sawhill (1988), discussing underclass behaviors, indicated that incidents of welfare dependency, weak labor force attachment, nonmarital childbearing and school dropouts are concentrated in many inner-city neighborhoods. Attaining lower levels of education, becoming a parent earlier, marrying earlier and early entry into jobs increase the likelihood of living in poverty and long-term welfare dependency (Krein, 1986; Mueller & Cooper, 1986; Veum & Weiss, 1993). Studies showing a modest growth of underclass neighborhoods between 1970 and 1980 (Hughes, 1990; Ricketts & Mincy, 1988) imply that urban neighborhoods are changing for the worse, because the values and behavior of urban residents are becoming more and more different from the mainstream population. Other studies that examined differences in values, behavior and attitudes of the poor from the mainstream population have questioned the validity of the culture of poverty theory (Coward, Feagin, & Williams, 1974; Davidson & Gaitz, 1974; Rank, 1994; Schiller, 1995).

Using structural perspective, others studying urban poverty have maintained that regional economic restructuring and out-migration of middle class populations have resulted in a rise in urban poverty and underclass behaviors (e.g, nonmarital childbearing, dropping out of school, staying on welfare for a long period) (Kasarda, 1989; Wilson, 1987; 1991; 1996). Douglas Massey (1989a; 1989b) proposes that a rise in urban poverty is due to racial segregation and an in-migration of poor populations because of availability of low-cost housing in the inner cities. As a result, since the 1970s, poverty in urban neighborhoods has not only increased but is also spatially concentrated. Proponents of the structural perspective view underclass behavior as an outcome of factors that are external to the individual and can be addressed by improving social and economic conditions in the inner cities.

Still other studies have linked rise in divorce and single parent families with rise in urban poverty. Children raised in single parent families tend to marry early, attain lower levels of education, become parents early and tend to have a higher rate of divorce than children raised in families with both biological parents (Astone & McLanahan, 1991; Haurin, 1992; Krein & Beller, 1988; Li & Wojtkiewicz, 1992; McLanahan & Sandefur, 1994; Michael & Tuma, 1985; Wojtkiewich, 1992).

CONSEQUENCES OF RISE IN NEIGHBORHOOD POVERTY

Studies of urban poverty show that poverty contributes to the social and economic decline of urban neighborhoods, leading to a rise in unemployment, births to unwed mothers, infant deaths, delinquency, teen pregnancy, crime, drug related problems and drops in housing values (Coulton, Chow, & Pandey, 1990; Coulton & Pandey, 1992; Pandey & Coulton, 1994). There is also evidence that some extremely poor areas have higher rates of child abuse (Garbarino & Kostelny, 1992; Garbarino & Sherman, 1980; Steinberg, Catalano, & Dooley, 1981) and mental health problems, such as low levels of self-esteem and self-efficacy (McLeod & Shanahan, 1993; Wilson, 1991).

Urban neighborhoods, however, are not homogenous. They vary significantly in their social conditions (e.g., crime, delinquency, drug problems, infant death), economic conditions (e.g., poverty rate, unemployment rate, housing values) and demographic makeup (residents of extremely poor neighborhoods tend to be younger and minorities) (Pandey & Coulton, 1994; Coulton & Pandey, 1992; Coulton, Pandey, & Chow, 1990). There is variation in the way social, economic and demographic conditions affect the residents of these neighborhoods (Pandey & Coulton, 1994; Coulton & Pandey, 1992; Coulton, Pandey, & Chow, 1990). It is not clear, however, why poverty or a declining economic base has a differential effect on those who reside in these neighborhoods (Tienda, 1991). While there is general agreement that these neighborhood conditions affect the well-being and life chances of people residing in them, studies have shown mixed results and little definite impact (Coulton, Pandey, & Chow, 1990).

NEIGHBORHOOD POVERTY AND PARENTAL EXPECTATION OF CHILDREN'S SUCCESS

The expectations poor parents have of their children and if and how neighborhood poverty affects parents' expectation of their children's achievement are important to understand. Parents' expectation of their children's success in life is not only an expression of their ability to supervise and invest in the future of their children (Sherraden, 1991) but also their assessment of barriers and opportunities in the neighborhoods where they reside. Parents'

expectations not only embody the prevailing social norms of the neighborhoods, but also social and economic changes that are taking place in their neighborhoods. Parents' expectation is also an expression of the kind of achievement the society in which they live values and of what represents realistic aspirations.

A study found that parental expectation of their children's educational achievement is a strong and positive predictor of actual educational achievement of their children across urban, suburban, towns and rural areas (Smith, Beaulieu, & Seraphine, 1995). This study also noted that parental expectation of their children's educational achievement varies across rural and urban or suburban areas but not across urban and suburban areas (Smith, Beaulieu, & Seraphine, 1995). This study did not examine if parental expectation of their children's achievement varies within urban areas. Other studies have mostly examined if poor people's aspirations for themselves and for their children differ from those of the mainstream population (Farber, 1989; Schiller, 1995). These studies have shown that parental aspirations for their children's success are independent of parents' socioeconomic status; parents from across the socioeconomic spectrum expect to see similar social and economic success for their children (Schiller, 1995). Farber (1989), in a study of aspirations of adolescent unmarried mothers from different social and economic backgrounds in Chicago, found that race and socioeconomic status were independent of their aspirations for themselves. These mothers held mainstream aspirations about educational and vocational achievement irrespective of their race or social and economic status and were aware that becoming a parent earlier in life was a barrier for their economic success (Farber, 1989).

Analysis in this paper combines both family level and census tract data to examine factors explaining parental expectations of their children's future. At the family level, parents' demographic characteristics, employment status, parents' perception of their neighborhood as a place to live, assets and income were included in the analysis. These variables have considerable support in the literature. Sherraden (1991) points out that parents with assets tend to perceive a brighter future for their children than those who do not hold any assets. This is because parents with assets are likely to invest more in their children's health, education and well-being and transfer any remaining assets, through inheritance, to their children. Also, educated parents tend to have higher expectation of their children's educational attainment (Smith, Beaulieu, & Seraphine, 1995). Similarly, studies indicate that poverty among children is directly linked to parental employment and earnings capacity (Lichter & Eggebeen, 1994). In this analysis, we not only included parents' employment status but also actual earned and unearned (welfare) income. We examined the effect of parents' demographic characteristics, employment status, income status, asset holdings, perception of their neighborhood as a place to live and neighborhood poverty rate on parents' expectation of their children's success in life. We also examined, using a select

number of cases for which data were available, if parents' expectation of children's success in life is congruent with actual outcomes experienced by children.

METHODOLOGY

The data come from a survey of 2,490 inner-city residents of Chicago and were collected by the National Opinion Research Center in 1986-87 for the Urban Poverty and Family Structure Project of the University of Chicago (Wilson et al., 1987). Data include neighborhood or census tract level and individual level variables. Those respondents who were born in the United States, were parents, and had children under the age of 18 were selected for the analysis. The final sample included 1,316 cases, all living in inner-city neighborhoods of Chicago.

Variables included in the analysis were: 1) percentage of families below poverty in a Census tract (1980); 2) parental demographic characteristics, employment characteristics, income (nonwelfare and welfare), asset holdings, perception of neighborhood as a place to live and expectation of their children's achievement; and 3) actual events in the life of the first child. Parental expectation of children's success included parents' expectation of children's overall success compared to their own, expected educational achievement, age at which parents expect their children to marry, age at which parents expect their children to have the first child and age at which parents expect their children to begin their first job.

Neighborhoods were divided into three areas based on the prevalence of poverty: low poverty neighborhoods (20 or less percent of families living in poverty), moderate poverty neighborhoods (21-40 percent of families living in poverty), and high poverty neighborhoods (above 40 percent of families living in poverty). Of the total sample (n=1,316), 226 respondents (parents) resided in low poverty areas, 861 respondents resided in moderate poverty areas and 229 respondents resided in high poverty areas. Variation in demographics, labor force participation, income characteristics, asset holdings, parent's expectation of children's achievement and children's actual achievement were examined across the three types of neighborhoods. Using a χ^2 test of significance (φ [phi] coefficient = $\sqrt{(\chi^2/n)}$, which is a measure of the strength of the relationship is also reported) and one-way analysis of variance, we examined the differences in parents' demographic, economic, and asset characteristics by poverty areas. Hierarchical regression analyses were employed to determine the factors that explained the variation in parents' expectation of children's achievement.

TABLE 1. Results of One-Way Analysis of Variance (for Ratio Level Variables) and φ Coefficient ($\chi 2$ Values) (for Nominal Level Variables) on Parents' Demographic, Economic, and Asset Characteristics by Poverty Areas (n=1,316)

VARIABLES	LOW POVERTY 20 or less % of families are poor (n=226)	MOD-ERATE POV-ERTY 21-40% of families are poor (n=861)	HIGH POVERTY above 40% of families are poor (n=229)	F values	φ coefficient (χ^2 values)
Demographic characteristics					
Mean Age	32.06	31.24	29.80	6.95**	----
Mean Education	12.64	11.83	11.53	16.84**	----
Mean # of children born to respondent (R)	2.26	2.50	2.63	3.83*	----
Race					
% African American	40.70	64.00	89.50	----	.30 (118.5**)
% Hispanic	13.30	16.40	6.1	----	.11 (15.91**)
Sex					
% male	33.20	28.80	22.3	----	.07 (6.84*)
Marital status					
% married	54.40	39.40	21.4	----	.20 (52.55**)
% never married	19.90	36.60	54.6	----	.21 (58.84**)
Mean # of yrs. lived in this neighborhood	8.01	9.76	10.98	5.99**	----
Mean # of times changed residence in last 5 yrs.	1.63	1.23	1.19	6.46*	----
Labor force participation related variables					
% worked last week	62.4	51.1	31.0	----	.19 (47.24**)
Mean # of hours usually worked per week	27.27	21.45	13.78	24.28**	-----
% relied on public transportation to go to work	25.30	33.60	30.80	----	.08 (8.66**)
% went to work alone in automobile	53.20	45.50	44.90	----	.14 (26.46**)
% with working telephone	87.60	82.10	72.10	----	.12 (18.95**)

Income characteristics					
Mean earned income in the last month	1053.02	727.15	339.29	23.28**	----
Mean investment income in the last month	21.60	26.59	0.00	----	----
Mean gift income in the last month	10.30	6.96	7.83	.23	----
Mean alimony income in the last month	26.44	13.28	9.84	2.95*	----
Mean welfare income in the last month	98.61	217.76	355.97	16.20**	----
Asset holdings	48.0	28.10	17.1	----	.21 (54.28**)
% with personal savings account	22.7	16.20	6.1	----	.15 (24.31**)
% owns a home	11.7	8.60	4.4	----	.08 (7.91**)
% with retirement account	29.1	20.00	7.0	----	.17 (36.25**)
% with pension plan	14.8	9.50	5.7	----	.10 (10.82**)
% with stocks and bonds					
Parents' expectation of children's achievement					
Mean age R expects children to marry	25.28	24.98	24.89	0.66	----
Mean age R expects children to have kids	26.42	24.83	23.64	20.19**	----
Mean age R expects children to begin first job	19.92	19.24	19.03	6.62**	----
R's expectation of children's overall achievement	2.73	2.81	2.89	----	.11 (15.52**)
[a]Expectation of children's educational achievement	college graduate	some college	some college	9.96**	----
Actual 1st child behavior (asked only to respondents who were grandparents, n=171)					
Mean age at which 1st child became a parent	18.67	18.40	17.68	1.11	----
% of 1st child married at the birth of 1st grandchild	13.60	15.90	11.80	----	b

• P<=.05; ** P<=.01. [a] This is a continuous variable all the way up to 12th grade; labels were assigned for college education. φ coefficient (χ^2 statistic) not executed because of insufficient cases in each cells.

RESULTS

Demographic characteristics by type of neighborhood.

Differences between low, moderate and high poverty neighborhoods on salient factors identified in the literature are presented in Table 1. Parents' mean age, educational level and number of children varied significantly across the three types of neighborhoods. Respondents from high poverty neighborhoods were twice as likely to be African American (89.5%) as those in low poverty neighborhoods (40.70%). Also a significantly higher proportion of respondents from low poverty neighborhoods were male (33.20%) compared to those in high poverty neighborhoods (22.3%). More than half the respondents from low poverty areas were married (54.40%), whereas only one fifth of the respondents from high poverty neighborhoods were married (21.4%). One out of five respondents living in low poverty neighborhoods were never married (19.90%), whereas 54.6% were never married in high poverty areas. Respondents from low poverty neighborhoods lived significantly fewer years in the same neighborhood (mean yrs. = 8.01) and changed residence significantly more often than did respondents from high poverty neighborhoods (mean yrs. = 10.98).

Labor force participation.

The proportion of respondents who were employed varied from 62.4% in low poverty neighborhoods to 51.1% in moderate poverty neighborhoods and 31.0% in high poverty neighborhoods. Respondents from low poverty neighborhoods worked twice the amount of hours per week (mean hrs. = 27.27) compared to those from high poverty areas (mean hrs. = 13.78). The difference in number of hours worked per week by type of neighborhood was statistically significant. Also a significantly higher percentage of respondents from low poverty neighborhoods had a working telephone (87.60%) compared to those in high poverty neighborhoods (72.10%). More than half (53.20%) of respondents from low poverty neighborhoods used an automobile to travel to work, whereas only 44.90% of respondents from high poverty neighborhoods used a car to travel to work. Instead, a significantly higher percentage of respondents from high poverty neighborhoods (30.80%) relied on public transportation to go to work, compared to 25.30% from low poverty neighborhoods.

Income characteristics.

There was a significant difference across the three types of neighborhoods in earned income, alimony income and welfare income. Respondents from high poverty neighborhoods earned three times less, had no investment income and had much less gift or alimony income compared to those from low poverty neighborhoods. They received more in welfare income than those from low poverty neighborhoods.

Asset holdings.

A very small fraction of respondents from high poverty areas had savings accounts (17.1%), retirement accounts (4.4%), pension plans (7.0%), owned homes (6.1%%) or invested in stocks and bonds (5.7%). A greater number of respondents from low poverty neighborhoods had saving accounts (48.0%), retirement accounts (11.7%), pension plans (29.1%), owned homes (22.7%%) and invested in stocks and bonds (14.8%). Chi-square tests indicated significant differences in all asset holdings by poverty areas.

Neighborhood as a place to live.

Parents' rating of their neighborhood as a place to live is presented in Table 2. A much higher percentage of respondents from low poverty neighborhoods preferred to live in the same neighborhood (42.7%) compared to those from high poverty neighborhoods (23.1%). A much lower percentage of respondents from low poverty neighborhoods preferred to live in another part of the city of Chicago (21.8%) when compared to those in high poverty neighborhoods (41.5%). While 32.1% of respondents from low poverty neighborhoods would have preferred living in the suburbs, only 12.7% of residents from high poverty neighborhoods preferred living in the suburbs.

Table 2 Respondent (Parent)'s Perception of His/Her Neighborhood As a Place to Live (n=1,316)

VARIABLES	LOW POVERTY 20 or less % of families are poor (n=226)	MODERATE POVERTY 21-40% of families are poor (n=861)	HIGH POVERTY above 40% of families are poor (n=229)
Neighborhood preference			
prefers to live in this neighborhood	42.7%	32.8%	23.1%
prefers to live in another Chicago neighborhood	21.8%	26.0%	41.5%
prefers to live in the Suburb	23.1%	24.0%	12.7%
prefers to live somewhere else	12.4%	17.2%	22.7%
Rate neighborhood as a place to live			
very good	14.2%	6.3%	3.1%
good	32.9%	24.2%	10.5%
fair	40.4%	50.0%	57.0%
bad	7.1%	14.3%	15.8%
very bad	5.3%	5.2%	13.6%
How has neighborhood changed over yrs?			
become a lot better	7.0%	4.9%	5.2%
somewhat better	23.7%	22.1%	21.0%
same	37.2%	32.2%	27.9%
somewhat worse	21.4%	27.8%	25.3%
a lot worse	10.7%	12.9%	20.5%
Where will neighborhood go in future?			
will become a lot better	15.6%	12.2%	10.5%
somewhat better	33.3%	29.1%	24.0%
same	25.3%	26.5%	27.5%
somewhat worse	13.3%	18.4%	18.8%
a lot worse	12.4%	13.8%	19.2%
How many men in this neigh. working steadily?			
Almost all	33.3%	19.0%	4.5%
most	31.9%	20.4%	12.5%
some	20.7%	29.7%	25.4%
very few	13.6%	27.9%	49.6%

none at all	0.5%	3.0%	8.0%
Has men working changed over past 10 yrs?			
decreased	29.4%	42.5%	44.8%
stayed the same	53.3%	40.7%	37.3%
increased	17.3%	16.8%	17.9%
Friends lost jobs due to shut down over 10 yrs?			
none	35.3%	26.8%	23.3%
few	36.6%	39.6%	33.5%
some	24.6%	22.4%	30.4%
most	3.6%	11.2%	12.8%
Gangs a problem in this neighborhood?			
big problem	33.3%	47.1%	57.2%
small problem	41.4%	37.7%	33.2%
not a problem	25.2%	15.2%	9.6%

Nearly half of the respondents from low poverty neighborhoods rated their neighborhoods as a good or a very good place to live (47.1%), whereas only 13.6% of the respondents from high poverty neighborhoods had a similar opinion of their neighborhoods. Only 12.4% of residents from low poverty neighborhoods felt that their neighborhoods were a bad or a very bad place to live, whereas 29.4% of residents from high poverty neighborhoods gave similar ratings. Similarly, 32.1% of respondents from low poverty neighborhoods felt that their neighborhood had gotten somewhat worse or a lot worse over the years, compared to 45.8% from high poverty neighborhoods. Similarly, 25.7% of respondents from low poverty neighborhoods felt that their neighborhoods would only get worse in the future, whereas 38% of residents from high poverty neighborhoods felt the same about their neighborhood. A lower percentage of residents from low poverty neighborhoods felt that men working on steady jobs declined over the past 10 years (29.4%) compared to those from high poverty neighborhoods (44.8%). A similar percentage of respondents from low poverty neighborhoods (33.3%) felt that gangs were a big problem in their neighborhood compared to 57.2% from high poverty neighborhoods. Results of all measures of neighborhood as a place to live were significantly different by type of poverty area.

Parents' expectation of children's achievement.

There were no significant differences across the three types of neighborhoods in parents' expectations of when their children would get married. Parents from low, moderate and high poverty neighborhoods expected their children to get married in their middle twenties. However, a statistically significant difference existed in the age at which parents expected their children to have kids or start their first jobs. Parents from low poverty neighborhoods expected their children to have kids approximately three years later and start their first job a year later than parents from high poverty neighborhoods. There was also a significant difference in parents' expectation of children's educational attainment among the three types of neighborhoods. Parents from low poverty neighborhoods expected their children to graduate from college, whereas parents from moderate and high

poverty neighborhoods expected their children to have some college education but not to graduate.

Actual behavior of first child.

To examine the consistency between parental expectations of their children's achievement and actual outcomes, we selected only those respondents who had grandchildren, because one of the expectations was related to the age that their children would have kids. There were 171 cases. Actual mean age at which the first child of a respondent had a child of his/her own did not significantly differ across the three neighborhoods (mean ages by type of poverty were: low = 18.67; moderate = 18.40; and high = 17.68). However, there was a discrepancy in parental expectation and actual age at which the first child had an offspring of his/her own. This discrepancy was evident in high, moderate and low poverty areas (see Table 1). Parents had expected their children to have children in their mid-twenties (expected mean ages were: low = 26.42; moderate = 24.83; high = 23.64), whereas the actual mean age was in the teens. Most of these children were unmarried at the time they became parents.

REGRESSION ANALYSIS

To follow up on results from the descriptive analysis and analysis of variance, we conducted a hierarchical regression analysis of parents' expectations of their children's success in life on parents' characteristics and neighborhood type (see Table 3). The order of the predictor variables were: parents' demographic characteristics, parents' work history, earned and unearned income, asset holdings, perception of neighborhood as a place to live and level of neighborhood poverty. Level of neighborhood poverty had no effect in three of the four outcome variables after parents' demographic characteristics, their work history, earned and unearned income, asset holdings, and perception of neighborhood as a place to live were controlled. The only significant effect of neighborhood poverty was on the age at which parents expected their children to have kids of their own. Parents from low poverty neighborhoods expected their children to have kids at a slightly later age than those in moderate and high poverty neighborhoods (see Table 3).

Table 3 Regression Coefficients (Standardized Coefficients) Demographic, Economic, Asset Holding, Perception of Neighborhood As a Place to Live, Type of Poverty Neighborhood, Affecting Parents' Expectation of Children's Success in Life, in Inner-city Chicago, 1987

Independent variables	Expected children's education (n=604)	Expected age child will get married (n=566)	Expected age child will have a child (n=560)	Expected age child will find job (n=605)

INTERCEPT	2.451** (0.000)	22.658** (0.000)	23.126** (0.000)	14.190** (0.000)
Demographic characteristics				
Age	-0.002 (-0.014)	-0.029 (-0.051)	0.030 (0.043)	0.027 (0.060)
Race (African American=1; else=0)	0.214* (0.094)	1.063** (0.142)	-1.265** (-0.144)	-0.164 (-0.028)
Race (Hispanic=1; else=0)	0.409 ** (0.132)	0.113 (0.011)	-0.427 (-0.036)	0.469 (0.058)
Sex (male=1; female=0)	0.081 (0.036)	-0.933** (-0.124)	-0.997** (-0.113)	0.482 (0.082)
Education				
Marital status (never married=1; else=0)	0.135** (0.271)	0.241** (0.148)	0.234** (0.122)	0.255** (0.199)
Marital status (married=1; else=0)	0.088 (0.035)	-0.157 (-0.019)	-0.380 (-0.039)	0.010 (0.002)
# of children	0.173 (0.077)	0.166 (0.022)	0.515 (0.059)	0.285 (0.049
Work history				
# of yrs worked in past 10 yrs	-0.039 (-0.047)	-0.071 (-0.026)	0.001 (0.0003)	-0.100 (-0.047)
# of hours worked per week	-0.015 (-0.075)	0.011 (0.016)	0.015 (0.018)	0.006 (0.011)
Earned and unearned income				
Last month's welfare income	-0.013** (-0.134)	-0.011 (-0.033)	-0.030 (-0.078)	0.009 (0.035)
Last month's investment income	-0.00006 (-0.009)	0.001 (0.062)	0.0008 (0.029)	0.0008 (0.045)
Last month's earned income	-0.0003* (-0.078)	-0.00004 (-0.004)	0.0006 (0.040)	0.0004 (0.042)
ASSET (has retirement account=1; no=0)	0.00005 (0.056)	0.00004 (0.012)	0.00004 (0.012)	0.0001 (0.044)
ASSET(has pension	-0.207 (-0.064)	-0.122 (-0.011)	0.293 (0.023)	0.669 (0.080)

plan=1; no=0)	0.166 (0.070)	0.234 (0.030)	0.983* (0.107)	0.185 (0.030)
ASSET (has stocks and bonds=1; no=0)	0.204 (0.068)	0.083 (0.008)	-0.340 (-0.029)	-0.365 (-0.047)
ASSET (has saving account=1; no=0)	0.118 (0.053)	-0.286 (-0.039)	-0.444 (-0.051)	0.112 (0.019)
ASSET ($ amount in saving account)	0.018 (0.026)	0.262 (0.114)	0.408 (0.150)	-0.196 (-0.108)
ASSET (owns home=1; else=0)	0.078 (0.030)	0.050 (0.006)	-0.163 (-0.016)	0.043 (0.006)
Neighborhood as a place to live	0.002 (0.018)	0.009 (0.022)	0.012 (0.024)	-0.025 (-0.078)
Yrs. lived in this neighborhood	-0.028 (-0.038)	-0.049 (-0.017)	0.162 (0.051)	-0.163* (-0.088)
# of times changed residence in past 5 yrs.	0.030** (0.127)	0.015 (0.018)	-0.018 (-0.020)	0.062* (0.100)
Neighborhood as a place to live, perceived index[1]	0.153 (0.054)	0.270 (0.029)	1.018* (0.094)	0.231 (0.032)
Poverty type				
Type of neighborhood (low poverty=1; else=0)	0.111 (0.031)	-0.306 (-0.026)	-0.656 (-0.048)	0.178 (0.019)
Type of neighborhood (high poverty=1; else=0)	0.199 0.165	0.082 0.042	0.150 0.112	0.129 0.093
R^2				
Adjusted R^2				

* P < = .05
** P < = .01

[1] The neighborhood perceived index include sum of the scores on all variables listed in Table 2.

All of the independent variables in the regression model were weak predictors of the age at which parents expected their children to get married (R^2 = .08; Adjusted R^2 = .04), have children (R^2 = 15; Adjusted R^2 = .11), start their first job (R^2 = .13; Adjusted R^2 = .09) or attain a certain level of education (R^2 = .20; Adjusted R^2 = .17). The only variable that was a significant predictor across all

outcome variables was parents' education. Educated parents expected their children to attain higher levels of education (b=.135), begin their first job at a later age (b=.255), delay marriage (b=.241) and start families at a later age (b=.234). We further examined the effect of fathers' education and mothers' education separately, and results indicated that education of both fathers and mothers were signifcantly related with all four outcome variables. In addition, mothers' education was a stronger predictor of parental expectation of their children's educational attainment (R^2 = .12; Adjusted R^2 = .12) than fathers' education (R^2 = .05; Adjusted R^2 = .05). Two other demographic factors that significantly correlated with some of the dependent variables were race and gender of parents. Minority parents (African Americans and Hispanics) expected their children to attain higher levels of education compared to Whites. Also, African American parents expected their children to get married at a later age but have kids at an earlier age compared to parents belonging to other races. Male parents expected their children to get married and have kids earlier than female parents.

Parents' work history, earned and unearned income and asset holdings had very little or no effect on the outcome variables. Of the different types of assets included in the regression analyses, only one of them significantly correlated with a dependent variable. Parents who had pension plans expected their children to have kids at a later age compared to those who did not have pension plans (b=.983).

Parents' perceptions of their neighborhoods as places to live were weak but significant predictors of parents' expectation of their children's success in life. Parents who changed residence more times expected their children to take their first jobs at an earlier age (b=-0.163). Parents who perceived their neighborhoods as better places to live expected their children to attain higher levels of education (b=0.030) and begin their first jobs at a later age (b=0.062).

DISCUSSION AND POLICY IMPLICATIONS

This study shows that neighborhoods in the inner city varied demographically. High poverty areas had a high concentration of African Americans, a majority of whom were female and had never married. Parents from low poverty neighborhoods were significantly older, had more years of education, and had fewer children. Yet, only education of parents (both fathers and mothers) significantly and positively affected all four outcomes of parents' expectation of their children's success in life. This finding indicates that education or human capital is key to enhancing parents' expectations of their children's success in life. This finding is consistent with the findings of other studies (Haveman & Wolfe, 1994; Smith, Beaulieu, & Seraphine, 1995).

Respondents from high poverty neighborhoods gave very low ratings to their neighborhoods as places to live. Compared to those from low poverty neighborhoods, a much larger percentage of respondents from high poverty neighborhoods felt that their neighborhood had gotten worse and would continue to get worse in terms of gangs and unemployment levels. A much larger percentage of residents from high poverty neighborhoods preferred to move out of their neighborhoods compared to those from low poverty neighborhoods. Unfortunately, those in high poverty neighborhoods often face discrimination in many areas (Wilson, 1996; Massey, 1989b) and lack the resources required to move out of their neighborhoods. Also, parents who felt better about their neighborhoods as places to live expected their children to attain higher levels of education and begin their first jobs at a later age. This may be a reflection of better school systems in these neighborhoods.

Labor force participation varied by type of neighborhood. However, parents' labor force participation had a negligible effect on all of the outcome variables. Consistent with Kasarda's (1989) findings, poor people from high poverty neighborhoods relied more on public transportation compared to those from low poverty neighborhoods.

Personal earned and unearned income and assets of respondents varied by type of neighborhood. The majority of those who lived in high poverty neighborhoods did not have any assets, whereas nearly half of those from low poverty neighborhoods had some form of assets. Respondents from high poverty neighborhoods had higher welfare income and very few held assets. This finding is expected; there is considerable theoretical support from the work of Sherraden (1991), who argues that welfare policies prohibit the very poor from accumulating assets. Surprisingly, parents' earned, unearned incomes and assets did not change their expectation of their children's success in life.

Interestingly, this study shows that parents' expectations for their children's success do not vary across high, moderate and low urban poverty areas. Parents' expectations of their children's success is independent of where they live after parents' demographic characteristics, employment status, asset holdings and income are controlled for. These findings are consistent with previous studies. Davis and Proctor (1989) concluded that beliefs, attitudes and values of people are independent of their socioeconomic status. Parents on welfare hold mainstream aspirations for their children (Rank, 1994; Schiller, 1995). Children, however, achieved less than what parents expected. On the one measure (age at which one expects their children to have kids) available in this data, parents had a higher expectation of their children but it did not match the actual behavior of children. Lower achievement of children is a reflection of lack of opportunities and other social and structural realities that confront poor children (Schiller, 1995).

This study shows that not only parents' expectations of their children's success does not change across family level social and economic status, but also that their expectations for their children are independent of the poverty level of the urban neighborhood in which they reside. Parents' education, especially mothers' education, is a strong predictor of their expectation of their children's achievement. This finding underscores the importance of investing in education for low-income families, especially low-income mothers. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (Public Law 104-193) has, however, reduced access to postsecondary education of poor women with children by removing entitlement status and imposing strict work requirements and time limits. The PRWORA replaced Aid to Families with Dependent Children (AFDC), Job Opportunities and Basic Skills (JOBS) and Emergency Assistance programs with a Temporary Assistance for Needy Families (TANF) block grant, which requires states to place increasing percentages of adults in work or work-related activities (U.S. Congress, 1996). The PRWORA represents a change in the definition of job training from the way that training was previously defined in the Job Opportunity and Basic Skills (JOBS) program. The JOBS program, under the Family Support Act of 1988, allowed a portion of welfare recipients to pursue postsecondary education. Under TANF, most postsecondary education and job training will not count as work. This represents a change in the policy. Under the PRWORA, states must put a substantial portion of their adult recipients into narrowly defined work programs (Albelda, 1997). TANF is designed to place recipients directly into jobs—any job, making states less likely to provide education. The findings of this study, however, suggest that education empowers parents and enhances their expectation of their children's achievement. This underscores a need to promote education of poor women with children. When the U.S. Congress revisits this policy in the year 2002, social work researchers, policy makers and practitioners can inform welfare policy debate and help transform current work based policy into a policy that supports education of parents.

LIMITATIONS OF THE STUDY

A limitation of this study is that the sample includes only parents with children under the age of 18; this biases the sample toward adults with younger children. Also, the data are cross sectional, and, therefore, it was not possible to compare actual behavior of children with the expectation of parents on all outcome variables. We could not examine if parenting ability (e.g., supervision) varied by type of neighborhood. A longitudinal study examining parents' ability to supervise their children and the actual behavior of these children would provide greater scope for examining how outcomes in children's behavior vary by type of neighborhood. Also, the data lacked variables measuring social conditions. Poverty is known to contribute to social decline of urban neighborhoods (Coulton & Pandey, 1992; Coulton, Pandey, & Chow, 1990; Pandey & Coulton, 1994). Future studies should examine how various neighborhood level social, economic, and demographic factors, in addition to

neighborhood poverty, affect parents' expectation of children's achievement and the actual behavior of children.

CONCLUSION

It is critical to understand the impact of neighborhood poverty because poor people have limited options in terms of where they can reside. Often they have no choice but to live in areas that have high concentrations of negative social conditions (such as crime, substandard housing, juvenile delinquency and teenage pregnancy), negative economic conditions (such as high unemployment rates, low housing values) and negative demographic conditions (such as a high concentration of children and unemployed males) (Coulton & Pandey, 1992; Coulton, Pandey, & Chow, 1990; Pandey & Coulton, 1994). This study finds that parents' expectations of their children's achievement do not vary across different urban neighborhoods. This finding questions the validity of the culture of poverty theory. The study also finds that education of parents is a consistent predictor of high and positive parental expectations for their children. This finding underscores the importance of investment in education for low-income parents, especially low-income mothers. The 1996 welfare legislation is myopic; it must be revised to encourage the education of poor parents, especially mothers with children.

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