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CARING FOR THE VULNERABLE: THE STATE OF SOCIAL WORK IN AMERICA

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTHY FAMILIES AND COMMUNITIES

COMMITTEE ON EDUCATION AND LABOR

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

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CARING FOR THE VULNERABLE: THE STATE OF SOCIAL WORK IN AMERICA

Tuesday, July 29, 2008
U.S. House of Representatives
Subcommittee on Healthy Families and Communities
Committee on Education and Labor
Washington, DC

The subcommittee met, pursuant to call, at 3:00 p.m., in room 2175, Rayburn House Office Building, Hon. Carolyn McCarthy [chairwoman of the subcommittee] presiding.

Present: Representatives McCarthy, Shea-Porter, Yarmuth, and Davis of Tennessee.

Staff Present: Tylease Alli, Hearing Clerk; Denise Forte, Director of Education Policy; David Hartzler, Systems Administrator; Jessica Kahanek, Press/Outreach Assistant; Deborah Koolbeck, Policy Advisor, Subcommittee on Healthy Families and Communities; Susan Ross, Director of Education and Human Services Policy; Margaret Young, Staff Assistant, Education; Stephanie Arras, Minority Legislative Assistant; James Bergeron, Minority Deputy Director of Education and Human Services Policy; Cameron Coursen, Minority Assistant Communications Director; Kirsten Duncan, Minority Professional Staff Member; and Linda Stevens, Minority Chief Clerk/Assistant to the General Counsel.

Chairwoman MCCARTHY. A quorum is present, the hearing of the subcommittee will come to order. Pursuant to committee rule 12(a) any member may submit an opening statement in writing which will be made part of the permanent record.

Before we begin I would like everyone to take a moment to ensure that your cell phones and BlackBerrys are on silent. We like it when everybody looks in their pocketbooks and purses to make sure it doesn't go off.

I now recognize myself, followed by the Congressman Davis from Tennessee, for an opening statement. I want to thank each and every one of you for being here today for this informational hearing on the state of social work in America.

Social work is a profession involving the education, treatment, care, support, and often nurturing of vulnerable individuals and families, with the objective of assisting or guiding them on how to improve their lives.

The average person's image of a social worker is someone who is very passionate about what they do in the face of challenging, difficult, mean, horrific situations, and whose work results in life-

changing experiences, all while being underpaid and under appreciated.

I am not sure if this is exactly the case for each social worker in America, and that is why we are having this hearing today, to educate the subcommittee on the work of social work.

The year 2008 to 2009 edition of the Bureau of Labor Statistics Occupational Outlook states that social work employment is expected to grow faster than average and that a Master's Degree in social work or related field has become standard for many positions. Further, it is expected that opportunities for employment in the social work profession should be good in rural areas, competitive in urban areas.

In the year 2006, there were 595,000 social workers, and that number is projected to reach 727,000 by the year 2016. Each year social work is expected to experience a growth of projected employment, with some areas expecting a larger increase than others. For example, it is expected that as the Baby Boom generation ages that there will be a greater demand for health and related services. Clearly if you are a young person looking for job opportunities in the future, social work is a field to consider.

However, that being said, most people don't know what social work is and what social workers do on a given day. Social workers engage in many fields and in many locations, including working with children, families, the elderly, those who are incarcerated or at risk of incarceration, those facing serious or life-threatening illness, those with mental health or substance abuse challenges, and with public health organizations and agencies.

Social workers also engage in public policy and government. We have six social workers in Congress, including my colleague, Congressman Shea-Porter, who is on the subcommittee here today. Welcome.

I employ a licensed social worker on my staff in my district. It was actually one of the first things I did because I had a feeling that with the work that I was getting into it was going to need a lot of hand holding and somebody that knew the way to get around, giving the services to my constituents. I think that somehow nearly all of us are connected to or have interacted with a social worker in some capacity.

Today we will learn about the various fields of social work, an overview of the profession, and perspectives on the state of the profession through the lens of educated, research diversity, and on-the-ground experience.

Again, I want to thank each of you for attending the hearing, and I look forward to your testimony.

Now I would like to introduce my colleague, Mr. Davis from Tennessee, for his opening statement.

[The statement of Mrs. McCarthy follows:]

Prepared Statement of Hon. Carolyn McCarthy, Chairwoman, Subcommittee on Healthy Families and Communities

I want to thank each of you for being here today for this informational hearing on the state of social work on America.

Social work is a profession involving the education, treatment, care, support, and often nurturing of vulnerable individuals and families with the objective of assisting or guiding them on how to improve their lives.

The average person's image of a social worker is someone who is very passionate about what they do in the face of challenging, difficult, and even horrific situations and whose work results in life-changing experiences, all while being underpaid and underappreciated. I am not sure if this is exactly the case for each social worker in America, and that is why we are having this hearing today—to educate the Subcommittee on the state of social work.

The 2008-2009 edition of the Bureau of Labor Statistics Occupational Outlook states that social work employment is expected to grow faster than average and that a master's degree in social work or a related field has become standard for many positions.

Furthermore, it is expected that opportunities for employment in the social work profession should be good in rural areas and competitive in urban areas. In 2006 there were five hundred ninety-five thousand social workers and that number is projected to reach seven hundred twenty seven thousand by the year 2016.

Each area of social work is expected to experience a growth in projected employment, with some areas expecting a larger increase than others. For example, it is expected that as the Baby Boom generation ages that there will be a greater demand for health and related social services. Clearly, if you are a young person looking at job opportunities in the future, social work is a field to consider. However, that being said, most people don't know what social work is and what social workers do in a given day.

Social workers engage in many fields and in many locations, including working with children, families, the elderly, those who are incarcerated or at risk of incarceration, those facing serious or life-threatening illness, those with mental health or substance abuse challenges, and with public health organizations and agencies. Social workers also engage in public policy and government.

We have six social workers in Congress, including my colleague Congresswoman Shea-Porter who is on this Subcommittee and here today. I employ a licensed social worker on my staff in my district. I think that somehow nearly all of us are connected to or have interacted with a social worker in some capacity.

Today we will learn about the various fields of social work, an overview of the profession, and perspectives on the state of the profession through the lenses of education, research, diversity, and on-the-ground experience.

Again, I want to thank each of you for attending the hearing and I look forward to your testimony.

Mr. DAVIS. Good afternoon. Thank you, Chairman McCarthy, for holding this important hearing. I would like to thank each of our witnesses who have taken the time to provide this subcommittee with their testimony. I would like to extend a special welcome to my fellow Tennesseean, Sarah Wells, who I will introduce later.

The importance of social workers cannot be overstated. These professionals serve every age range, race, ethnic group and social background, and they do so selflessly. Social workers advocate for people who cannot do it themselves and help them navigate the sometimes confusing array of public services available to them. Whether it is ensuring that an abused child is placed in a safe foster home or helping a family cope with a terminal illness, social workers improve the lives of individuals and families and their communities on a daily basis.

Chairwoman McCarthy, I look forward to working with you on this important issue. Again, I thank each of you for being here today and I am eager to hear your testimony. With that, I yield back.

[The statement of Mr. Davis of Tennessee follows:]

Prepared Statement of Hon. David Davis, a Representative in Congress From the State of Tennessee

Good afternoon. Thank you, Chairwoman McCarthy, for holding this important hearing. I'd like to thank each of our witnesses who have taken the time to provide this Subcommittee with their testimony. I'd like to extend a special welcome to fellow Tennessean, Sarah Wells, who I will introduce later.

The importance of social workers cannot be overstated. These professionals serve every age range, race, ethnic group and social background, and they do so selflessly. Social workers advocate for people who cannot do so for themselves and help them navigate the sometimes confusing array of public services available to them. Whether it is ensuring that an abused child is placed in a safe foster home or helping a family to cope with a terminal illness, social workers improve the lives of individuals and families in their communities on a daily basis.

Chairwoman McCarthy, I look forward to working with you on this important issue. Again, I thank each of you for being here today and am eager to hear your testimony. I yield back.

Chairwoman McCarthy. Thank you, Mr. Davis. Without objection, all members will have 14 days to submit additional materials or questions for the hearing record.

Let me explain our lighting system. In front of you, you will see three boxes there, green, yellow and red. Red basically means we would like to you stop your testimony. If you are in the middle of a sentence, believe me, we will let you go on. But just try and keep your testimony into that, and that goes for the members also.

So with that, if we have additional time, we will be asking additional questions.

Today we will hear from a panel of witnesses. Your testimonies will proceed in the order that I introduce you. I would like to introduce our first witness, Mr. Gary Bailey. He is an Associate Professor of the Simmons College for Social Work in Massachusetts and Assistant Professor at the Boston University School of Public Health. He is immediately past President of the National Association of Social Workers and serves as Chair of the International Federation of Social Workers Commission on Policy, Advocacy and Representation. In 1998, he received the honor of Social Worker of the Year and has received numerous awards since.

Today, Mr. Bailey will give us an overview of the social work profession, and we will look forward to learning what social work is and the success and challenges of the profession from him.

Our next witness, Dr. Mama, comes to us from New Jersey. I know Congressman Rush Holt wanted to be here, but unfortunately he got tied up back in his district. He wanted to introduce you. Dr. Mama is the Dean of School of Social Work at Monmouth University. She also serves as the representative of the International Federation of Social Workers at the United Nations in New York City.

Dr. Mama will speak to us about undergraduate and graduate education as well licensure requirements for the social work profession.

Mr. Michael Bird comes to us from New Mexico. Welcome. Mr. Bird has over 25 years of public health experience in the areas of medical social work, substance abuse prevention, health promotion, and disease prevention, HIV/AIDS prevention, behavior health and health care administration. Of his many accomplishments from 2000 to 2001, Mr. Bird was the first American Indian and the first social worker to serve as President of the American Public Health Association. He has also been involved in numerous health disparity projects and programs on a local, tribal, national, and international level.

Most recently, he was named to serve on the Robert Wood Johnson Foundation, Urban Indian Health Commission. Today Mr. Bird

will discuss the impact and necessity of diversity in the social work profession, in which he is a living example. Welcome again.

Our next witness, Dr. Bergeron——

Ms. BERGERON. Bergeron.

Chairwoman MCCARTHY [continuing]. Bergeron, will be introduced by our subcommittee social worker, Congresswoman Shea-Porter.

Ms. SHEA-PORTER. Thank you. It is my privilege today to introduce a constituent of mine. Dr. Rene Bergeron's impressive resume includes over 30 years of experience and numerous publications that focus on various topics from elder abuse and neglect, to family poverty, to domestic violence, just to name a few. She is a monthly contributor to the New Hampshire Senior Times and on the Board of the Advising Editors for the Journal of Elder Abuse and Neglect.

Dr. Bergeron serves as an Associate Professor in the Social Work Department at my alma mater, University of New Hampshire. We are both so proud of it. And as if all that is not enough to keep anyone busy, she currently serves as the President of the New Hampshire chapter of National Association of Social Work.

As a social worker and administrator myself, I would like to thank you, Dr. Bergeron, for your work in our field and for taking the time out today. You have a very busy schedule, as we know, and you are testifying and we appreciate it very much, and I look forward to your testimony.

Thank you, Madam Chairwoman.

Chairwoman MCCARTHY. You are quite welcome.

Next I turn to my colleague from Tennessee, Mr. David Davis, to introduce the Reverend Sarah Wells.

Mr. DAVIS. Thank you, Chairwoman McCarthy. I appreciate the opportunity to introduce our next witness. Reverend Sarah Wells has been an Executive Director of the Good Samaritan Ministries in Johnson City, Tennessee since 1998. Sarah graduated from East Tennessee State University from the Department of Social Work as a certified social work manager. Sarah served east Tennessee's first homeless education liaison for the upper east Tennessee region and worked to expand this program to what it is today throughout the State of Tennessee. Today Sarah strives to work towards learning new ways to reach out to her community.

Sarah is married to Dr. Vernon Wells and is the mother of four children and grandmother to 14.

Sarah, welcome to Washington.

Chairwoman MCCARTHY. Our next witness is Ms. Fuller. Ms. Fuller is a licensed social worker at the Department of Youth Rehabilitation Services in Washington, D.C.'s juvenile justice system. Her daily work involves a caseload of 27 young people who have been committed to the DYRS for acts of delinquency. Today she will share with us a view of her day-to-day work to help us gain an understanding of what social work is on a daily basis in the JJ system here in Washington. I want to thank you for being here today and joining you us.

I have already explained to you the lighting system. I am fairly lenient on that, but if you go way over you will probably hear me tap a little bit first, and then hopefully you will finish up your tes-

timony. We are now going to hear from our first witness, Mr. Bailey.

STATEMENT OF GARY BAILEY, MSW, ACSW, ASSOCIATE PROFESSOR, SCHOOL OF SOCIAL WORK, CLINICAL ASSOCIATE PROFESSOR, SCHOOL OF HEALTH SCIENCE, SIMMONS COLLEGE

Mr. BAILEY. Thank you, Madam Chair and Mr. Davis. It is an honor to have been invited here today to address you and to talk about the state of social work in the United States.

My name is Gary Bailey, and I am proudly an Associate Professor of Social Work at Simmons College School of Social Work in Boston, Massachusetts. Simmons was established in 1904 and was the Nation's first institute of higher learning to offer training for clinical social workers, and was begun in response to the need to professionalize charity.

I feel very fortunate to have been a professional social worker for the past 30 years, having worked in direct services and administrative capacities in the field of child welfare, gerontology, social work education, and having volunteered in the area of HIV/AIDS early on in the epidemic at the AIDS Action Committee in Boston, one of the Nation's foremost AIDS service organizations.

As I speak before you today, the Nation faces many complex and converging challenges, from our military engagement abroad to rising food and commodity prices and untenable mortgages at home. While each of the challenges individually demand the comprehensive engagement of the Nation's social workers, these trends taken together suggest a significantly increased need for professional social work services within vulnerable communities, both locally, nationally and internationally.

While it is clear that the Nation's social work community will be strained to meet this increased demand, a broader work community and an assessment of the true scope of these demands, along with the comprehensive plan to provide for adequate service to all in need is of vital importance.

I have had the honor of serving as President of the National Association of Social Workers from 2003 to 2005, and currently I am the Chairman of the National Social Work Public Education Campaign. I join you today to discuss the important role that the profession of social work plays in our society.

Social work is the helping profession. Across the Nation the profession of social work and social workers improve and enrich the lives of individuals and families and help build strong communities. Social workers provide critical services in rural, urban and suburban areas, and have long been society's safety net for a broad range of issues, including child welfare, mental and behavioral health, aging, corrections, health, and military and veterans affairs.

Much of society only encounters a social worker when dealing with a problem, such as moving a family member from a hospital to a nursing home, and there is limited public understanding of the role of social workers. However, we work to help individuals, families, and communities across the country, and the need for social work services will only grow with time.

As Chair of the Social Work Public Education Campaign, I have traveled this country and met numbers of people who have a universal awareness of social work as a helping profession. Many people lack, however, an accurate knowledge related to the education and credentials needed to be a professional social worker. They did not appreciate the diversity of the work, they were confused by the use of the more general term of caseworker, which at times is used interchangeably with that of social worker.

As the Baby Boomers continue to age, they will increasingly need social work services, ranging from mental health and family counseling to health, education, group programs and case management. Social workers, who provide the majority of the mental health services in the United States, will work with the 26 percent of the American population aged 18 and older that experience a diagnosable mental disorder. Professional social workers will counsel students to prevent high school dropout rates, work with formerly incarcerated individuals to ensure positive community reentry, and help patients diagnosed with serious illnesses such as cancer to make informed decisions about their care.

While the need for social work services will only increase with time, we are not equipped to keep pace with this demand, and Dr. Mama will go into that in more detail.

The social work profession has existed for over a century and has enriched many lives. Thirty years ago I made a decision to become a professional social worker, and I have never regretted that decision. While it is clear that the Nation's social work community will be strained to meet these increased demands, a broader assessment of the true scope of these demands, along with a comprehensive plan to provide adequate service for all in need, is a vital necessity.

So today I say to you again, my name is Gary Bailey and I am proud to be a professional social worker.

[The statement of Mr. Bailey follows:]

Prepared Statement of Gary Bailey, MSW, ACSW, Associate Professor, School of Social Work, Clinical Associate Professor, School of Health Science, Simmons College

Chairwoman McCarthy, Ranking member Platts, and honorable members of the Subcommittee on Healthy Families and Communities, I would like to thank you for inviting me here today to discuss the state of the profession of social work. My name is Gary Bailey and I am currently an associate professor at Simmons College of Social Work in Boston, Massachusetts. Established in 1904, Simmons was the nation's first institute of higher learning to offer training for clinical social workers. Simmons also was at the forefront of educating students for medical social work and managed care.

I feel fortunate to have been a professional social worker for the past 30 years having worked in many capacities including the fields of child welfare, gerontology and social work education. I served as President of the National Association of Social Workers from 2003 to 2005 and am the current Chairman of the National Social Work Public Education Campaign.

Background

I join you today to discuss the important role that the profession of social work plays in our society. Social work is the helping profession. Across the nation the profession of social work and social workers improve and enrich lives every single day. Social workers provide critical services in rural, urban and suburban areas and have long been society's safety net for a broad range of issues including child welfare, mental and behavioral health, aging, corrections, health and military and veterans' affairs.

As the baby boomers continue to age, they will increasingly need social work services ranging from mental health and family counseling to health education, group programs and case management. Social workers, who provide the majority of mental health services in the United States, will work with the 26 percent of the American population aged 18 and older that experience a diagnosable mental disorder. Professional social workers will counsel students to prevent high dropout rates, work with formerly incarcerated individuals to ensure positive community reentry, and help patients diagnosed with serious illness to make informed decisions about their care.

Social work began in the late 19th century when concerns about increasing poverty led people to question how to prevent and protect people from "falling through the cracks" in society. Many credit Jane Addams for the emergence of the profession as she created the first settlement house in America, Chicago's Hull House in 1889. Settlement workers were often women who settled in urban areas to address the various challenges facing immigrant communities. The settlements provided a vital service, Addams believed, both for the volunteer residents, who needed a purpose in life, and for the society at large, by building needed bridges between the classes in an increasingly stratified and fragmented society (Addams, 1893). Settlement house workers, charity organization societies, and child savers worked together throughout the end of the century to preserve healthy communities and ensure that biopsychosocial needs were being met.

During the Great Depression, economic, mental, and social needs rose dramatically and the social work profession was recognized as necessary to solve the seemingly intractable challenges of the times. Social workers created programs for the Department of Labor and the Department of Health, Education, and Welfare to combat widespread hunger and unemployment. The profession was dedicated to restoring hope for the American people and continued to see significant growth during the Civil Rights Movement and the War on Poverty as many of the architects of these important social initiatives were social workers. Recent decades have produced competition for financial resources and less understanding of the role of the social worker in society; however these professionals continue to help individuals, families, and communities across the country. The need for social work services will only grow with time.

Current Issues

The profession of social work has grown with and reflected the changing needs of our society. As previously mentioned, social workers are the largest group of mental health providers in the country. There are 192,000 clinical social workers across the United States treating adults, adolescents, children, veterans, the incarcerated, the elderly, and those diagnosed with diseases such as HIV/AIDS for a variety of mental health concerns ranging from emotional disturbances to serious debilitating illnesses. Social workers' most frequent specialty practice area is mental health whether it be in private practice, a mental health clinic , hospital, prison, or long term care facility.

Social workers not only practice in a variety of settings including child welfare and foster care agencies, community action centers, hospitals, government offices, mental health centers, homeless shelters, and schools but also cater to a diverse clientele. Social workers help people and communities overcome some of life's most difficult challenges including poverty, discrimination, abuse, addiction, physical illness, divorce, loss, unemployment, educational problems, disability, and mental illness.

Professional social workers have advanced educational preparation and practice experience. A professional social worker must have a bachelor's (BSW), master's (MSW) or doctorate (PhD or DSW) degree in social work. A master's degree in social work is the predominant degree for licensed social workers (79% for active practitioners) and we pride ourselves in being the profession trained to work with people in their environment, looking at all dimensions of the individual's life. Social workers recognize that most clients face complex situations and often have co-occurring needs and work to address all of these needs. For instance, a social worker specializing in aging would not only support their client's physiological, psychological, and social needs through mental health therapy, caregiver and family counseling, and health education but will also need to understand chronic illness as many elderly clients will be faced with these issues.

Social workers undergo advanced training in accredited education programs and grow their expertise through standards, credentials, and state licensing requirements. Social workers have the right education, experience, and dedication to help people help themselves whenever and wherever they need it. They understand complex support systems and work to connect people to the resources they need. Social workers focus on a person's strengths and help clients reach their full potential. It

is this unique blend of training, education, and experience that equips professional social workers with the tools necessary to tackle society's most pressing problems.

Challenges

Despite a century of service, the public is still not clear about what social workers do. The media often report on the profession only when a problem arises in the child welfare system and far too often these individuals are not professionally trained social workers as less than 35% of child welfare workers actually have any social work training. They may be performing in a social work capacity or hold a social work title without proper supervision or education. Despite some public perception, the vital services that social workers do provide in the child welfare system, as well as in numerous other areas, contribute to a healthy society.

There is confusion among the public as there is not one typical social worker. Social workers may work in traditional child welfare agencies or may hold public office as a member of Congress. They may own their own private mental health practice or work in a long term care facility. Few are aware that the largest employer of social workers in the nation is the Department of Veterans Affairs with over 5,000 professional social work employees. Uniformed social services play a critical role in our military efforts at home and abroad. It also often goes unnoticed that professional social workers are first responders to disasters such as Hurricane Katrina and the Virginia Tech shootings. They provide vital supports to victims and their families during times of crisis and for years beyond.

Professional social workers hold positions in government, nonprofit, business and educational settings. Informing the public about the breadth and depth of the profession is important as it affects the public's access to care, the ability of social workers to perform essential duties, and to impact important policy decisions. Many of the benefits U.S. citizens take for granted were implemented because social workers—working with families and institutions—spoke out against abuse and neglect.

During my tenure as Chair of the Social Work Public Education Campaign I have traveled the United States and met numbers of people who have a universal awareness of social work as a "helping" profession but who lack accurate knowledge related to the education and credentials needed to be a professional social worker; they did not appreciate the diversity of the work; they were confused by the use of the more general term of "case worker" used interchangeably with that of social worker. Generally the public has had a strong respect for the difficulty of the job and believes that social workers are overworked and are under valued. They also believed that we worked with the underserved, handle a variety of problems and generally believe that they will never need a social worker.

The need for social work services will only increase with time, however we are not equipped to keep pace with this demand. For example, there are currently 30,000 licensed social workers working in the field of aging; however the National Institute on Aging projects that 60,000 to 70,000 social workers will be needed by 2010. If schools of social work do not recruit young professionals and if we do not retain experienced social workers, the public will suffer from a lack of critical services. This is particularly true in the areas of aging and child welfare.

A key component of recruitment and retention of professional social workers is their ability to earn comparable salaries. Increases in social work salaries have not kept pace with other professions such as teaching and nursing. A survey conducted by the John A. Hartford Foundation, Inc. found that between 1992 and 1999 the annual rate of wage growth for degree-holding social workers was less than one percent. In addition, high educational debt is a concern of every graduating social work student. According to one study, 68 percent of individuals surveyed with a Master's Degree in Social Work (MSW) graduated with an average debt of $26,777. Many social workers will earn less than that upon graduation. Low salaries and high educational debt are making this profession an impossible choice for many.

These challenges must be overcome in order to ensure that the profession grows and thrives in the future and so that clients can continue to be served for years to come.

Conclusion

The social work profession has existed for over a century and has enriched many lives. Social work skills are broad and applicable in a variety of settings and make this profession unique and important. Social workers are educated, experienced, and ethical and provide a diverse range of services across the life span.

Thirty years ago I made a decision to become a professional social worker. I was introduced to the field of social work by a woman who was teaching a winter intercession course at my alma mater of Tufts University. Until that time I was preparing to pursue a career in medicine. In her class I was introduced to a field that

resonated with my desire to be a catalyst in people's lives for change; and to create opportunities where previously there had been none.

I have never regretted that decision and I am delighted to say that my name is Gary Bailey and I am a proud professional social worker.

Chairwoman MCCARTHY. Thank you very much, right on the mark too.

Dr. Mama.

STATEMENT OF ROBIN S. MAMA, PH.D., PROFESSOR AND DEAN, SCHOOL OF SOCIAL WORK, MONMOUTH UNIVERSITY

Dr. MAMA. Thank you, Chairwoman McCarthy and members of the committee, for allowing me to speak to you today about social work education. My name is Robin Mama, and I am the Dean of the School of Social Work at Monmouth University in West Long Branch, New Jersey.

My oral comments will be targeted to undergraduate social work education; however, my written testimony provides you with some additional information on Master's level education as well as social work licensure for practicing social workers.

There are over 400 Bachelor of Social Work programs in the United States. Some BSW programs stand alone, in departments that are combined with sociology, anthropology and/or criminal justice. Some BSW programs, like ours at Monmouth, are in the School of Social Work or a department that also offers a Master of Social Work program. And then there are a few who are combined with Master of Social Work, Bachelor of Social Work and Ph.D. In social work programs.

All undergraduate social work programs are generalist in their focus. Students in BSW programs do not concentrate in any area of practice or theoretical focus, as is the case with Master's programs. BSW students are taught to work in many areas of practice, whether it is casework or case management, group work, community practice, research or policy, and they should be able to work in any field of practice, be it gerontology, mental health, aging, child welfare.

Critical to the BSW curriculum is the field internship where students are placed in social service agencies to learn the day-to-day aspects of social service delivery. At Monmouth our BSW students complete a 30-hour volunteer experience in the sophomore year, a 100-hour junior internship, and 450-hour senior internship. These internships are always supervised by a licensed social worker at the Master's level and the agency supervisors often take a course in supervision that many social work programs offer.

So for example, Monmouth runs a course called SIFI, Supervision in Field Instruction, for all our new internship supervisors. The field internship is the place where academia meets practice. It is the applied aspect of social work and as such the vehicle that allows students to grow professionally and personally. A baccalaureate student usually knows they made the right choice of profession when they begin their field internship.

I was asked to address both the challenges of undergraduate social work education and their strengths, and I see these to be the following:

In terms of strengths BSW graduates have generalist skills and knowledge which allow them to work in many facets of social work. Their skills are portable, they are not tied to a specific job or function, but can be taken wherever the graduate goes and are applicable to a number of fields of social work practice.

BSW graduates are idealistic and enthusiastic. They want to change the world. This idealism often helps social services agencies because these interns allow agencies and their staffs to remember their own idealism, and many times they help the agencies to see the situations in a new light and help to renew their enthusiasm for social work. They also help to rejuvenate their faculty.

BSW students are at an advantage in the workplace because they are taught systems theory and learn to see the whole picture. They work well with professionals from other disciplines because they see everyone's role, they understand how roles fit together, and with their interpersonal skills they help to mediate difficult situations.

In terms of challenges, recruitment is the biggest challenge facing undergraduate social work programs. Many people, especially parents, are under the impression that social workers only help the poor and take children away from families. They also have the impression that social workers do not make livable salaries. All academic social work programs work hard to negate these impressions, but until the society at large begins to change their opinion this will be difficult. Public education on what social work is and what we do as professionals is essential.

Ensuring cultural awareness and sensitivity can also be a challenge, depending upon where the BSW program is located and who the students are. We need more bi- and trilingual social workers, and we need students to develop cultural awareness for all the clients and agencies that they come into contact with.

Finally, ensuring that social work as a program stays vibrant and respected at the college or university level is also a challenge. This is an applied working discipline that does not often garner large research grants nor garners large donations, and there are times when its usefulness to the larger university can be questioned.

Thank you again for this opportunity to speak to you.

[The statement of Ms. Mama follows:]

Prepared Statement of Robin S. Mama, Ph.D., Professor and Dean, School of Social Work, Monmouth University

Thank you for this opportunity to provide testimony for this important hearing. My remarks are focused on undergraduate social work education. I will generalize some of my comments to baccalaureate social work education, giving some specific examples from my experience at Monmouth University. I began teaching at Monmouth in social work in 1992, became the BSW Program Director in 1998 (when we added a master of social work program to our curriculum), became the Chair of the Department and MSW Program Director in 2004, and I am now the Dean of the School of Social Work which was just created on July 1, 2008.

Monmouth University has had a Bachelor of Social Work program since 1977 and we added a Master of Social Work program to our curriculum in 1998. We are very typical of a small to medium size baccalaureate social work program. Currently, we average 100 to110 BSW students in our program.

There are over 400 Bachelor of Social Work programs in the United States. Some BSW programs stand alone in a department that is often combined with sociology, anthropology and/or criminal justice. Some BSW programs (like ours at Monmouth)

are in a School of Social Work or a Department of Social Work which also offers a Master of Social Work program. Fewer are in Schools of Social Work that offer the BSW, the MSW and the Ph.D. in Social Work.

All undergraduate social work programs draw heavily from content in the liberal arts. Students are usually required to complete courses in Sociology, Anthropology, Psychology, Economics, Political Science, Biology, and Mathematics, along with History, English and Literature.

All undergraduate social work programs are generalist in their focus. Students in BSW programs do not concentrate in any area of practice or theoretical focus, as is common in MSW programs. BSW students are taught to be able to work in many areas of practice, whether it is casework or case management, group work, community practice or even research and policy. And they should be able to work in any field of practice, be it gerontology, mental health, child welfare, criminal justice, etc.

The undergraduate social work curriculum introduces students to human behavior (the life to death sequences of events and milestones that all individuals go through), they are taught to assess clients, how to interview them, and then how to form an intervention plan with the client for their treatment. Students then look to evaluate how well their interventions worked, engaging in both practice and program evaluations. Students learn to make these assessments at the individual level (micro), with families (mezzo) and with communities (macro). They use a variety of skills in making assessments and in planning for treatment or for an intervention. A key component to these assessments is learning systems theory which helps the students see all of the factors involved in a client's situation. Another component is to take a strengths perspective to all assessments, looking specifically for strengths of the individual first, and deficiencies second.

Critical to the BSW curriculum is the field internship, where students are placed in social service agencies to learn the day to day aspects of social service delivery. At Monmouth, our BSW students complete a 30 hour volunteer experience in the sophomore year, a 100 hour internship in the junior year, and a 450 hour internship in the senior year. These internships are always supervised by a licensed social worker at the master's level, and these agency supervisors often take a course in supervision and field that many social work programs offer. For example, we run a SIFI course—Supervision in Field Instruction—for all our new internship supervisors.

The field internship is the place where academia meets practice. It is the applied aspect of social work, and as such is the vehicle that allows students to grow personally and professionally. A baccalaureate student usually knows they made the right choice of profession when they begin their field internships. It is sometimes the case that students get hired by their field agencies upon graduation from their BSW program. For a social service agency that can hire their student intern, their investment into that student over the course of the academic year is very beneficial, as they know their new employee before they start work, and that person is already oriented to the agency and its culture.

Not all BSW students go right to work however. Our experience at Monmouth is that about 80% of our students go right on to graduate education, usually the Master of Social Work. The other 20% go into employment.

The advantage of going straight into an MSW program comes from the ability of a BSW graduate of an accredited program to apply for Advanced Standing in a number of MSW programs in the US. Advanced Standing programs allow accredited BSW graduates who meet admissions requirements to move into the 2nd year of graduate work. This means that the MSW degree is completed in one year, rather than the 2 years it normally takes for someone who enters an MSW program without a BSW degree (if the coursework is done on a full-time basis of 15 credits/semester).

This is an important feature of BSW—MSW education, as it indicates that the senior year of the BSW program theoretically is equivalent to the first year of graduate education and that prepared BSW graduates have the knowledge base and the skills to skip one year of graduate school. From my experience, properly prepared BSW graduates can move into graduate level education without a problem, and can then spend their year in graduate school refining their skills and deepening their knowledge.

The first year of most MSW programs contain "foundation" courses, like Social Welfare Policy, Research, Human Behavior and the Social Environment and usually several practice courses like Individuals and Families, Group work, etc. Students also complete first year internships. At Monmouth, our students in the MSW program take their classes concurrently with their field internship, and complete 500 hours of field work in the first year of the program. Two days of the week are spent in class and three days are spent in the field.

In the second year of the MSW curriculum students choose a concentration, where they focus their academic work and their internship in a more specific area of social work practice. Almost all MSW programs offer at least two concentrations; some offer more depending on the size of the School or University. At Monmouth, we have two concentrations: Clinical Practice with Families and Children and the other is International and Community Development. The latter concentration is the only one of its kind in the US in a social work program. The ICD concentration allows students to go overseas in the spring semester of their final year to complete an 8—10 week internship in an NGO or government agency. We have internships currently in Ghana, Bangladesh, Southern India, Mexico, Chile, and Hong Kong. Both concentrations require another 500 hours of field internship.

The Master of Social Work is the terminal degree in the social work profession, meaning that you do not need a Ph.D. to practice as a social worker and to receive third-party reimbursement for your clinical work. However, you do need a license. Licensure for social workers is required in all 50 states, and all 50 have varying requirements to obtain a license to practice social work. Each state differs on the naming of their licenses and not all states offer reciprocity to social workers who want to move their license from say New Jersey to Florida or to Wisconsin. Some states require a re-test, others require verification of clinical course work.

In New Jersey, there are two social work licenses and one certification (the CSW, the LSW, and the LCSW). If you graduate with a BSW and go right to work, you apply for your CSW—or Certification in Social Work. There is no test for this certification, you need only to submit proof of your graduation from an accredited undergraduate social work program and pay the fee to the State.

When a student completes the MSW, they can then take a test for their LSW—the License in Social Work. Any student at the MSW level should apply for their LSW. If you want to specialize in clinical social work and receive 3rd party reimbursement for your services (from Medicare, Medicaid, HMO's etc), then you have to take an additional test and work (with your LSW) under the supervision of another social worker who has the License in Clinical Social Work (LCSW) for approximately 2,000 hours to qualify for the LCSW license.

Those social workers who desire the Ph.D. or DSW (Doctorate in Social Work) usually pursue doctoral work in order to enter the academic world. It is increasingly a requirement at Colleges and Universities for tenure-line faculty to hold a Ph.D. in their discipline in order to teach and to be conferred with tenure.

Strengths of a BSW degree:

1. BSW graduates have generalist skills and knowledge, which allow them to work in many facets of social work.
2. These skills are portable—they are not tied to a specific job or function, but can be taken wherever the graduate goes and are applicable to a number of fields of practice.
3. BSW graduates are idealistic and enthusiastic—they definitely want to "change the world." This idealism often helps social service agencies because social work interns allow agencies and their staff to remember their own idealism and many times can help agencies see their situations in a new light and can bring about needed change and renewed enthusiasm.
4. BSW graduates are at an advantage in a workplace, because they are taught systems theory, and learn to see "the whole picture." They work well with professionals from other disciplines because they can see everyone's role, see how all roles fit together, and with their interpersonal skills can help to mediate difficult situations.

Challenges for undergraduate social work education:

1. Recruitment is the biggest challenge facing undergraduate social work programs. Many people (especially parents) are under the impression that social workers only help the poor and take children away from families. They also have the impression that social workers do not make livable salaries. All academic social work programs work hard to negate these impressions, but until society at large begins to change their opinion, this will be difficult. Public education on what social work is, and what we do as professionals is essential.
2. Ensuring cultural awareness and sensitivity can also be a challenge, depending on where the BSW program is located and who the students are. We need more bi- and tri-lingual social workers. And we need students to develop cultural awareness for all the clients and agencies that they might come into contact with.
3. Ensuring that social work as a program stays vibrant and is respected at the College or University level can also be a challenge to programs. This is an applied, working discipline that does not often garner large research grants, or large donations, and there are times when its usefulness to the larger University can be questioned.

Chairwoman MCCARTHY. Thank you.
Mr. Bird.

STATEMENT OF MICHAEL BIRD, MSW, MPH, PUBLIC HEALTH CONSULTANT

Mr. BIRD. Chairman McCarthy and members of the subcommittee, I am pleased to be here with you today. As was mentioned, my name is Michael Bird. I have over 25 years in social work in a variety of areas. Most notably, I was the first American Indian and the first social worker to serve as President of the American Public Health Association.

I have been fortunate in many respects. Most notably, I also have a Master's in public health, and I have found that the combination of the MSW and the MPH has served me well, served both my associations, and provides a unique perspective that I think has been relevant to the issues we are addressing today.

Most importantly, we have mentioned some of the things and I have mentioned some of the things I have accomplished, but I think more importantly to me is the fact I am from Santo Domingo and San Juan Pueblo. I am a Pueblo Indian. My people have a documented history of being in the Southwest from anywhere from 30 to 40,000 years, with a unique culture and unique tradition and unique language. That has shaped and forced and focused my whole personality and my experience.

But I am here today to talk about the importance and the role of diversity in social work. There really is a need to begin to really look at increasing the workforce and increasing a workforce that better serves the diverse population, the diversity of this country, but also increasing that workforce so that it better serves all of us.

The social worker strives to ensure access to needed information, services, and resources, equality of opportunity and meaningful participation and decision making for all people. The profession is unique in that social workers are expected to understand different cultures and the function that culture plays in everyday life. They believe that strengths can be found in every culture and that building upon those strengths is the best way to help clients reach their full potential.

The profession of social work values an understanding of different political, religious, and ideological beliefs, and social workers are expected to respect the dignity and worth of each individual that they work with.

Social workers are not only expected to understand the role that social diversity plays on the society, but actively to work to end all forms of discrimination. The clients that social workers work with often are vulnerable and face prejudice and discrimination.

Professional social workers support and advocate for recruitment, admissions, hiring, and retention efforts in social work programs and agencies to ensure diversity within the profession. They also seek to provide an advocate for the profession and information referrals and services in the language appropriate to the client.

My career as a social worker and my background in public health have led me to a deep understanding of diversity issues in this country. Having worked to address health disparities with American Indian, Alaska Native, and Native Hawaiian communities, as

well as all ethnic minority communities for over 25 years has been a major area of my personal and professional body of work. This is a moral and spiritual issue and cries out to be addressed. It is also wasting our most important natural resource, our human capital and the Nation's potential.

As early as the U.S. census report in 1970, it chronicled there are major differences in social, economic, political and health conditions in the U.S. population. A Federal court also identifies the Latino and African American populations as having the lowest per capita income in the United States. And an argument can be made that Native Americans on reservations have lower per capita incomes but not included in the Federal studies.

These statistics are unacceptable and social workers are the professionals equipped with the tools and understanding to make a real difference in the lives of their clients.

Although the profession of social work has a rich history of respecting and appreciating social diversity, it also has a historical tendency to attract Caucasian women to the field. While women have done an exceptional job building a strong foundation of social service and strengthening individual families and communities, we must look to the future, and that involves reevaluating our recruitment and retention techniques with a commitment to diversity.

Another concern is that of the aging. Not only does social work serve the aging Baby Boomers, but there will be a significant need to recruit new social workers once the professionals begin to retire.

When I reflect upon my career in social work and public health, I believe that what attracted me to this area was a simple desire to help others who might be confronted by something larger than themselves. As a child I felt I had no control over my situation at home in growing up with an alcoholic father. This experience instilled in me a desire to help people gain some control in their lives. I also wanted to give them hope and a sense of direction.

I also thought that only Indians had these kinds of problems. As I grew wiser I came to understand that we all have problems, just different kinds of problems, and that we all need help now and again. Social workers made a critical difference in my life, as they do in the lives of people every day.

Thank you very much for this opportunity today.

[The statement of Mr. Bird follows:]

Prepared Statement of Michael Bird, MSW, MPH, Public Health Consultant

Chairwoman McCarthy, Ranking member Platts, and honorable members of the Subcommittee on Healthy Families and Communities, I am honored to be here today to discuss the state of the profession of social work. My name is Michael Bird and I feel fortunate to have worked in this profession for over 25 years in many capacities including medical social work, substance abuse prevention, health promotion, disease prevention, and health care administration. In addition to my professional training as a social worker, I also have a master's degree in public health and have found this combination of careers and professional experience to be extremely valuable in my practice. I was the first American Indian and the first social worker to serve as President of the American Public Health Association and have been an active member of APHA for over 18 years. I've also served as president of the New Mexico Public Health Association and was a fellow in the U.S. Public Health Service Primary Care Fellowship Program.

Background

I'm here today to not only discuss the important role that social work plays in our society but also the unique value placed on diversity in the social work profes-

sion. Social workers provide critical services to clients across the nation everyday. They work with a broad spectrum of clients including the homeless, the elderly, students at risk of dropping out of school, and the incarcerated from all racial, ethnic, and linguistic backgrounds. Social workers have an ethical responsibility to pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and group of people. They also seek to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity. Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people.

The profession is unique in that social workers are expected to understand different cultures and the functions that those varying cultures play in everyday life situations. They believe that strengths can be found in every culture, and that building on those strengths is the best way to help clients reach their full potential. Specialized knowledge and understanding about the history, traditions, values, family systems, and artistic expressions of major client groups is a key component to the practice of social work as well as the use of appropriate methodological approaches, skills, and techniques that reflect the workers' understanding of the role of culture in the helping process. Through education, experience, and training, social workers strive to understand the nature of social diversity and oppression. The profession of social work values an understanding of differing political, religious, and ideological beliefs and social workers are expected to respect the dignity and worth of each individual they work with.

Social workers are not only expected to understand the role that social diversity plays on society but to also actively work to end any form of discrimination. Again, the clients that social workers work with are often vulnerable and oppressed and face prejudice and discrimination. In order to promote the welfare of each client, social workers recognize the importance that the environment plays in each situation. The profession utilizes a "person in environment" approaches that acknowledges the role that all social influences play on a person's biopsychosocial needs.

Professional social workers support and advocate for recruitment, admissions and hiring, and retention efforts in social work programs and agencies to ensure diversity within the profession. They also seek to provide or advocate for the provision of information, referrals, and services in the language appropriate to the client.

My career as a social worker and my background in public health has led me to have a deep understanding of the diversity issues in this country. Having worked to address health disparities with American Indian, Alaska Native and Native Hawaiian Communities as well as all ethnic minority communities for over twenty five years has been a major area of my personal and professional body of work. This is a moral and spiritual issue and cries out to be addressed. It is also a wasting our most important natural resource, our human capital and nation's potential.

As early as the first U.S. Census in 1790, federal reports chronicled major differences in socioeconomic, political, and health conditions in the population. (U.S. Bureau of the Census, 1975). Today we feel the effects of these disparities. For instance, in 2001 Native Americans were the group most likely to be uninsured (35% lacked health insurance) (Census Bureau/National Center for Health Statistics, 2001). This has far reaching effects, particularly for the children of Native Americans. In fact, the Indian Health Service spends $1,914.00 per person for medical care which is lower than Medicare at $5,915.00 and less than the United States spends on federal prisoners at $3,803.00 (U.S. Commission on Civil Rights Report titled "A Quiet Crisis" Federal Funding and Unmet Needs in Indian Country. July 2003).

Federal reports also identify Latino and African American populations as having the lowest per capita income in the United States (U.S. Census Bureau, 2007). However, Taylor and Kalt (2005) argue that Native Americans on reservations have lower per capita incomes but are not included in many federal income studies.

These statistics are realistic, yet unacceptable and social workers are the professionals equipped with the tools and understanding to make a real difference in the lives of their clients.

Challenges

Although the profession of social work has a rich history of respecting and appreciating social diversity, it also has a historical tendency to attract Caucasian women to the field. According to one study by the National Association of Social Workers Center for Workforce Studies, "social work, like most health care professions, is less ethnically diverse than the U.S. population." Licensed social workers who responded to the survey were overwhelmingly White, non-Hispanic (86%) and are disproportionately likely to be women (81%). While white women have long led the profession of social work, the clients social workers serve often belong to a non-White minority

group (51% or more). According to this study of licensed social workers, ten percent of social workers have caseloads that are predominantly Black/African American, and five percent handle caseloads that are predominantly Hispanic/Latino. Additionally, only 14 percent of social workers work in settings in which their caseloads are 75 percent or more female. Efforts have begun to recruit more men into the profession to ensure that the needs of all our clients are successfully being met.

Another concern is the aging of the profession. Not only do social workers serve the aging baby boomers, but there will be a significant need to recruit new social workers once experienced professionals begin to retire. Licensed social workers are significantly more likely to be in older age groups than the U.S. civilian labor force. A higher percentage of social workers are ages 45 to 54 (33% compared with 23%), ages 55 to 64 (24% compared with 11%) and 65 and older (5% compared with 3%).

While women have done an exceptional job of forming the important tenets of the profession, building a strong foundation of social service, and strengthening individuals, families, and communities, we must look to the future and that involves re-evaluating our recruitment and retention techniques. While a deep understanding of culture is intrinsic to every social worker, there is great value in reflecting the populations we serve. When every voice is present at the table, more informed decisions can be made and the community can be more fully served. Not only does everyone deserve the right to service, but they also deserve the right to be served by a social worker that makes them comfortable and can best understand and work to address their various social needs. More social workers of color must be recruited into the profession to ensure that clients can continue to have exceptional, culturally competent service.

Conclusion

When I reflect upon my career in social work and public health I believe that what attracted me to this area was the simple desire to help others who might be confronted by something bigger than themselves. As a child, I felt that I had no control over my situation at home in growing up with an alcoholic father. This experience instilled in me a desire to help people gain some control in their lives. I also wanted to give them hope and a sense of direction. I also thought that only Indians had these types of problems. As I grew wiser, I came to understand that we all have problems, just different kinds of problems, and that we all need help now and again. Social workers made a critical difference in my life as they do in the lives of people every day.

Social work and public health have always been guided by values of equity, diversity and social justice and these values should be guiding values for us all.

Chairwoman McCARTHY. Thank you.

Ms. Bergeron.

STATEMENT OF L. RENE BERGERON, PH.D., ASSOCIATE PROFESSOR OF SOCIAL WORK, UNIVERSITY OF NEW HAMPSHIRE

Ms. BERGERON. I would like to thank Chairwoman McCarthy and the members of this subcommittee for allowing me to testify today. I have a Bachelor's from the University of New Hampshire, a Master's from the University of Connecticut, and a doctorate from Boston College all in social work. Social work is truly the profession I love, and I am so pleased to be able to talk to you about it today.

My testimony is based on my 30 years plus of practice as a medical social worker and as an outreach worker to elderly people in the community. Included in those years is also 24 years of teaching at a university level and 10 years of conducting research. I would also like to add that social work has been personally very important in my life, as I have a child with Fragile X disease and so social work entered into our family's life at the date of his birth, and continued to be a part of our life as my father died of a brain tumor at home and as my mother developed severe Parkinson's and had to be placed in assisted living, and now with myself as I struggle with my battle with cancer. So social work is extremely important and just in my own family very varied in what it does.

My testimony is going to focus primarily on research. To simplify, I am going to organize this into three categories: Who is responsible for research; what are the fields of practice that research needs to be conducted in; and where social work needs to go in the future with research.

Social work education, as you heard, is primarily divided into three levels, baccalaureate level, Master's level and the doctorate level. The expectation is that the commitment of the baccalaureate worker is minimal. However, the work that they do opens our research base in order to see what is effective and useful in practice.

The master level, while preparing primarily for practice, supervisory and management position, does have the expectation to do research. However, high caseloads often inhibit them from doing so.

At the doctorate level the expectation is that in addition to administration and teaching they certainly will conduct research. Thus, this level of education is what drives research and places an obligation on doctors of social work to link with the baccalaureate workers, the Master's workers, agencies and clients themselves to produce a practice-based research that will enrich the field and identify effective interventions, as well as discourage interventions that are not very effective.

The field of practice of social work, as you have heard, is very global, and this in fact can make research difficult. An overview is: Family interventions; that includes family violence. Child services, medical services; that include mental health issues, as well as catastrophic issues. Aging and gerontology; that includes elder abuse, neglect and financial exploitation. Anti-poverty programs; that include homelessness, job training, income assistance. Transitional programs, immigrant, refugee services, as well as veterans services. Clinical issues and discrimination issues.

These practice fields suggest that creative approaches in research may include coordination of efforts among educational institutions, the various levels of practitioner education, practice agencies and organizations and of course the clients themselves.

Research is basically divided into two types, qualitative research, which is exploratory and develops hypotheses for future studies. It also incorporates ethnographic types of studies. And then we have quantitative, which is just survey data based types of work, and it can include meta-analysis of large data banks like the U.S. Census.

The future agenda of social work is multi-faceted and really is going to involve four main areas: Health care, general family issues, underserved communities, which is going to include substance and violence issues, and community needs such as disaster preparation.

Research has an obligation to analyze creative approaches and meeting both national and international needs of clients. That involves faith-based services, volunteerism, and education. The need to know what changes in behavior and social factors could contribute to the effective functioning of clients and the efficiency of programs is important, both from a human factor and a cost factor.

We cannot afford in this country not to support social work because those areas that go unsupported will have a great impact on all of the citizens who live here.

Thank you very much.

[The statement of Ms. Bergeron follows:]

Prepared Statement of L. Rene Bergeron, Ph.D., Associate Professor of Social Work, University of New Hampshire

Organizing the needed research and developing standards of research matching other bodies of knowledge, such as medicine, sociology, and psychology began in the schools of social work and later translated into the complex fields of practice. What quickly became apparent is that the diversity of practice would dictate that no one theory could guide social work practice, but there would need to be several theories. Social work practitioners would need to be taught how to assess and choose the necessary theory for the particular client situation, evaluating its effectiveness and changing the intervention as dictated by its effectiveness. It also became clear that more than one theory may drive a case (a "case" being defined as a single client, family, or group). In 1949 the Social Work Research Group was established to help bring special focus to these challenges. Such challenges continue today.

Social work education is primarily divided into three levels, the Baccalaureate (BSW) level, the Master (MSW) level, and the Doctorate (DSW or PhD) level. The expectation is that the commitment of the BSW practitioner is minimal in adding to the research base. What is expected is that BSWs have knowledge of theory and research, how to read and interpret it, and how to use it in practice. Their practice outcomes add to the field of research.

The MSW level, while preparing primarily for practice, supervisory, and management positions, does have an expectation that these practitioners will contribute to the field of research by examining cases and conducting studies that show the effectiveness of their practice. However, the reality is that these practitioners, with high caseloads, do not have the time to conduct research.

At the DSW/PhD level, the expectation is that, in addition to administration and teaching, research will be of paramount importance. Thus, this level of education is what drives research and places an obligation on Doctors of Social Work to link with the BSW, and in particular, the MSW practitioners to produce practice-based research that will enrich the field and identify effective interventions or discourage approaches that do not achieve the desired results.

Research Needs

Because social work focuses on the intra- and the interpersonal aspects of clients' lives research must consider these aspects as well as the various settings of the client. The broad range of practice settings and roles makes it difficult to succinctly explain the various areas of that social work research that are needed because practice modalities and client needs continue to change.

Fields of Practice Affecting the Research Agenda

The following is an overview of the various fields of practice; while not a final list it is meant to identify the complexity of and need for social work research today. In social work interventions it is understood that assessment is necessary in determining what the issues are facing the client or client system and the need for case management (the organization and assistance in implementing a case plan) is necessary. Additionally, The National Institutes of Health clearly states that critical behavioral and social factors affect the health and wellbeing of people and are important areas for research regarding treatment and, very importantly, prevention. (See Department of Health and Human Services, National Institutes of Health, NIH Plan for Social Work Research).

The need to know what changes in behavior and social factors could contribute to the effective functioning of clients and the efficiency of programs is important both from a human factor and a cost factor perspective:

Family Interventions

- Employment issues
- Family therapy
- Crisis intervention
- Housing
- Adult education
- Incarceration and integration back to communities and families
- Family violence
- Family planning

Child Services

- Safety/child welfare/foster care/prevention abuse and neglect
- School social work

- National and international adoption

Medical Services

- Mental and physical illness
- Substance use and abuse
- Catastrophic
- Congenital and accidental disability
- Developmental/learning disability
- Hospice/end of life counseling

Aging and Gerontology

- Community services
- Residential care
- Caregiver issues
- Medicare
- Housing
- Elder abuse, neglect, emotional abuse, financial exploitation

Anti-poverty Programs

- Job training/placement
- Income assistance
- Food bank
- Homelessness

Transitional Programs

- Immigrant and refugee services
- Veteran services

Administration

- Program development and implementation
- Clinical supervision and consultation
- Ethical issues
- Board and task force involvement

Clinical Issues

- Counseling/psychotherapy/psychoanalysis/group therapy

Discrimination Issues

- Racism, ageism, sexism
- Lesbian, gay, bisexual, and gender supports

Research Agenda

Examination of the above practice fields and issues suggest that creative approaches in the area research may include coordination of efforts among educational institutions, the various levels of practitioners' education, practice agencies and organizations, and of course the clients themselves. Two types of research approaches dominate the research field: qualitative research (exploratory research and the development of hypotheses for future research; ethnographic study; and single case designs); and quantitative research (survey data gathering and analysis; may include meta-analysis of completed survey date, e.g. U. S. Census, large study data banks). In addition, social work is very concerned with outcome studies to determine if practice approaches are as efficient and effective as they should or could be to assist clients and maintain agency and organization implementation of services.

Social work research must be practice based; practice must inform research and research similarly informs practice. Educational institutions are well positioned to interface with the practice community in order to ensure the focus of research meshes with the real world needs, and also critical is the need to coordinate on a multidisciplinary level with allied professions and organizations.

The future agenda of social work research is multifaceted and involves four main areas. One area, health care, includes discharge planning and care management, prevention of illness, effectiveness of health promotion, teen pregnancy prevention, mental health services including returning veterans and survivors of domestic violence. A second area needing continued attention is general family issues of child care, aging, family supports, family-centered practice, and family preservation. An added area are the underserved communities including persons substance abuse issues, refugee and immigrant groups, minority rights, welfare reform, housing and community development, economic depreciation and the accessing of services. This also encompasses community needs such as disaster preparation and response services, homeless service needs, the delivery of human services, public housing, schools in communities, and welfare to work programs. And last, creative approaches in

meeting both national and international needs of clients that involve faith-based services, volunteerism, educational externship and internship programs, forming linkages among various disciplinary teams for more effective and efficient delivery of services.

Conclusion

Social work is a dynamic field of practice driven by sound educational programs and research methodologies that build on that of other disciplines, as well as research that stands on social work practice exclusively. Social work research also has assisted, and will continue to do so, in the development of programs that affect the daily lives of the citizens of the United States from all social classes with an array of social issues that if left unattended will affect the quality of life for all or our citizens.

Chairwoman MCCARTHY. Reverend Wells.

STATEMENT OF REV. SARAH WELLS, EXECUTIVE DIRECTOR, GOOD SAMARITAN MINISTRIES

Rev. WELLS. Thank you very much. I appreciate you so much allowing me to come today and to share with you. I share with you the generalist view of social work. And social workers throughout America today are facing tragic situations, and we hear this every single day as someone will come and sit before us and break and begin to cry. But I would like to tell you a story of a young lady that I know of very well.

This young lady had gotten married when she was only 14 years old, which was very normal in the life of Tennesseeans, and she quit school and at 28 years old she found herself being divorced and left alone. So she didn't know any way at all to take care of herself. As she went off she took what money she had and she traveled all the way to Florida, where she had never been before. And there she set up a tent and began her family.

She would tell her children that they were on vacation and everything was fine, that it was an enjoyable time. But at night when they would go to sleep she would hold them very tight and she would cry herself to sleep. She admits that this is the most frightening part of her whole life and she didn't know what to do and didn't know who to turn to. But her faith kept her strong, even though depression and thoughts of suicide plagued her every single day.

In case you have not heard or that you have not guessed at this time, I am that woman and those are my children.

I am very pleased to be able to tell you about a gentleman that came into my life. He was a social worker. It was the first time I had ever heard the words. They seemed very strange and frightening at first, but very important to me. He was a generalist, which meant that he looked at the whole picture. He was able to dissect my problems, break them down, and help me to be able to face them and confront them head on. We were able to make decisions together. He gave me all the facts that I would need.

While I was going through this time being homeless nine times in 10 years I was also electrocuted, and I was told by one doctor I was very, very blessed to be able to be alive. And for that I admit today I am. At the time I did not feel that way. The pain was much greater than the pleasure of being alive.

But through that time I did learn all about social work from all the way through the Master's and the LCSW and those who would walk by my side to help me become whole and healthy again. So I look at this and I know that the plan for me—I am a generalist social worker. That is very much important to me. I like being able to see the whole picture, to be able to find the resources, to give those people the life skills that they have need of. So walking together is very important.

Today I am much happier, much healthier, and much stronger all because there was a social worker along the way in my life, and I am so very thankful for that.

Today I see the greater needs at the time of homelessness for those that I am serving than even when I had. During that time I had people who at least could help me find part-time jobs, and now finding a part-time job is very hard. Waiting lists for housing is so hard. Recently I had a woman and 5 children, I couldn't even put her in a shelter because her two older children were boys and they were ages 12 and 14.

So we are facing so many different barriers that are stopping us from getting the care that they do need. Struggles are not new for social workers; however, for some of their very own, working for a ministry is very difficult. I have a lower income than most would ever expect. I work many more hours, I am paid very little, but also I have insurance. I do not have a retirement to look forward to, but what I have every day is the joy of being able to be with others that are hurting and to be able to lead them through that journey.

I believe with all my heart social workers are helping angels. They are there to walk by the sides of those in pain each day. They work to bring positive change in this world, as you have already heard. Solutions are not simple; however, by working together well we will receive answers.

Thank you very much.

[The statement of Rev. Wells follows:]

Prepared Statement of Rev. Sarah C. Wells, BSW, CSWM, Good Samaritan Ministries

"While the social service needs are dramatically rising, the ability to meet those needs is getting tighter."

Good Afternoon, my name is Sarah Wells, I hold a BSW from East Tennessee State University, I am Certified Social Work Manager, a minister with the United Methodist Church, and I work for Good Samaritan Ministries in Johnson City Tennessee.

Last Monday I arrived to work to find that we had three consecutive families coming in with medical emergencies. All three had a parent with cancer, were facing death, and had to accept they were becoming homeless. The most urgent was a father, mother, and three children that were behind in rent and their utilities were in danger of being cut-off. The father had been diagnosed with stage four cancer, the wife had lost her job while missing work caring for her husband, and they had received an eviction notice. The children were very quiet and seemed to cling to their parents during the interview. Soon I had heard that they were three months behind in rent totaling $1,200.00. The power bill was another $289.00, there was very little food for the family, and medical bills were piling up. It was hard to believe that this family's income last year was $60,000.00 and now they had lost everything. Due to a recent acquired homeless prevention grant, I was able to pay the rent, utilities, and give them food. Then I began my task of helping the family find the community and government resources needed in the future days to come.

Social Workers throughout America face these tragic stories each and every day. They are trained to look at the "whole picture" and to assist individuals and families to form positive action plans. While the social service needs are dramatically rising, the ability to meet those needs is getting tighter. Many times finding the needed resources becomes difficult at its best, to an almost impossible task. By working for a ministry I normally would not have had the financial resources to help this family to the tune of $1,489.00, but due to the new grant opportunity that better allows our ministry to aid our community's homeless prevention assistance, they were assisted in-house. However, this just began the wide array of services that still had to be located to under-gird the needs. It is absolutely necessary to have excellent knowledge of, and communication with all community and government agencies. It is the role of the social worker to pull all of these resources together to be able to offer the means to solutions. In the aforementioned case, this particular family was rescued from homelessness and having to move at such a delicate time, but many others are forced to leave the security of their sanctuary and all that is familiar to them. America's schools are now overwhelmed with the special needs of homeless and at-risk children. The elderly are now facing homelessness at a greater rate than ever before.

I would now like to tell you about another family: a mother that quit school at fourteen to marry and had to face divorce at age 28. She, like so many, had no idea how to support herself, or her two children. She got into her car with her children and drove from Tennessee until she ran out of money for gas in Florida. She had a tent for the family to stay in until she could find work and housing. She reminded her children that they were on "vacation" and that camping was fun. Each night after the children went to sleep she cried and held them tight. The mother admits to having more fear during that time than ever in her life. She was blessed with two part time jobs and a small apartment in which to live. Unfortunately, there was never enough money to pay the bills and each month the family faced eviction and termination of the utilities. They found themselves homeless nine times in ten years, and during one period they lived with no power for six weeks, without water for four, and knew no one to help. The mother had never asked for help in her life and was raised to be strong. Depression and thoughts of suicide were with her everyday, but because of her children, she had to go on. One day she walked into a social service ministry and met a wonderful gentleman. This was the first time she had ever heard the title "social worker." He listened as she cried and watched as she dumped all of her bills and receipts on his desk. After reviewing the items, he pulled out a checkbook. She cried out that she had not come to beg, but to be taught to budget. He said, "No money, no budget." He paid all her current bills and then set a budget. As the visits continued over the next few weeks, he helped her to see areas that she could receive help. Finally, he helped her enroll in school and she began her road to a new future.

If you have not guessed by now, I am that mother and those are my children. I am your homeless * * * the hopeless, but now one that knows success and hope for a lifetime. I was privileged to have a social worker that was educated, that cared, and listened to me. He did not feed me for a day, but taught me to fish. I completed my education with lots of help and I too, became a social worker and now even a minister. I now give back by helping others as they overcome their journeys of pain. My past has made me more sensitive to the struggles of others, to have deeper wisdom, and to firmly believe in accountability. I have helped start 8 agencies that assist the poor, and I serve as the pastor of a United Methodist Church. Being able to work each day to lighten one person's load makes my past struggles worth it all.

Today, I see much greater needs than those in my time of homelessness. It is harder to find and to keep jobs these days not to mention the lack of safe, affordable housing. Utility and rent deposits are astronomical. Most of the low-income people cannot meet the needed payments to obtain housing. Waiting lists for affordable housing are as long as two years. If a person with no income gets into public housing, they are required to still pay a minimum of $25.00. There is not enough transitional housing or shelters, with lengthy housing waiting lists. Many of the shelters do not allow mothers with boys over the age of twelve, nor single fathers with children to stay at all. Disability requests now take from 2-4 years for a decision and there is very little help for those waiting. The list goes on for obstacles to service and we face services being cut each day.

Struggles are not new to social workers; however many have some of their own. Working for a ministry is financially difficult. Most are paid very little, are provided no benefits, insurance, nor retirement. Fulfillment and dedication keep them serving and doing work for others. The role of the social worker is evolving to become even more intricate, however it remains the stronghold and bridge for those in need.

Lives are guided by the "helping angels" serving in ministries, agencies, and government settings each day as they work to bring positive changes to our world. Solutions are not simple; however by working well together we will receive answers.

Chairwoman McCARTHY. Thank you.

Ms. Fuller.

STATEMENT OF ADINA FULLER, MSW, LICENSED GRADUATE SOCIAL WORKER, DEPARTMENT OF YOUTH REHABILITATION SERVICES

Ms. FULLER. Good afternoon, Madam Chair, committee members.

Chairwoman McCARTHY. Could you bring the mike a little closer?

Ms. FULLER. My name is Adina Fuller. I am a licensed social worker with the Department of Youth Rehabilitation Services in Washington, D.C.'s juvenile justice system. As a social worker with DYRS, I am responsible for the management and care of 27 youth on my caseload who have been committed to our agency by D.C. Family Court for acts of delinquency.

D.C. case management protocols require that I meet with youth twice a month, speak with them over the phone weekly, also make collateral contacts with parents, teachers, anyone else who is involved with the child.

Most of the young people committed to DYRS come from the most vulnerable communities in D.C. I often have to provide supporting guidance not only to the child but also the families. And my job takes me into their schools, their neighborhoods and their homes.

The goal of our agency is to ensure that young people are provided with an enriching and educational experience that will enable them to become productive citizens in their communities.

Over the past 4 years, DYRS has taken on the task of reforming the juvenile system with the idea of improving community safety, as well as achieving better outcomes for young people. We have adopted the principle of positive youth development, which draws upon the strengths and the needs of the families, as well as helping them to find the resources and the support that they need to meet their own needs, but also we don't like to focus on the deficits, because we know that people struggle. So we definitely look for the strengths in the youth in the family.

We have added a host of services to young people to include in-home family counseling, service-learning projects, new educational experiences, employment training and job placement assistance.

A day in the life of a social worker is often varied by the crisis that a family is in. It also requires counseling support, information, and referrals. I spend countless hours researching information over the Internet, reading newspapers, and also speaking with fellow social workers who obviously are doing the same thing I am doing in terms of finding those community-based programs that are available to youth and families.

Part of my job entails that I help them to develop viable transitional plans so that they can successfully return home. Throughout the process of engagement an assessment is important for youth and families to identify their strengths and their needs. It is my

job to identify the resources, the services and support that would enable them to achieve their goals with the help of them becoming self-sufficient and accepting personal responsibility. Those meaningful experiences is what enables youth and families to improve the quality of their own lives.

Today I have a young person who is placed in a therapeutic group home, and right now his relationship with his mother has significantly improved, because he is in our care, but also because the youth and the family understand that they must now work together so that there is less conflict and more cohesion within the family system. This young man attends an after-school program with Sasha Bruce Youthworks, and it is our collective responsibility to help the family improve their functioning.

We have monthly team meetings to discuss our next steps, plans and goals. And when given an opportunity most families learn that they can effectively communicate with each other. And this particular young man will be returning home within the next 30 days. He will continue to receive special education services, intensive third-party monitoring, family therapy, and participate in those after-school programs so that he doesn't have a lot of idle time in the community.

I have another youth who invited me to attend his high school graduation, and this was a young man who came into the system for committing an obvious offense, but with individual therapy he learned how to manage conflict, as well as to peacefully resolve his differences. We met biweekly to discuss what he had learned in anger management and to explore after-school employment opportunities. So as a social worker I assisted him with completing online job applications, but after some careful thought he decided that he wanted to play in the high school band and serve meals to the homeless.

Although he made a poor decision, he did not allow that to ruin his opportunity to become a productive young person. He participated in a group interview at Trinity College where he was selected as a candidate to receive one the scholarships available through Bill and Melinda Gates Foundation, and he will be attending Johnson and Wales university in Providence, Rhode Island this coming fall. So for him this was a meaningful experience and it is something that he desired to do.

So I am glad that I have those experiences and those successes, and that is what makes me enjoy social work as well.

[The statement of Ms. Fuller follows:]

Prepared Statement of Adina Fuller, MSW, Licensed Graduate Social Worker, Department of Youth Rehabilitation Services

Good morning Mr. Chairman, committee members, and other distinguished participants. My name is Adina Fuller and I am a licensed social worker at the Department of Youth Rehabilitation Services—Washington DC's juvenile justice system.

Prior to coming to DYRS, I was a social worker in DC's child welfare system.

As a social worker at DYRS, I am responsible for managing the care and supervision for 27 youth on my case load. These are all youth who have been committed to the department by the DC Family Court for acts of delinquency.

DYRS case management protocols mandate that I see all the youth on my case load twice a month, talk to them once per week, regularly update their case files in our data management system, and connect my youth with appropriate services, programs, supports, and opportunities.

Most of the youth committed to DYRS come from the most vulnerable communities in Washington. I often have to provide support and guidance not only to my client, but also to their families. My job takes me into the schools, neighborhoods, and homes of all the youth I serve.

The goal of our agency to ensure that youth are provided with opportunities that will provide an enriching and educational experience that will enable them to become productive citizens in their communities.

Over the past four years, DYRS has been engaged in a huge reform effort. In order to improve public safety and achieve better outcomes for youth DYRS has been making a number of changes in the system.

DYRS has adopted the principle of Positive Youth Development as its overarching reform agenda—to build on young people's strengths and assets instead of solely dwelling on their deficits.

DYRS has added a host of new services and supports for the youth and the family we serve, including: in home family counseling, service leaning, employment training and job placement, new educational experiences, and other Evidence Based Practices.

To give a snap shot of a day in the life of a DYRS social worker, I will briefly review the case of one of my youth:

Case Review

A day in the life of Social Worker is often varied by the circumstance of the youth and family whether is it a crisis, counseling support, and/or information and referrals that will enable a youth and family to address their needs and concerns. I spend countless hours beyond my tour of duty counseling youth and families on developing a viable transition plans out of the juvenile justice system. Throughout the process of engagement and assessment, it is important for youth and families to identify their strengths and needs. It is my job to identify the resources, services, and supports that would enable to them achieve their goals that would enable them to become self sufficient and to accept personal responsibility for their lives. Those experiences must be meaningful, which improves the likelihood that the youth and family will be vested in improving the quality of their lives.

Some parents seem to rely upon me as a co-parent, particularly, if they are unable to effectively reason with their adolescent. I have a young person who will completing his stay in one of our therapeutic group homes whose relationship with his mother has significantly improved during this out of home place. While in placement, the youth and family were connected to the Department of Mental Health Services to receive individual therapy (youth), family therapy, and medication management. The family meets with the Psychologist on a biweekly basis in their home while the young person participates in individual and group therapy with a Psychologist in the therapeutic group home. He also attends an after school program at Sasha Bruce Youthworks. It is our collective responsibility to ensure that the young and family have improved their capacity to function as a unit. We have regular team meetings on a monthly basis to discuss our next steps and goals that will ensure the young person will successfully transition home. I have to maintain regular contact with parents who have provided insight of how they intend to supervise, reward and encourage her child to continue making responsible choices. When given an opportunity whereby parents and children can learn to effectively communicate with each other, it is amazing how they come to appreciate each other's differences when placed in an setting that is non threatening and non judgmental. I also work closely with teachers who often contact me to set schedule parent/teacher conferences and to schedule individual education plans (IEP) meetings to ensure that the young person is receiving educational supports and services. I have to maintain contact with the group home staff and therapists to discuss the young person's adjustments in a structured settings and encouraging youth to sustain their compliant attitudes and behavior during weekend visits at home. This young person will be returning home within the next 30 days with an identified transition plan. He will continue to receive special education services with District of Columbia Public Schools, third party intensive monitoring, continued in-home family therapy with Universal Healthcare, a core service agency with the Department of Mental Health, and continue to participate in the afterschool program with Sasha Bruce, which will continue to provide him with the opportunity to participate in constructive activities

I have a youth who invited me to attend his graduation from a DC Public School. While under my supervision, the youth and family were referred to individual where he learned how to manage conflict and peacefully resolve differences by asking for the support of other adults in the school setting. We met on a biweekly basis to discuss what he learned in anger management and to explore after school employment opportunities. He was assisted with completing online job applications with CVS

Pharmacy, Harris and Teeter, and Home Depot. After some careful thought and consideration, he decided that he would pay in his high school band and volunteered at So Others May Eat, serving meals for the homeless, because it was important for him to demonstrate that he had varied interests, talents, and his way of giving back to those who were less fortunate. Although he erred in his judgment, he demonstrated that it was a regrettable offense, but he did not allow it ruin his chances of becoming a productive young adult. He recommended by his teachers to participate in group interviews that were held at Trinity College asked to vie for an opportunity to receive a scholarship from the Bill and Melinda Gates Foundation. He seemed so posed when he answered questions whose themes centered about race/ethnicity, team building, and diversity. I am happy to report that he will be attending Johnson and Wales University in Providence, Rhode Island in August 2008. He plans to major in Business Administration and Culinary Arts because he intends to own his own restaurant in the Washington, DC. He was awarded a scholarship after completing the rigors of their program. He plans to major in Business Administration and Culinary Arts because he intends to own his own restaurant in the Washington, DC.

Chairwoman McCARTHY. Thank you. With that, I will start the questioning.

Listening to your testimony and having read the testimony the other night, one of the things that I want to ask is obviously we have talked about diversity, and I represent a fairly large underserved area and to me sometimes its overwhelming with some of the constituents that come to us when they don't know where to go. I had mentioned earlier that I have a social worker on my staff, but even with that, trying to pull together the services for some of these constituents that have multiple issues that need to be worked out, and each agency is a separate entity to start with, I find it mind boggling, I truly do. So I have gone through, unfortunately, serious injuries in my family. So I know what the social worker did for me. I spent my life as a nurse, by the way, up to that point and so I thought I knew everything until I couldn't handle anything and that is what it came down to.

With that being said, we are talking about diversity and, Dr. Mama and Mr. Bird, I think that you bring that subject up. How do we get the diversities to be able to see their way on becoming social workers to become part of the community, to heal their community, to help their community? What is being done to try to recruit?

Obviously, you know when we look at our Nation today, it is a very large diversity. And those communities and all communities at one time or another are probably going to need the help of a social worker. Is there anything that you see or any of you see on how we could bring that diversity into encouraging young people, anybody, second jobs actually, not even a second job, second careers that we can fill those needs?

And I will open that up.

Dr. MAMA. That is a very good question, and I think in terms of schools and social work programs we try to be as available in the community as possible. One of the things that helps when we try to recruit students—in fact, we take this from a student perspective—is that we try to reach students in high schools, in community colleges. We try our own students in their social work activities, try also to go into various communities surrounding the college, all of which are diverse at Monmouth, and to do service projects, learning projects, research projects, help with the commu-

nity. So they are almost like ambassadors into those communities in helping them to see some of the value of social work.

But the university itself tries to make available themselves to students from diverse communities to try and pull them into the university. And some of that has to come through recruitment and marketing and those usual pieces. But some of it also needs to come in the form of financial assistance for students in diverse communities to be able to come to college and making loans available to families and opportunities available in terms of financial assistance.

I think it also requires that programs themselves be open to opportunities. Right now Monmouth has an increasing number of men and women, but mostly women from an orthodox Jewish community south of the university coming into our program, into the Master's program, for the reasons that you mentioned. They want to now go back into their own community to help their community. And the only reason I think that we are seeing increasing numbers come to Monmouth is because we have been very open in terms of how we structure our classes, allowing them to miss classes for religious observance and not penalizing them in their education and being respectful of their needs as a religious community.

Chairwoman MCCARTHY. Mr. Bird.

Mr. BIRD. Yes. As I understood your question, you were talking about—my response would be that in terms of I think we have to begin to view diversity as a strength, not as a weakness or a threat. In many cases, at least in my experience both in social work school, graduate school and as well as in the public health arena, there were times because I was different, because I was different than dominant society, I think there were times that people felt like embarrassed to engage me in discussions about what the reality for Indian people in this country is today. And because of that we wouldn't go there and we wouldn't have a fruitful discussion or a dialogue that really would benefit everyone. This goes beyond the Indian community obviously. I think all of us have so much to learn from each other, and I am reminded of a quote by Will Rogers, Cherokee humorist, and that quote is, we are all ignorant, just about different things. And I think until we come to the table recognizing that we are all ignorant and that we all have something to learn from each other and find some common ground in terms of—like the lady who spoke of her homelessness, that condition in that situation, that is, you know—I mean, I respect that, appreciate that, but that sort of experience transcends her community or her State. There are native people throughout this country, they are in rural and urban areas, who experience very similar sort of circumstances.

So rather than sort of look at what makes us different, I think we need to move towards the common experience, what can we learn from that experience and how can we really build a community that is inclusive, that recognizes that we all are part of a larger community. And until I think we have that sort of honest bringing people to the table, I think we will continue to face many of the challenges that we face.

Chairwoman MCCARTHY. I hope you are right, because I have been waiting a long time to see that happen in this country.

With that, Mr. Davis.

Mr. DAVIS. Thank you. It looks like we are all the health care providers today. You are a nurse, I am a respiratory therapist and a lot of social workers. We could just about start a clinic today.

Ms. Wells, thank you again for sharing your very personal testimony. I know sometimes that is not easy to do and I do appreciate you doing that for us. Could you talk a little bit about how your background and your education came together, and how you used those together to provide services in our community and a little bit about your personal philosophy of how you actually help families.

Rev. WELLS. At age 14 years old when I quit school, and that was the norm for growing up in my family. Most the women were married by the age of 15 years old. But I still had this desire to go back to school, even though my mother told me I didn't need it, I was just going to be a wife anyway. So at 18 years old after I had been married for 4 years, I went and I took my GED. I had to slip off in order to do that and to hide. And when I went in they told me that I would not be able to take it that day because I had not gone back to school in order to take the GED. But I talked the young lady into letting me going in and taking it. And I walked out with my paper stated that I had indeed graduated that day.

I was very proud of that, and that helped me in seeing the needs of those that I work with on a daily basis. I work with so many that quit school as they are very, very young, and there is no hope for them to go back to school. Of course working with our Families First in the State of Tennessee, we at Good Samaritan Ministries are a site for those coming in. And when they can't get a job, they come in to us for job training and placement.

So the exciting part is to be able to share my story with them on each and every day basis and letting them know that I know where they have worked, what journey they are going down and that I too can be there as a help for them. But it is an encouragement to know you can escape poverty, which is definitely a killer of dreams.

The young man that worked with me taught me something very special. He sat down and he said, barring the fact that you have no money and you don't know anybody, you don't know where you are going in life, if you were to dream today, what is it that you would tell me that you would like to do? So that is where we began because I also wanted the help field more than anything. And after meeting him I wanted to be a social worker. I wanted to be able to share with others and hold them and to help them, but also bring that wisdom that it is also in our minds and in our hearts whether we want to go forward.

As I told you, it was very difficult for me because every day I wanted to escape and I wanted to be able to take my own life even at those points. And it is for me that he gave me that hope to allow me to dream. So now when you come to my office the very first thing is we have a dreaming session. We go back to the very first thing that you ever knew that you wanted to be. And then we look to see what would it take today for you to be there and what is it you would like to do today.

So I believe in having those dreams and to getting up and going on and being strong. That helps me so much in working with those

that are actually the street homeless also. This past year we had six that came and had been with us for several years. We lost all six of those to death. And on one of those, one of our homeless ladies did something I didn't know to do. She went to the library and typed in and she found his family. She came in and told me their phone numbers. So we had a gathering that night and had a funeral. And we had cell phones all over the room and the family was able to have closure by being there and hearing how their loved one lived and how they grew and were healthy in the end. So there was closure for their family.

That is in my heart, it helps me to know that without a doubt that that is very important. I have closure in my life, too. It doesn't bother me at all to talk about my past, not anymore, there is no pain and there is no sorrow, because I have been allowed to know success, and I just want to share that success with others.

Mr. DAVIS. Thank you. One of my favorite quotes comes from Henry Ford. He said if you think you can or if you think you can't, you are right. That is the type of people we deal with as Members of Congress; that is the type of people you deal with in your profession. And I thank each and every one of you for doing that. And if you let people know if they have a dream, they can do anything they want to in America.

Just real quickly, Ms. Wells, you talk about you provide an all encompassing type of social work. How do you pool the resources together to be able to provide these other services, homeless, food, education? Just real quickly.

Rev. WELLS. At Good Samaritan Ministries we have an on-site food pantry, we have off-site feeding called the Melting Pot in Johnson City, Tennessee. So we are able to come up with a list that we can give them about food, and we can help them with food. That is never a problem. Our community does very well at feeding its poor.

When we get into the complicated cases such as those like mine, it is pulling together our resources. For me it was vocational rehabilitation, it was going back to school. Even though I was told by the college and so was my social worker that with my disabilities, because I was legally blind for 3 years and was disabled, and they felt that my disabilities were much too great in order for me to go. So even above those disabilities it was looking at the programs that were community and government-based that would be able to work hand in hand.

Our office on a daily basis are gleaning out all of the resources, checking to see what the situation is, what do you have to do in order to be able to apply for their services. We keep all of their applications there in our office, so they are helped to fill out their applications. We also make their appointments, and if they need an advocate that is what we are, we go with them, especially getting into housing.

Like I told you, the woman who really frustrated me the other afternoon, this is one of the first times I have felt this frustration for us in our community. She was from Nigeria, she spoke very little English. She had five children ages from 4 to 17. Two of the boys were ages 4 and 17, so they couldn't go into the shelter with the mother. I called every shelter in the tricities area and they all

told me the very same thing. Then I began what would be the normal thing for the night, I can't let her sleep on the streets. So I called a motel and they refused to allow me to bring her in to the motel due to the fact that for her—you are not allowed more than three people in a motel.

So we are still facing a lot of barriers and resources that are needed. Family shelters is the one that I realized for our community that we are needing. So now we just work together in finding those resources on a daily basis.

Mr. YARMUTH. Thank you, Madam Chairman.

I want to thank all the witnesses also for their testimony.

One of the things that has been very striking to me, as I have traveled around my district in Louisville, Kentucky, and visited many varying social service agencies and different programs, is that you can analyze the value of social work in a variety of ways. Certainly we have talked a lot about the compassionate side. Social workers do provide comfort and aid to a lot of people in distress, as we have heard.

But I also want to focus for a minute—I am going to sound like a Republican here—I want focus a little bit on the economic side.

Ms. Fuller, you talked about one young man that you helped take from a very at-risk, vulnerable position and turned him into a person with a promising future. We have done a lot of work here on the Runaway and Homeless Youth Act, and we hope that the Senate will get its act together and pass it on their side, as we did.

One of the things that I found in my hometown, we had a young man named Rusty Booker, who testified before this full committee some time ago, who was someone who had been in five different foster homes, had been homeless and was destined statistically for a dependency status. He was going to be a drain on society, there is no question about it.

A similar thing happened to him through the programs that the Runaway and Homeless Youth Act funds. Case managers, social workers got him the services, the guidance he needed. He is going to go off to college this fall as well.

So my question to you is over the course of a year, how many young people do you think that you help move from a position in which they are going to be a drain on society and which they are likely to be a positive contributor to society?

Ms. FULLER. I think every youth I serve, they don't intend—I mean, they didn't grow up wanting to become criminals. I mean, sometimes just the circumstances, the impoverished states of the family just puts you in a position where it is about survival. But most do want to do something different.

So it is my responsibility to, in any way I can, to find that service that meets their needs, because it is a host of programs that we can refer them to. But if it is not a good match, if they don't feel comfortable, if they don't feel like someone is connected to them, then they won't complete.

So it is about relationships, and it is about engagements. Those youth do go on to complete the programs, and most end up in just entry-level jobs, but that is a good thing, because we are helping them to establish their character, their work ethic, their integrity.

Mr. YARMUTH. I am just trying to get a sense of a cost-benefit analysis. If you pay a social worker—I don't know what the average social worker makes, I know it is not very much. Certainly it is probably lower than the average income in the country, I would say, not much more—you are smiling. But I am talking about how many people during the course of the year, in the same situation as that young man you talked about, would you help turn their lives around?

Ms. FULLER. Every one of them if given the opportunity.

Mr. YARMUTH. Because I think what——

Ms. FULLER. This is about vocational training, because some students are somewhat behind, so by the time they get to 16 and 17, there is a lot of catching up to do. So my focus becomes skill-based; what is it that you are good at, what can you do, what do you want to do, and then taking that skill base and helping them to sort of foresee whatever it is that they want to do.

So for me it is about connecting them to employment assistance training programs, job-training programs. In part of that you do get that educational piece in terms of their GED, but 16, 17 is about being able to have a skill so that you can become employable.

Mr. YARMUTH. Thank you.

I want to ask Dr. Bergeron, because you do research, has there been any research done on the cost-benefit analysis of money spent on social work?

Ms. BERGERON. Yes, and I certainly could send you some. There has not been enough. What we do know is that the earlier we begin intervention, the less costly it is, and the more successful we are. It is so broad-based. I mean, I am just thinking of your story, and, you know, right away I was thinking, research, research.

You know, whoever decided that in adult education, for somebody to get their GED, that they had to return back to school, is that a good policy? That is a great research question. We decided not to let boys ages 14 and up into shelters. Originally that was decided because of violence issues. But is that a good policy? We need research to begin to decide, you know, if we are going to attract women to shelters. They are not going to give up their boys any more than they are going to give up their little girls.

So there is a cost benefit. The question really is if you don't intervene, what is the cost? The cost is huge. Had my son not received services, and had I not had the professional background I had, I can tell you right now he probably would not have his driver's license. He would not be employed. He would not be able to communicate very well to people. The cost benefits to society would be huge.

So let me see what I can get to you, because it is an excellent question.

Mr. BAILEY. May I also respond briefly, if that is within the protocol?

There are some studies, Michael Barth out of a Hartford study in 2001, that really looks at the cost-benefit analysis of the role of intervention—of prevention versus intervention, which I think is part of the question; that clearly it costs more on the back end to provide the service than it does to try to remediate the service on the front end and prevent the care, long-term care.

We also know, through the National Association of Social Workers, Center for Workforce Studies, as we begin to evaluate the value added of social work to the United States, that, indeed, having social workers present reduces more costly episodes in children's lives. And we can also think about this in terms of the elder parent who is at home who, if they can get the geriatric wrap-around services, won't require a nursing home immediately, won't break a hip. So that we know that prevention is always, always the way to go rather than waiting for intervention. Intervention is always more costly.

Yes, social workers are not compensated at that time rate—the average social worker salary is about $26,000 across the United States. That does well in some places and not well in most.

Chairwoman MCCARTHY. We actually are going to have a second round, I just asked some of my colleagues, because I think a lot of us have a lot more questions.

Is anybody on the panel in a time restraint? Great.

Mr. Davis.

Mr. DAVIS. Thank you. I am just going to have some very generic questions for anybody on the panel that would like to answer.

The first, how do you protect privacy of your clients, anyone?

Mr. BAILEY. Part of our code of ethics of the profession is protecting the confidentiality of your client, with the exception of suicidality and homicidal threats or tendencies, so that confidentiality is of paramount importance in the field of social work that we are—it is part of what is trained into you from the very beginning, that you respect the confidentiality of your clients, with those exceptions, if that is the question.

Mr. DAVIS. Yes.

Mr. BAILEY. We also are looking at the moves around electronic records and particularly around medical records, and are going to be looking at and coming up with recommendations from the national association around standards dealing with electronic—with electronic records. That is of concern.

Mr. DAVIS. Anyone else like to answer that?

Rev. WELLS. I know as far as for our office, when they come in, we do it by the HIPAA rules, and we are very, very cautious. If someone calls to talk with someone on the telephone, I do not even allow anyone in my office to identify that they are present there.

We will take the name of the person and go and seek, and let them know if they are present, they will give them a call back. So we will not even make mention that they are in our office for any reason. So we go the extra mile to protect their privacy.

Mr. DAVIS. Thank you.

Next general question for anybody on the panel. Can you talk to me about faith-based initiatives and faith-based programs; are they working, not working? Would you like to see them continue? Anyone.

Rev. WELLS. I think the White House just came out with a new research, according to the faith-based funds that have been released and how effective they were, and we were very excited to see that the faith-based programs are much more effective due to the fact that we are used to already operating on a shoestring. So we make those dollars go even tighter and longer than most of the

other agencies can do. It is also because we pay less, and our operations are much lower.

The faith-based programs themselves are working. The major thing for me was this young man, when I came into the program, he was working for a ministry, and the fact was he asked me what my preferences were, if I had any leaning, you know, towards the fact that—and, seeing that I was suicidal in particular, wanting to make sure, is there a way for faith-based programs to intervene.

So he offered; he did not demand. That is one of the greatest things for us, coming into my office. It is not a practice that anyone has to participate in to receive services, nor to even hear about, but the major thing is they are there for the offering.

But in particular programs such as Celebrate Recovery, in those it gives them that faith and be able to go through the recovery at the same time. I feel it is one of the greatest programs that ever was, that we have been able to have.

Having to have—you know, being able to give the privilege of faith-based programs is greater than just giving them one side, and that is very important in our office.

Mr. DAVIS. Anyone else?

Mr. BAILEY. Social work comes out of the faith-based community, and it is at its genesis. What we know is that especially within the Catholic, Protestant, Jewish faith, there has been a tradition around social justice, social action, and that there are many years of history of faith-based organizations.

Many of these agencies utilize social workers and are very active in their communities. I would like to share with you one group, which is Coalition against Religious Discrimination, which is comprised of many long-standing faith-based groups who really are looking at ways of working together and including a variety of ways of thinking.

When we talk about diversity, faith is one area, one of the key areas, of diversity and the ways in which people can be engaged in doing social work, professional social work, but also be connected to faith-based organizations, Lutheran Services, Catholic Charities, et cetera, wonderful examples of organizations that have done amazing work over the years.

Mr. BIRD. I would just like to just say, since the beginning of time, American Indian people have offered prayers for this land and for all things and the blessings we have. So this mind, body, spirit sort of recognition by everyone is welcome, and it is an important, critical aspect to all of us that we acknowledge the role of spirituality and people's religious sort of traditions, because, in fact, there is health and well-being in that.

Mr. DAVIS. Thank you.

One last question: High energy costs, what it is doing to your clients? Anybody? High energy costs, high cost of gasoline, high cost of heating in the winter, if somebody could just talk to that, and that will be my last question.

Ms. BERGERON. I am sorry, I missed the first part of your question. I didn't get it all.

Mr. DAVIS. I think I am out of time. I will come back around if the Chairman will give me that opportunity. I will hold my question for now.

Chairwoman MCCARTHY. Ms. Shea-Porter.

Ms. SHEA-PORTER. Thank you. I have had to hold myself back, want to jump on that side of the table and talk about this myself. Thank you so much for being here.

First of all, I wanted to say that so often we get a phone call, and it will be, well, somebody has to do something about this, and social workers are the somebodies that do something about it. So I am very proud to identify myself with all of you, and thank you.

You know, social workers find that little spark of faith and that little spark of hope in somebody when other people write them off, and it is our job. I will say that, miserably paid, I can remember getting a job that required a master's degree, which I have, and yet in a different department within this organization, high-school graduates were earning more. So obviously something else motivates people to work like that. It is a love of other people.

Often, very often, it is also inspired by faith. I have been privileged to work in organizations that didn't have—they were government organizations, and also I started up a private nonprofit that was faith-based, and it was interfaith. And we only set one set of rules there, which was that you did not try to convert anybody, and you did not discuss that at all; that everybody who came came out of need, and we didn't try to, you know, position ourselves so that one had an advantage or tried to proselytize.

So I think it works very well because we are driven by something, all of us, and whatever the reason is, when we come to the table to help each other, that can be a great motivator. Then, again, for some it is not. So I think you have to be very careful and respectful about that.

What I wanted to ask all of you was if you had one item on your wish list that you wish people knew, or you wished that they would give, or they would know, what would it be, because each one of us has that one thing that we wish people would know. I would tell you what mine is; that if Americans really understood and policymakers really understood that if you provided housing, even if it were just a simple room somewhere, you could stabilize people so that they could get on with the rest of their business, but that need for housing is so essential in order to provide the stability to work on everything else. So I give you mine, showed my hand. Would you all like to take a stab at it?

Mr. BAILEY. Mine would be one part with a semicolon, divided into two pieces, if I may.

Ms. SHEA-PORTER. That is a politician for you.

Mr. BAILEY. I have been called that.

The first part would be that people have a sense of belonging to community, a place of belonging, that that place of connectedness, either to one other person or multiple other people, however they define that sense of connectedness, helps us to have a wholeness and a functionability.

In that I would also like to have recognized and understand at the level of government, both Federal, State and local, the role that professional social work plays in helping to maintain healthy communities, that, indeed, people need support and help to be able to achieve health and wholeness, and that the social work profession is that.

Ms. SHEA-PORTER. Thank you.

Dr. MAMA. I think my one wish would be education, but education and social work from a very early age. The schools that we place students in for social work internships, those that have a school-based youth program that includes school social workers as well as the usual case study team, have a better program in their schools for students, and you find that students make better progress when you have got social workers right in the school system, from elementary all the way up through high school. And so that will be mine.

Ms. SHEA-PORTER. Thank you.

Mr. BIRD. Mine comes from the Southwest in that when you live in a region that is dependent, I mean, high desert, and you grow your own crops, and oftentimes one very important crop historically has been corn, or any other sort of vegetable or something that you rely on, well, one of the elements you have to have, metaphorically speaking in today's discussion, is rain. Without rain, you can't grow anything. So we need to be aware of the fact that in order to provide the kind of resources we are discussing today, you have got to have a little rain. Without a little rain, nothing grows.

Ms. SHEA-PORTER. I think I got that, thanks.

Ms. BERGERON. I think mine would be very creative approaches to health care. Right now in New Hampshire, we cannot get dental care for children on Medicaid because of the payment system and the fact that dentists can't afford to give dental care to Medicaid patients.

So I think, while we have probably the best medical services in the world, we do not have universal access on any level. I mean, right now we have Helen's van in Portsmouth. That is a wonderful thing. It is very creative. It drives around to both the towns and the cities and the rural areas to try to encourage people to do preventive as well as treatment health care.

Ms. SHEA-PORTER. Thank you. I think that is a good point.

Madam Chairman, do you want me to finish the last two?

Chairwoman MCCARTHY. Sure.

Ms. SHEA-PORTER. Reverend Wells.

Rev. WELLS. I think I would like for all of us to have unconditional respect for one another and to see the value of human life, and that helping them is much greater than just helping.

Ms. SHEA-PORTER. Thank you.

Ms. Fuller.

Ms. FULLER. I would like to see everyone with a liveable wage, where you didn't feel the struggle every day. So that is what I would like to see.

Ms. SHEA-PORTER. Thank you. Thank you for the extra time. I told you they are great people. Thanks.

Chairwoman MCCARTHY. Thank you.

Mr. Bailey, and certainly Ms. Fuller, and to my colleague Mr. Yarmuth, maybe because I am a nurse, we always try to look at things holistically. When you were talking about cost analysis on how many young people you have helped, and how to put a cost analysis on your—basically saying we don't have enough research, I will tell that you when my son was seriously hurt and about 4 months into his rehabilitation, which is only really the beginning

of that, because, of course, it lasted for years, the insurance companies basically turned around and said he wasn't going to get any better, and that they did not feel that it was worth spending the extra money so that he could learn how to feed himself.

Now, I have taken care of a lot of stroke patients in my life, and I know that it was a lot of patience and perseverance on the patient and certainly the nurse on just trying to get that patient to feed himself if that was the only thing they could do. It changed their life tremendously.

So I don't know how you could put a cost analysis on something, and I mean this with all my heart and soul, because I have tried to go to CBO and say, give me a cost analysis if we do prevention. They say, we can't give you a cost analysis because we don't know. But people know, because you see the results.

I know that we have to do that, because we are the Federal Government, and we need to certainly watch the taxpayers' money, and I believe in that. But I also know that when you are dealing with human life, and you are dealing with the family, which all of you are doing, you say, I am sorry, you just don't quite fit into the criteria, and we can't give you any more help.

When do you cut that off? I haven't found that spot yet and believe I am very conservative and very thrifty, but there are certain things that I think are worth putting a dollar towards to prevent.

And going back earlier on early education, from the day I first got here, if we spent the money that we need to spend on early education, preeducation, we wouldn't have half the problems we see in society. What I never understood is even though those young children that we help, for some reason, we stop giving those services in junior high. Now, I am old enough to realize what junior high was like even back then. Let me tell you, a lot of people got into a lot of trouble. Of course, I didn't, I was very good.

But with that being said, I mean, how much information do we need?

But I guess the one thing I will say to you for many years as a nurse, our pay was really, really bad. And the only difference is most of us worked in a nursing home or hospital, so they would set salaries. I know that all social workers that I deal with in my different communities, they are getting paid nothing, and I live on Long Island. They live on Long Island, and I don't know how to raise your pay, and I think especially with those that are nonprofit, they don't have the money. They are always scrambling for money. They will always scramble for money. There is not enough money that we could give them to take care of the problems they have.

The only thing I am thinking, and I wish I had this hearing a long time ago, from my nurses and teachers, we actually are giving student loan forgiveness, mainly to help them this way: If they stay in the profession for 5 years, their loans would be forgiven. So, hopefully, that is something that we can look into help for those that are going into social work.

Maybe it is not even too late, although I hear higher education is coming on Thursday. I don't know, I will work on it. With that, I just need to say that, because people don't understand what is going on until you have been affected by it.

Unfortunately, the one thing I did want to say, because we are dealing with this in Financial Services, Reverend Wells, my committee came up to me and they said, well, we have a problem with the housing problem. We have this much money, even though it has been bumped up a little bit. We have two different groups that take care of people, terrific groups. One takes care of the most desperate, homeless people out there that don't have a house or anything over their roof. Then we have our families that might be living in a car, or they might be living with a second family, just so they get through it. They can't go to a shelter for exactly the same reason you said, because they have two teenage boys. The mother is not going to allow the two teen age boys go into the shelter without her being here.

Here is the dilemma. Each group is trying to open up the wording. Those that are taking care of the homeless don't want the wording to be changed because that will take away their pot of funds. Obviously those with families, they want to open up the wording, because they want to take care of those families that they are taking care of.

I feel like I am splitting the baby here. That, unfortunately, is what we deal with constantly here. I am hoping that through these hearings, people actually understand we are just trying to take care of each other.

Mr. Davis.

Mr. DAVIS. One last question, and I started down this road before.

One of the biggest issues facing the American family right now is the high cost of fuel, gasoline. This winter we are going to go into a problem with not having enough supply, and energy costs are going to be high. Home-heating costs are going to be high. Tell me some stories if it is affecting the people that you care for and work with on a day-to-day basis. I open it up to anyone on the panel or everyone on the panel.

Rev. WELLS. Briefly I had a case that came to me, and it was two elderly ladies living together. They had been without power for 5 weeks. By that time it was $689 for me to get their power restored. Because our—there is—another vision of this is the deposits in order to have utilities. Our utility deposit is now $200. If their power is disconnected, then you have another deposit. And each time that it is disconnected, there is another deposit that is added on to that.

So one of the things that I have to come up with is—to be able to pay for the utilities is including paying for their new deposits in order to get it turned back on; of course, then bringing in services that would help them—especially with these being elderly people, we were able to get several agencies that would come in and help undergird their situation so that they could stay in their home.

But we are seeing utility bills, in particular right now, where most of the people can't even come in for gas in order to get food. We are actually having to go and deliver the food to the elderly. Our elderly are calling our offices on a daily basis and crying because they—just because they get Social Security, they get $10 worth of food stamps. You and I both know you can't buy much for

$10. But they are wanting milk and eggs and bread, margarine, the simple things of life we look at and take for granted. This is what they call asking us. Then we have to take it to them, because there is no way for them to be able to have their gas to come in.

We are also seeing the fact that our young men and women who are on Families First program and the struggle they are having with gas, with fuel, to be able to get to work. They are already working at minimum wage. So when we added these high costs now, they are not even able to afford to go to work. If they miss work, then they lose their jobs, so we are back to square one.

You are going to be seeing much greater of this, and you are going to be hearing more stories like this, I truly believe this, over the next few months to come.

Mr. BAILEY. You are also going to see the impact and continue to see in food banks and other programs the increased cost of food that is given out to people who do not have enough food, that that cost is also being spread. In Boston, where I live, where we have a very, very successful food pantry, food bank program, they already are talking about the increased cost of having food. Also we are seeing a reduction in people giving food because they are needing to hold onto it for themselves.

So we are going to face both challenges in terms of the cost, donations, as well as the rise in energy costs, enormous concerns now coming from Boston, which is heavily dependent in terms of old housing stock on oil heat. So the cost of oil for many older people, many families, will be for them the difference between eating, getting their oil. I just talked to someone the other day who says that she is trying to manage to keep a quarter of a tank if she can hold onto that and not go below that, but that is all she can afford to do. She is afraid because she knows the cost is going to go up even to just keep that quarter of a tank and how is she going to get through the winter.

Mr. BIRD. Also I think the case—I think it is very much the case for rural and reservation communities where people have to travel large distances to buy gas, to buy groceries and to just conduct their business. They are not—they can't rely on public—any sort of public transportation systems that urban areas have, so I think it is sort of a unique issue.

Ms. BERGERON. Yes. I would agree with everything that has been said. And, in addition, you know, States like New Hampshire, we have such poor structure, public transportation, that you are not only talking about the cost of gas, they are talking about the cost of a vehicle, if you really wish to employ people and have them working in areas that may earn them money.

Mr. BAILEY. I would also add one other comment that very often people think about when they are thinking about older people, and they are saying, well, we are going to raise the bus fare, but you seniors get a discount. If you have ever worked with older adults who talk about what that difference of a dime or when something goes up a quarter when they are on fixed income, and the anxiety that that creates when it speaks to reducing their activities of daily living, that what for some of us seems minimal for other people is catastrophic.

We really have to look at the context in the which these activities and changes occur. For some people something that appears very negligible, for someone else is a life-and-death catastrophic issue and has a catastrophic impact.

Chairwoman MCCARTHY. Mr. Yarmuth.

Mr. YARMUTH. Thank you, Madam Chairman.

I want to follow up on something that you began, and this is the question of education and early childhood development. David Brooks had a fascinating column this morning in the New York Times, I hope everybody reads it, that talked about the real challenge to American revival as an economic power.

He talked about—he made the statement in the column that boosting educational attainment at the bottom is more promising than trying to reorganize the global economy. His point was that what we have seen over the last 30-something years in this country is actually a decline in educational attainment, largely attributable to the fact that we have so many at-risk families where children, in their very early years, before they are 5 years old, are not developing the social skills, the confidence levels, the nurturing that many others do. Actually, because of this, this contributes to drop-out rates and so forth. We know we have a horrible problem with drop-out rates throughout the country.

My question, after that long introduction, is what role do social workers have to play in trying to correct or—and I know, Reverend Wells, this sounds like something that was your personal situation—in trying to balance, if you will, the early childhood development of at-risk families? As a corollary question, is there anyone else who can do that?

Rev. WELLS. I think in particular for my situation and in growing up is that I was never encouraged to go to school because it was already cut out that—you know, that I was going to be a wife and a mother and nothing else. That was to be my role. That was something to be very proud of. That was—not to put that down, that was an important role for us to play.

But I think the schoolteachers—and they are another one who steps in—the schoolteachers I had encouraged me and kept me going. At that time there was no such thing as social work in the field of education, but my schoolteachers kept me going and dreaming and desiring and believing in myself that there was something else that I could do.

Now, being able to have social workers that specialize in the testing and development and being able to work with the children at risk are very important. Also the agencies that work with children, as we have at home, Coalition for Kids and Boys to Men, these are mentoring programs to keep the children going forward instead of stopping and giving up.

We have such a hopelessness among our at-risk families because it is multigenerational, as we all know. You are fighting—I have them coming into my office, well, we filed for Social Security today. This is a thrill, this is an excitement, you know, we finally got to the point where we can file for Social Security on our own and be able to be supported by the government. They are not looking to see what can I do for my government in order to help support others.

So it is the mentality all the way around, and that is why the social worker is so important, I believe, this day and time, is to be able to help them to keep dreaming and go forward.

Ms. BERGERON. I think social work also will come up with some innovative programs. At the University of New Hampshire, social work, along with the other disciplines in the College of Health and Human Services, has started an early intervention assessment program that includes physical therapy, occupational therapy, psychosocial assessment, speech therapy, and developmental profiling. This is made free to anyone who, you know, can get there.

We are still trying to fine-tune it, we are trying to broaden the scope of it. We partnered with Dartmouth College. It has been a wonderful program that has helped the schools. We provide consultation to schools in order to help them learn how to deal with the multitude of diagnoses that they are getting.

Let me just insert here, we tend to talk about the needs of developmental disabled children, but we also need to think about—and I think social work is just beginning to get into this area—the gifted child that gets lost in the educational system, and we can't afford to lose those children.

Mr. BIRD. I would just like to mention that, you know, we have programs that have clearly demonstrated their effectiveness through research, and Head Start is clearly one of them. So we have models already in place.

I think that we also, in the research, have a knowledge and understanding of what goes into creating or recognizing the resilience of children coming out of dire circumstances. We know what it takes to intervene.

One of the critical pieces that has been mentioned today is the ability to create a positive relationship with someone or people over time, whether it be a grandparent, a teacher or other sort of people that are there for that child when they are in crisis or to provide support.

The other thing I wanted to mention was that, getting back to your question, I think there has been some research about incarceration, and that there has been some research, and I am sure we can find that data or the study, that, as I recall, given what we are paying to incarcerate people per capita, that we could almost send them all to Ivy League schools.

One of the realities and—personally speaking, one of the realities when I was growing up was the low expectation that people—some teachers, not everyone—and some people placed upon Indian students and expecting that they would not achieve, could not achieve, and were not capable of higher education, were not capable of having a dream, and that reality is still out there for many in this country, that there is a low expectation. They don't expect many of us to achieve. They don't expect us to be productive. They don't expect us to be president of the American Public Health Association. They don't expect those sorts of things. Consequently, that is what they get. They don't—and those children are marked, and their dreams end and are dashed, and we all lose out on a very valuable resource to this Nation.

Chairwoman MCCARTHY. I want to thank everybody for the testimony that you have put forth, and certainly with your answers.

Mr. Bird, it wasn't that many years ago that they said the same thing about Irish, the Polish, the German. So a lot of people kind of forget their ancestry.

I know when I first came on this committee and started visiting schools on Mondays, and people will say our children can't learn. Our children can learn if we give them the opportunity, and that is proven. We already have the statistics on that.

But with that being said, again, I thank you all for your information, anything that you feel that this committee should have, and the only thing I would ask you to think about, you know, is what can we in Congress do. Obviously, because you are so diversified, the pay scale is going to be totally different. Those for nonprofits are going to be there because that is where they want to be, and the pay, unfortunately, is going to be low. Those who are in Civil Service and other areas will have better pay. Those that are teaching, you know, you will be where salaries are going to be different. So you are all over the place, and I don't even know how to address that, to be very honest with you.

I will try to do what I can do on student loan forgiveness. That is someplace where you can go. This way we can hopefully educate our young people to go into a field that they can actually help an awful lot of people.

With that, I am not going to read my closing statement. I think we are all on the same page on what we want to do.

As previously ordered, Members will have 14 days to submit additional materials to the hearing. Any Member who wishes to submit follow-up questions in writing to the witnesses should coordinate with the Majority staff within the requested time.

[The statement of Mr. Altmire follows:]

Prepared Statement of Hon. Jason Altmire, a Representative in Congress From the State of Pennsylvania

Thank you, Chairwoman McCarthy, for holding this important hearing on the state of social work in America.

I look forward to learning more about the social work profession today from our esteemed panel of witnesses. Social work is one career that the Bureau of Labor Statistics estimates will grow faster than average. Some fields of social work are anticipated to grow by as much as 30 percent by 2016. Social workers perform a great service in our communities, providing our children, families and seniors with guidance and education.

Social workers often face difficult and challenging work, and I appreciate all that they do to help members of our communities. I look forward to today's testimony and I would like to thank the witnesses for lending us their time today.

Thank you again, Chairwoman McCarthy, for holding this hearing. I yield back the balance of my time.

[Additional submissions for the record by Mrs. McCarthy follow:]

NATIONAL ASSOCIATION OF SOCIAL WORKERS,
Washington, DC, August 14, 2008.

Hon. CAROLYN MCCARTHY, *Chairwoman,*
Subcommittee on Healthy Families and Communities, U.S. House of Representatives, Washington, DC.

DEAR CHAIRWOMAN MCCARTHY: On behalf of the National Association of Social Workers (NASW), I would like to thank you for the important role you played in the Subcommittee hearing on July 29, "Caring for the Vulnerable: The State of Social Work in America." Congressman Yarmuth had several questions regarding the cost effectiveness of social work interventions, and I would like to clarify a few points and provide some additional materials.

Research has proven that social work is necessary to solve the seemingly intractable societal problems we are facing. For instance, professional social workers are more likely to find permanent homes for children who were in foster care for two or more years. Yet, fewer than 40 percent of child welfare workers are professional social workers. Professional social workers not only have a positive impact on the over 500,000 children in the U.S. foster care system but provide significant cost saving services. Child welfare agencies that hire social work staff also have lower turnover than those that do not. Likewise, the Child Welfare League of America determined that targeted case management "enhances the child's condition and/or reduces the likelihood that more intensive, more expensive Medicaid covered services will be needed in the future." Social workers play an important role in social services and psychosocial care that leads to increased successful outcomes in a variety of fields.

Studies of the cost effectiveness of social work are still a burgeoning area of research, yet Rizzo and Rowe note that, "it provides convincing empirical evidence that social work services can have a positive and significant impact on quality of life and health care costs and use for aging individuals." Research has been done on the cost effectiveness and efficacy of social work practice with various populations, including caregivers of the elderly, elders receiving geriatric evaluation and management, those in poverty with individual development accounts, substance abusers, stroke patients, and aging individuals receiving social work services. Research on Social Work Practice published a full issue in 2006 dedicated to these issues, which we will deliver to you as soon as possible.

Again, thank you for the important role you played in the July 29 hearing and we look forward to working together to strengthen our families and communities.

Sincerely,

ELIZABETH J. CLARK, PH.D., ACSW, MPH,
Executive Director.

Research on Social Work Practice
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Cost Outcomes and Social Work Practice
Victoria M. Rizzo and Anne E. Fortune
Research on Social Work Practice 2006; 16; 5
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Cost Outcomes and Social Work Practice

Victoria M. Rizzo
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School of Social Welfare, State University of New York at Albany

In response to escalating health care costs, especially costs for which Medicare and Medicaid are the primary payers, government officials, policy makers, and health administrators have placed increasing pressure on health care providers and mental health providers to answer the following question: What is the relationship between the cost of the services provided and the benefit to the consumers receiving it? In other words, can health and mental health providers demonstrate the *cost-effectiveness* of the services they provide to consumers? Answers to these questions are increasingly used to determine reimbursement structures for private insurance, Medicaid, and Medicare. Therefore, evidence about the cost-effectiveness of social work interventions is needed to convince government officials, policy makers, and health administrators that these services are essential. For this reason, the use of economic analysis to examine the efficacy of social work practice is the focus of this special issue.

What is cost-effectiveness analysis? Several methods for the economic evaluation of health and mental health interventions exist, including cost-identification analysis, cost-utility analysis, cost-benefit analysis, cost-consequences analysis, and cost-effectiveness analysis (Drummond, O'Brien, Stoddart, & Torrance; Neumann, 2005). However, the evaluation method receiving the most attention of late is cost-effectiveness analysis (CEA). Its prominence is a result of the recommendations of The United States Panel on Cost-Effectiveness in Health and Medicine (Weinstein, Siegel, Gold, Kamlet, & Russell, 1996) and the fact sheet entitled, "Focus on Cost Effectiveness Analysis at the Agency for Healthcare Research and Quality" (AHRQ; U.S. Department of Health and Human Services Public Health Services (USDHHS/PHS), 2001). CEA is the recommended economic evaluation method because

1. CEA can quantify health costs and benefits into a single ratio. CEA involves comparisons between two interventions or the presence and absence of an intervention. The cost-per-effect ratio provides the difference in costs divided by the difference in health status change. To standardize health status change, the Panel recommends using quality adjusted life years (QALYs) to measure health status change. QALYs represent the benefit of an intervention as the time spent in certain "quality weighted" health states ranging from 1 (*perfect*) to 0 (*death*). Once these quality weights are calculated for each health state, they are multiplied by the time spent in the health status state. These calculations are then summated to receive the total number of QALYs (Gold, Siegel, Russell, & Weinstein, 1996).
2. CEA can help state and federal policy makers, health insurers, managed care organizations, and health care organizations make educated policy and reimbursement structure decisions based on which services are most efficacious and cost-effective (Holosko, Dobrowolsky, & Feit, 1989, 1990); and
3. CEA can help advocacy groups, consumers, and the general public promote the integration of research into practice by identifying which interventions are the most efficacious and cost-effective (USDHHS/PHS, 2001).

Despite the promotion of CEA by the Panel on Cost Effectiveness, the AHRQ and its use in other countries, such as the United Kingdom, the United States has resisted the use of CEA in health and mental health research (Neumann, 2005). The reasons for resistance reveal some of the difficulties encountered when attempting to use CEA to examine the cost-effectiveness of social work practice (Drummond & McGuire, 2001; Gold et al., 1996; Neumann, 2005). What are some of the limitations of CEA? The limitations include the cost data, CEA methodology, and research motives of investigators.

COST DATA

Collecting uniform and reliable cost data is no small feat for social work researchers for a variety of reasons. The first problem with data is the reporting of charges and payments by private insurers, Medicare, Medicaid, and

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provider agencies. Some entities report billable charges, whereas others report the amount actually paid. Furthermore, the cost of resources may differ greatly by region or state and may be calculated using different formulas. Some billable charges may include overhead costs, such as office space, employee time, and equipment, whereas others do not. If doing research in sites with different payment sources and billing/payment structures, the researcher may have to calculate average costs by applying unit costs across all the sites or calculating average costs in each site and then combining these costs for a total average cost. These two average cost methods can result in very different treatment cost outcomes. Reconciling the two methods requires additional research time to calculate costs (Drummond & McGuire, 2001).

The second problem with cost data is what to include in the cost of an intervention and the uniformity of this costing across studies using similar interventions. Does one include in the cost of the intervention staff time, materials, office space, and equipment? Does one include the cost of transportation and time lost or gained at work for the person receiving the intervention? Also, how does one calculate the cost of informal care, such as caregivers' and volunteers' time in transporting and providing care outside the intervention for consumers of the intervention? How does one calculate the cost of improving the quality of life of caregivers as well as consumers beyond productive work hours? These are questions not easily answered, and there are no uniform guidelines for costing interventions.

The third problem with cost data is access. Although obtaining Medicare and Medicaid data is not impossible, state and federal guidelines and applications for obtaining cost data can be cumbersome and lengthy, making it difficult to complete cost analyses in a timely fashion. Furthermore, the lack of a single payer for health care in the United States presents its own challenges. Private insurers may be willing to provide average costs across a diagnosis or population, but they often view the amount actually paid as proprietary information that they are not willing to release to researchers. If one is doing research in sites with multiple private payers, the information may not only be hard to obtain but also difficult to make uniform for comparisons across payers. It is no wonder that most CEA in social work practice has been done with populations in Veterans Administration hospitals or one identified managed care organization where, despite the difficulties of obtaining data, it will at least be uniform with the particular population under study.

CEA METHODOLOGY

CEA methodology is not uniform, making it difficult to make generalizations across studies that examine similar interventions. Neumann (2005) has stated that CEA has a credibility problem due to (a) discrepancies in costing methods across studies that make comparisons impossible, (b) a lack of uniform standards for CEA, and (c) the perception that CEA analyses do not meet the practical needs of decision makers. In their report of cost-effectiveness studies of social work practice in aging, substance abuse, dual diagnosis, health, and child welfare, Rizzo and Rowe (2003) reported that studies in the areas of substance abuse, dual diagnosis and child welfare provided the most explicit explanation of the cost-effectiveness methods used as well as the cost data, but these studies did not explicitly mention social workers as the provider of services even though social workers are the largest provider of services in these areas. Nor did these studies explicitly describe the intervention for costing purposes. Furthermore, in cost-effectiveness studies in social work interventions with aging populations, some researchers missed opportunities to demonstrate the cost-effectiveness of some interventions by neglecting to quantify cost in terms of decreased nursing home costs or hospitalization costs.

RESEARCH MOTIVES

The motives of investigators using CEA are under intense scrutiny (Neumann, 2005). Two questions convey the mistrust of CEA studies, and health and mental health intervention studies in general:

1. Are the investigators promoting the cost-effectiveness of a particular intervention because they can gain financially? Much of this fear resulted from investigators reporting positive outcomes but suppressing negative outcomes when they had much to gain financially if a drug were effective. Unfortunately, highly visible drug studies with negative outcomes (e.g., Vioxx, Ephedra, and Reflutan) have created a cynical environment for studies employing CEA as well as a general mistrust of research findings (Kassirer, 2005). Beyond drug studies, most intervention studies are conducted by researchers who developed the intervention, which also creates some level of mistrust in today's research environment. In response to these issues, *The New England Journal of Medicine* issued strict conflict-of-interest requirements for publishing CEA studies in its journal (Kassirer & Angell, 1994).
2. Are CEA studies being conducted to deny services to consumers? The general public views policy makers, government officials, and private insurers as wanting to save costs above all

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else. For this reason, studies conducted to determine the cost-effectiveness of treatments are often seen as attempts to deny people services because of their expense rather than as providing them with the best service that is also cost-effective. To encourage positive publicity, insurers go to great lengths to minimize the cost-effectiveness benefits and maximize the health status benefits of interventions that they will approve for payment. Another question posed is: Should services that are more expensive not be provided if they are efficacious but not cost-effective? This question addresses the "value added" component of an intervention that cannot be calculated with CEA analysis. Intensive case management (ICM) is a case in point. ICM for dually diagnosed patients may be more expensive than usual care, but the "value added" components of treatment, which cannot be measured monetarily, may far outweigh the extra cost.

Despite the difficulties and limitations inherent in cost-effectiveness analysis, the articles in this issue make a significant contribution to our understanding of the cost-effectiveness and efficacy of social work practice with a variety of populations, including caregivers of the frail elderly, elders receiving geriatric evaluation and management (GEM), those in poverty with individual development accounts (IDAs), substance abusers, stroke patients, and aging individuals receiving social work services. The articles provide a variety of cost-effectiveness methodologies and provide findings that will inform social welfare policy, program development, and the delivery of social services in the United States.

For example, Toseland and Smith examine the cost implications of a caregiver health education program (HEP) for spouse caregivers of frail elders who are members of a staff-model health maintenance organization (HMO). Their description of the intervention and explanation of cost calculations provide a practical model for cost analyses within an HMO setting that allows for replication in similar settings. Furthermore, their positive results for health utilization and cost make a convincing case for the reimbursement of the HEP by private insurers, Medicare, and Medicaid.

Engelhardt, Toseland, Gao, and Banks examine the long-term effects of an outpatient GEM program on health care utilization and costs. GEM program studies provide the most rigorous studies of the efficacy and cost-effectiveness of psychosocial interventions in aging. Unlike previous studies of the GEM program, this study highlights the role of social workers in the intervention model and makes a convincing argument for a change in Medicare reimbursement structures that will allow for the adoption of GEM programs outside of Veterans Administration hospitals.

Scheiner, Tin Ng, and Sherraden provide an excellent overview of a framework for cost-effectiveness analysis with an application to IDAs. The seven aspects of their framework contribute an important extension of cost-effectiveness to "macro level" interventions, which have not been a major focus of cost-effectiveness analyses. Their simple framework is highly adaptable to other macro- and micro-level interventions in social work practice.

Saleh, Vaughn, Levey, Fuortes, Uden-Holmen, and Hall clearly identify social workers as the providers of the substance abuse treatment models in their study. Despite the fact that social workers are major providers of substance abuse treatment, most cost-effectiveness studies do not identify social workers as providers of the interventions examined. In this respect, this article has much to offer to the knowledge base of social work practice in substance abuse. Furthermore, the authors' discussion of the importance of the provision of case management services despite their lack of cost-effectiveness highlights the ethical dilemma between the cost-effectiveness and value-added components of social work interventions. The article provides a perfect avenue for further discussion of this struggle between cost and value in psychosocial service delivery.

Schilling, Dorning, and Lundgren provide an excellent overview of the existing evidence of the efficacy, costs, and benefits of psychopharmacological treatment of opiate addiction and, more specifically, methadone maintenance. The authors point out that social workers assess, recommend, and monitor treatment of substance-abusing clients, but there is no evidence that their decisions are based on the available empirical evidence. Based on this premise, the authors argue that the extent to which social workers currently refer clients for treatment that is known to be efficacious and cost-effective is an indicator of how our profession will fare in an environment that is demanding evidence of the cost-effectiveness of social work interventions.

Claiborne examines a care coordination model for stroke survivors who have recently been discharged from inpatient physical rehabilitation programs. The difficulty measuring case management interventions and care coordination models for use in cost-effectiveness studies is well documented in the literature. This small ($N = 28$), randomized controlled trial adds to the literature because it provides a model for the clear articulation of a care coordination model so that its components can be specifically identified and measured. Furthermore, the author

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demonstrates how charges from different sources can be used effectively to determine the efficacy and cost-effectiveness of social work practice in an outpatient setting.

Rizzo and Rowe (2003) present the findings of a literature review of the studies of the cost-effectiveness of social work services in aging. The authors use the results to (a) make explicit the current knowledge base of interventions in aging, (b) identify gaps in knowledge, and (c) promote a research agenda for cost-effectiveness studies in aging to build a case for the modification of present federal reimbursement structures for social work services in aging. The small body of literature available presents convincing evidence that social work interventions can have a positive impact on health care utilization and cost as well as the quality of life of older Americans.

Taken together, the articles in this special issue, which is devoted to cost outcomes and social work practice, add much to the knowledge base of the efficacy and cost-effectiveness of social work practice with a wide variety of populations. In the coming years, there is bound to be increasing pressure on social workers and social work researchers to demonstrate both the efficacy and cost-effectiveness of social work practice. This evidence will be the basis for crafting policy changes for reimbursement structures for the provision of social work services. Our hope is that this special issue will be one of many focused on this topic and the first in a series of special issues devoted to the cost-effectiveness of the interventions social workers deliver that will continue the profession's development of a cost-effectiveness research agenda that demonstrates the importance and value of our work with the populations that we serve.

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Relationships between Social Work Involvement and Hospice Outcomes: Results of the National Hospice Social Work Survey

Dona J. Reese and Mary Raymer

In a struggle to balance fiscal realities with hospice philosophy, some hospices have attempted to cut costs by reducing social work involvement. This cross-sectional survey of 66 hospices found, however, increased social work involvement was significantly associated with lower hospice costs. Additional benefits included better team functioning, more issues addressed by the social worker on the team, reduced medical services, and fewer visits by other team members, along with increased client satisfaction and lower severity of case. The authors concluded that higher salaries should be paid to a sufficient number of highly educated and experienced social workers. These social workers should be dedicated solely to the hospice social worker position, should participate in intake interviews, and should be supervised by a social worker.

Key words: *hospice; hospice costs; intake interviews; outcomes measurement; team functioning*

Over the past two decades the U.S. hospice industry has struggled to provide holistic palliative care to the terminally ill population and their families. The birth of hospice movement occurred in the United States when it became clear that the traditional medical model did not meet the complex needs of people at the end of life; in this void hospice workers built a system of interdisciplinary care designed to meet the physical, psychological, social, and spiritual needs of terminally ill people and their families. Slowly but surely, hospice care carved its niche in the health care system and finally achieved reimbursement through third-party payers.

From the advent of the Medicare hospice benefit, though, and particularly because of the advent of managed care, the health care system, including hospice, has been challenged to contain costs in patient care while improving quality and outcomes (Dinerman, 2002; Rizzo, 2002). Medicare reimbursement has been seen as inadequate to cover hospice costs (Mahoney, 1997; "Seeking Stability," 2003); as a result, administrators have experienced tremendous pressure to make decisions based exclusively on fiscal realities. This has created considerable role conflict as they struggle to maintain the original hospice vision of holistic patient care (Dinerman; Mahoney).

Since the beginning of Medicare coverage, the strong psychosocial emphasis in hospice has begun to fade; reports from around the country suggest that economic realities of the health care system have left little or no role for social work (Colone, 1993; Sontag, 1996). Social work has been viewed by some administrators as an "ancillary service," that is, nice but not necessary; and Kulys and Davis (1986) found that hospice nurses were more active than social workers in

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the provision of psychosocial care. Reports by MacDonald (1991), Sontag (1996), and Csikai (2002) revealed the continuation of this pattern.

Many social workers see patients only on an "as needed" basis, as determined by a nurse. Non–social workers regularly provide psychosocial care, and social workers are involved primarily in assessment. Social workers may have difficulty gaining access to patients and families; and hospices may be reluctant to acknowledge a family's need for social work intervention until a problem has reached crisis proportions. Social workers in many areas of the country have seen their caseloads rise as colleagues were laid off or positions were not replaced. At the same time, nursing caseloads are much lower, hospices hire many more nurses than social workers, and patients receive many more nursing visits than social work visits (Ita, 1995–1996; Reese & Brown, 1997; Sontag, 1996).

The social work section of the National Hospice and Palliative Care Organization (NHPCO) received many reports of this situation from social workers nationwide and called a meeting of hospice social work leaders to develop a plan of action. The purpose of the current study, formulated at a roundtable discussion at this meeting, is to provide documentation of the relationship of social work involvement to hospice outcomes.

Effects of Social Work Involvement on Hospice Outcomes

Despite the underutilization of social work in hospice, several studies have demonstrated that increased social work involvement in hospice was related to reduced costs. These studies implemented new programs in which social work involvement was increased, including involvement in the intake interview (Cherin, 1997; Mahar, Eickman, & Bushfield, 1997; Paquette, 1997). Also, these studies found beneficial differences between pre- and posttest measures, including fewer hospitalizations, on-call visits, and hours for nursing visits (Mahar et al.; Paquette). Increased social work involvement was also associated with lower pain medication costs (Cherin; Mahar et al.); less frequent use of IVs (Paquette); higher quality of life for patients (Cherin); improved nurse, client, and physician satisfaction (Paquette); and a reduction in staff turnover (Paquette).

In summary, studies have consistently indicated that early and continuing social work involvement is associated with beneficial hospice outcomes. Few studies have been conducted, however, and those few have consisted of nonrandom, local samples. The studies have been quasi-experimental; therefore, they have not documented relationships between a variety of specific social work involvement measures and specific hospice outcome measures. This study provides a national probability sample with a survey design to address these gaps in the literature. Based on previous findings and the authors' practice experience, the following hypotheses were developed for this study:

- Social work involvement is significantly associated with hospice processes.
- Hospice processes are significantly associated with hospice outcomes.
- Social work involvement is significantly associated with hospice outcomes.

Method

Three volunteer hospices participated in a pilot study to test the instruments and methods for the survey. The formal survey was conducted with 330 patient cases in 66 hospices. The NHPCO selected a stratified random sample of 350 hospices from their list of provider members—15 percent of the member organizations. The sample was restricted to home hospice programs in operation for at least one year and stratified to reflect the proportions of hospices in NHPCO membership according to Medicare certification versus noncertification and for-profit versus nonprofit status. Seventy-six hospices responded, for a response rate of 20 percent. The data from 10 hospices were excluded from this analysis because they submitted incomplete data; thus, data analysis was conducted with a sample of five patients in each of the 66 hospices.

In each hospice, the most experienced social worker was designated as the social work liaison for the study. The social work liaison completed the social work questionnaire and selected the five most recently deceased patients for the study. The social worker who had been assigned to each of the selected cases completed the chart review form for that case. In addition, the hospice director completed the director questionnaire. The survey was conducted by mail; data collection procedures were monitored by telephone calls to each hospice. Data were collected regarding social work involvement, hospice processes, and hospice outcomes.

The coinvestigators, building on existing NHPCO guidelines for hospice social work services and input from experts in the field, developed most of the measures for the survey. In addition, we measured team functioning with the Team Functioning Scale (Sontag, 1997; $\alpha = .86$) and severity of case with a revised version of the Social Work Acuity Scale for Hospice (Huber & Runnion, 1996; $\alpha = .70$).

The data were entered into SPSS, assigning one line of data for each patient. There were five patients in each hospice, and some of the data pertained to the hospice as a whole rather than to an individual patient (that is, ratio of social workers to patients in the hospice). The hospice data were repeated on each of the five lines of patient data for that hospice, so that each line of data would contain both patient and hospice data. In this way, relationships could be tested between patient and hospice data (that is, the relationship of the social worker to patient ratio in the hospice to the severity level of an individual patient case). We note concern that repeating the hospice-level data in the database in this way could increase any existing measurement error.

Regression analysis was not feasible because of high collinearity between independent variables. Thus, to test the research hypotheses, we conducted bivariate analyses using *t* tests, correlations, and χ^2 tests. A significance level of $p < .05$ was used throughout.

Results

In calculating averages in the following, medians were used when skewed distributions biased the mean. Fifty-two percent of the patients in the sample had primary caregivers. Only 4 percent had unsanctioned emergency room visits. Seventy-eight percent of patients died in their homes as planned. The median number of nursing visits to patients in the sample was 10, in contrast to two social work visits.

The median daily census for the sample of hospices was 34. The social worker participated in the intake interview in only 38 percent of hospices. Only 18 percent of social workers were supervised by a social worker.

Social workers were paid less than nurses with similar education. The mean full-time equivalent of nurses was 8.33 ($SD = 7.80$); it was 2.84 for social workers ($SD = 2.65$). On average, there were six social workers for every 100 patients, compared with 18 nurses for every 100 patients. The social work liaisons had a median of 10.25 years of full-time experience after receiving their social work degrees, and 81 percent were MSWs.

Hypothesis 1: Social Work Involvement and Hospice Processes

A number of indicators of social work involvement were significantly associated with hospice processes (see Table 1). Addressing more issues on the hospice team was significantly associated with indicators of services delivery, qualifications of the social worker, qualifications of the supervisor, hospice spending, and hospice staffing. Having no duties in addition to the hospice social worker position was significantly associated with addressing more issues on the interdisciplinary team [$t(95.944) = 3.257$, $p. = .002$]. We also found that supervision by a social worker was significantly associated with the hospice social worker having no duties outside of the social worker position [$\chi^2(1, 66) = 20.306$, $p = .000$]. Also, qualifications of the social worker and staffing were significantly associated with better team functioning.

Hypothesis 2: Hospice Processes and Hospice Outcomes

The relationships of social work involvement and hospice processes are important because of the association of hospice processes with hospice outcomes. Better team functioning was significantly associated with a number of beneficial hospice outcomes, including level of medical services provided and costs (Table 2). In addition, addressing more issues on the team was significantly associated with fewer visits by other team members on a particular case ($r = -.18$, $p = .02$).

Hypothesis 3: Social Work Involvement and Hospice Outcomes

In addition to its association with hospice processes, social work involvement was also associated with a number of hospice outcomes. Services delivery was significantly associated with several hospice costs and patient outcomes. Qualifications of the social worker were significantly associated with level of medical services, costs, and patient outcomes. Hospice spending was significantly associated with costs and patient outcomes. Finally, staffing was significantly associated

Table 1

Significant Relationships between Social Work Involvement and Hospice Processes

	Hospice Processes	
Social Work Involvement	**Better Team Functioning**	**More Issues Addressed by Social Worker on Team**
Service delivery		
Participation in intake		$t(183.8) = -2.151, p = .03$
More client contacts		
Qualifications of social worker		
MSW	$t(196) = 2.531, p = .01$	$t(83.327) = -2.531, p = .01$
More experience since SW degree		
Qualifications of supervisor		
Supervision by social worker		$t(87.399) = -3.633, p = .000$
Hospice spending		
Higher BSW salary		$r = .28, p = .007$
Higher MSW salary		
Higher social worker costs		$r = .21, p = .02$
Staffing		
Higher full-time equivalent of social workers		$r = .30, p = .000$
No additional duties outside of hospice social worker position	$t(196) = 1.931, p = .05$	$t(95.944) = 3.257, p = .002$
Social worker to patient ratio	$r = .20, p = .02$	$r = .16, p = .05$

with medical services, costs, and patient outcomes (Table 3).

Discussion

The results of this study are consistent with the literature in documenting benefits to clients and hospices from increased social work involvement. Despite these benefits, however, we also documented a trend to minimize social work services in hospice care compared with nursing services. Despite the importance of social work participation in the intake interview, for example, social workers participated in the intake in only 38 percent of the hospices.

Table 2

Significant Relationships between Hospice Processes and Hospice Outcomes

	Hospice Processes	
Hospice Outcomes	**Better Team Functioning**	**More Issues Addressed by Social Worker on Team**
Medical services		
Lower average no. of hospitalizations per patient	$r = -.58, p = .000$	
Hospice costs		
Lower home health aide costs	$r = -.32, p = .000$	
Lower nursing costs	$r = -.32, p = .000$	
Lower labor costs	$r = -.33, p = .000$	
Lower overall hospice costs	$r = -.31, p = .000$	
Visits by other team members		
Fewer home health aide visits		$r = -.18, p = .02$

Table 3

Significant Relationships between Social Work Involvement and Hospice Outcomes

	Social Work Involvement									
	Service Delivery		Qualifications of Social Worker		Hospice Spending				Staffing	
Hospice Outcomes	**Participation in intake**	**More client contacts**	**MSW**	**More experience since SW degree**	**Higher BSW starting salary**	**Higher MSW starting salary**	**Higher social worker costs**	**Higher FTE of social workers**	**No additional duties outside of social work position**	**Higher ratio of social workers to patients**
Medical services										
Fewer nights of continuous care			$t(37.5) = 2.052$, $p = .05$	$r = -.17$, $p = .03$					$\chi^2(1, 66) = 14.41$, $p = .000$	
Lower average no. of hospitalization per patient								$r = -.18$, $p = .05$		
Hospice costs										
Lower average cost per patient				$r = -.29$, $p = .001$						
Lower average pain cost per patient	$r = -.64$, $p = .000$	$r = -.33$, $p = .000$	$r = -.29$, $p = .003$	$r = -.33$, $p = .000$	$t(84.9) = 5.55$, $p = .000$					
Lower home health aide costs	$t(66.9) = 2.06$, $p = .04$			$r = -.17$, $p = .05$						$r = -.17$, $p = .03$
Lower nursing costs										$r = -.16$, $p = .04$
Lower labor costs	$t(67.69) = 1.98$, $p = .05$									$r = -.15$, $p = .05$
Lower overall hospice costs	$t(69.9) = 2.48$, $p = .02$									$r = -.14$, $p = .05$
Patient outcomes										
Better client satisfaction		$r = .54$, $p = .000$		$r = .26$, $p = .009$	$r = .24$, $p = .03$	$r = .28$, $p = .003$	$r = .21$, $p = .03$			
Lower severity of case										$r = -.22$, $p = .003$

In addition to lending credibility to earlier studies, this study provided new information about the relationships among social work involvement, hospice processes, and hospice outcomes. We found new information about the relationships between social work involvement and hospice processes, including the contribution of social work input to the team and team functioning. The implications of these hospice processes to hospice outcomes facilitate a beginning understanding of the mechanism by which social work services predict hospice outcomes.

When interpreting the results of this study, several limitations should be kept in mind. First, the 20 percent response rate compromised the representativeness of the sample. Demographic patient data in our sample were similar to averages reported by the NHPCO (1999), however, indicating possible similarities in the other variables measured as well. Second, causal relationships cannot be assumed because of the cross-sectional survey design of this study. Despite these possible limitations, the results of this study are consistent with previously published literature and provide new information as well. We believe this study represents a useful step in the development of a body of knowledge in this area.

Social Work Participation in Intake

Social workers have unique skills that are important during intake. Using an ecological perspective, the social worker can identify problems in the environment that may affect care. A plan of care that mobilizes a supportive response from the environment can then be formulated. The social worker also has skills to help the patient and family adjust to the presence of hospice caregivers and the interaction with the social services network. In addition, the social worker is prepared to intervene with family dynamics, which often have an impact on the effectiveness of hospice services and outcomes for the patient. The social worker has the skills to identify high-risk characteristics at intake (that is, high levels of death anxiety or dysfunctional family interaction), which would not be resolved by more nursing visits (Silberstein, 1998), and plays a proactive role that helps prevent crises. Prevention of crisis may help explain the relationship of social work involvement to hospitalizations, pain costs, labor costs in terms of number of visits required, and overall hospice costs.

Client Satisfaction

Several studies have demonstrated that client satisfaction is strongly influenced by the quality of communication with health professionals (Grbich, Maddocks, & Parker, 2001). Health professionals often do not have adequate training in interpersonal skills (Schulman-Green, 2003), and patients complain that physicians do not pay enough attention to their treatment preferences (Childress, 2001). In contrast, communication and advocacy for client self-determination are two of the most highly stressed areas in social work training. Social work practice is directed to improving interactions between people and their environments, which includes modifying the environment to be more responsive to client needs and preferences (Germain, 1991). The social worker advocates for the patient's active participation in his or her own care and represents the patient's interests when communication breaks down between family and patient or between patient and staff. Thus, it makes sense that active social work involvement with hospice cases would be associated with improved client satisfaction.

Team Functioning

Quality of interaction also affects functioning of the interdisciplinary hospice team. Job satisfaction in hospice has been linked to team functioning (DeLoach, 2002; Vachon, 2000). Team communication has been found to directly affect client care (Childress, 2001; Thompson, Rose, Wainwright, Mattar, & Scanlan, 2001), but hospice workers report frustration with poor interactions with team members (Sontag, 1996). Social workers intervene in transactions between all subsystems in the client's environment, which includes interactions with the team (Germain, 1991).

Implications for Practice and Policy

This study suggests that an interdisciplinary approach that includes the full involvement of social workers is important in the delivery of effective end-of-life care. Unfortunately, the social work profession has been slow to measure empirically its contribution to hospice and palliative care. Patients, their families, hospice programs, and the social work profession have suffered the consequences of this oversight. Although there is limited research in this area, the findings of this study are consistent with other studies. Enough of a consensus exists to comfortably offer the following

conclusions and recommendations for hospice policy and practice.

Establish Higher Social Work Salaries and Hire Social Workers with More Education and Experience. Results of this study indicate that social worker education, experience, and salaries are associated with beneficial hospice outcomes. We conclude from this that hospice programs would benefit by hiring the most highly educated and experienced social workers available. We reason that higher social work salaries may help attract the best-qualified applicants.

Obtain Supervision by a Social Worker. Historically in hospice, administrators from disciplines other than social work have supervised social workers. We advocate for supervision by a social worker because of its association with beneficial hospice processes.

Implement Routine Social Work Participation in Intake Interviews. Study of social work participation in intake interviews has consistently found an association with beneficial hospice outcomes. One reason for this, in our opinion, is that joint visits present hospice as a team from the start of services and allow for smoother teamwork. As a result, productivity for all disciplines is enhanced. The social worker addresses more issues with the team, and fewer visits are necessary by home health aides and nurses. Hospice labor costs are reduced as a result. Social work participation in the intake interview is also important because early social work intervention allows prevention of crises.

Hire a Sufficient Number of Social Workers Dedicated Solely to Client Care. Social workers frequently wear too many hats in hospices. Our results indicate that assigning duties beyond the social worker position is associated with unfortunate hospice outcomes. Based on our practice experience, if a hospice has an insufficient number of social workers, social work services tend to be provided in crisis situations only, and there is little opportunity for in-depth social work contributions to the team. Consequently, the team does not function as well or adequately provide psychosocial care.

According to our experience, although clients may contact the on-call nurse with physical symptoms, frequently psychosocial needs such as anxiety management are at the root of after-hours calls. Client problems may become more severe, with increased physical pain resulting from increased psychosocial pain. This could explain our result of increased pain costs if the social worker had additional duties. Psychosocial needs may trigger hospitalizations or the need for continuous care. In this situation, clients may need more visits from other team members, more continuous care, and more hospitalizations and may be less satisfied with the hospice services. An end result is higher costs for the hospice.

Conclusion

We suggest that hospice social work intervention should not be the result of a crisis or an as-needed service. Social workers should participate in intake interviews and provide continuing intervention to prevent crises and reduce the severity of cases. Expert psychosocial interventions from the beginning of the case can ensure that all options are explored before less effective, higher-cost options are used. Skilled psychosocial care would have an effect on other aspects of a client's well-being, including pain and the need for continuous care and inpatient treatment.

We recommend, based on the results of this study, that hospice administrators establish adequate social work budgets to provide salaries that attract highly educated and experienced social workers. In addition, social work budgets should be adequate to hire a sufficient number of social workers with no duties outside of the social worker position and to provide supervision by a social worker.

Although increasing the social work budget may initially cost more, the results of this study strongly suggest that reducing social work involvement does not reduce hospice costs in the long run. The opposite seems to be the case. The importance of psychosocial care as espoused by hospice philosophy must become a reality and not merely an ideal. The role conflict experienced by administrators trying to balance fiscal realities with hospice philosophy appears to be unnecessary. This study supports earlier findings that true interdisciplinary care with full involvement of social workers is also the least expensive form of care. ■

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Cost-Effectiveness of Case Management in Substance Abuse Treatment

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Objective: The purpose of this study, which is part of a larger clinical trial, was to examine the cost-effectiveness of case management for individuals treated for substance abuse in a residential setting. Method: Clients who agreed to participate were randomly assigned to one of four study groups. Two groups received face-to-face case management and one telecommunication case management, and the fourth was the control group. Results: Using a ratio of cost to days free from substance abuse, the case management groups were less cost-effective than the control group at 3 months, 6 months, and 12 months. The telecommunication case management was least cost-effective of the three case management conditions. Conclusion: Results from the analysis revealed case management is not cost-effective as a supplement to traditional drug treatment over a 12-month follow-up period.

Keywords: *case management; substance abuse treatment; cost-effectiveness; social work*

An estimated 52 million Americans are believed to have mental health or substance abuse problems (Edmonds et al., 1997). Health expenditures incurred to treat these illnesses, especially substance abuse, constitute a significant proportion of the national health bill. Estimates of the costs to society from substance abuse have reached approximately $166 billion, with $99 billion because of alcohol abuse alone (Robert Wood Johnson Foundation, 1994). In 1995, a conservative estimate of Federal spending on substance abuse totaled $77 billion, representing roughly 10% of entitlement spending (health, disability insurance, Aid to Families with Dependent Children, etc.; National Institute on Drug Abuse, 1998). A major payer in the substance abuse field is the managed care industry whose role has increased in the past few years. By year-end 1995, 124 million out of the 142 million Americans enrolled in managed care plans were enrolled in a managed behavioral health program (Edmonds et al., 1997).

With the financial pressures that health care providers are experiencing, many organizations are examining strategies and interventions that would reduce cost and yield better or comparable results. The substance abuse treatment field is no exception. After the success of case management programs in the mental health field (Brindis, Pfeffer, & Wolfe, 1995) in Zimmerman and Wienchowski (1991), many proponents have advocated its use to supplement existing substance abuse treatment regimes. The rationale is that a comprehensive case management will help clients receive coordinated care (Ridgely, 1994) and ongoing support services (Ashrey, 1992; Katz et al., 2000; Siegal et al., 1996), thus reducing the intensity (i.e., costs) of substance abuse treatment and improving overall effectiveness.

Studies of case management have focused primarily on description, theory, and implementation aspects of the intervention (Siegal & Rapp, 1996). Although several studies have shown support for the cost-effectiveness of drug abuse treatment, few have examined the cost-

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effectiveness of case management accompanying drug abuse treatment (Hubbard et al., 1989). Although improved functioning and reduced substance abuse should be the primary focus of any program evaluation related to substance abuse treatment, understanding the costs associated with any intervention cannot be ignored. It is possible that case management may lead to significant decreases in clients' use of substances and significant improvements in their functioning, but if these benefits are accompanied by excessive costs, alternate programs may be more feasible.

This study, which is part of a larger clinical trial, examines the cost-effectiveness of case management for individuals treated for substance abuse in a residential setting. A program administration viewpoint (substance abuse treatment facility initiating a case management supplement to traditional treatment) rather than a broader societal viewpoint is adopted for these analyses. The assumption is made that case management can be an important part of the treatment regime in a substance abuse treatment program.

METHODS

Site and Participants

The study was conducted from October 1995 through October 1998 at Mid-Eastern Council on Chemical Abuse (MECCA) with clients in their residential facility for substance abuse treatment. MECCA is a community-based, nonprofit, substance abuse treatment agency with multiple programs. The main office is located in a metro county (as classified by U.S. Department of Commerce Bureau of Economic Analysis) with a population of 98,000. The three additional counties that comprise MECCA's catchment area are classified as rural counties adjacent to a metro county by the U.S. Bureau of Economic Analysis and have a total population of 42,000. Of MECCA's clients, 85% originate from within the four-county catchment area. Clients in the residential treatment program were recruited to the study if they met any of the following criteria: (a) had more than one drug- or alcohol-related offense, (b) had a breathalyzer test with a blood alcohol content of 0.2 or higher, or (c) were involved in a drug- or alcohol-related accident.

Potential study participants were informed that all information would be kept confidential and that the participant would be compensated for participation in the study. Written, informed consent was obtained from all participants. A total of 1,109 residential clients were assessed and invited to participate. Of these, 662 (60%) clients agreed to participate. Of these, study staff conducted follow-up assessments with 278 (42%) at 3 months, 306 (46%) at 6 months, and 263 (40%) at 12 months. A greater proportion of participants than nonparticipants were female, had recent periods of family conflict, had recent days of substance abuse, and had been arrested and incarcerated. Participants also had more psychiatric symptoms than nonparticipants (Vaughn, Sarrazin, Saleh, Huber, & Hall, 2001).

Participants were randomly assigned to one of three experimental conditions (conditions A, B, or C) or a control condition that did not include case management (condition D). The only differences between the case management conditions were the locations at which case managers practiced and the method of communication between case managers and clients.

All of the case managers were employed by the study and used the Iowa Case Management (ICM) model, a strengths-based problem-solving approach or philosophy of case management. The ICM model is grounded in traditional social casework and uses a health care problem-solving philosophy (Hall, Carswell, Walsh, Huber, & Jampoler, 2002). The overall approach with clients is based on a strengths perspective and uses language from solution-focused therapy to emphasize client strengths and resources (Hall & Carswell, 1996). By approaching clients with this perspective, case managers emphasized client assets, desires, abilities, and resources to deal with problems. The ICM approach also demonstrates respect for the clients' ways of thinking and dealing with life situations through specific procedures and activities. Case managers emphasized working with concrete behaviors and clearly delineated goals, rather than focusing on feelings or on vague or undefined outcomes. Furthermore, ICM provided specific techniques for eliciting behaviorally specific goals and examples of strengths and provided guidance on an appropriate clinical framework for therapeutic work. Along with these innovations, the ICM model emphasized outreach into the community with the client and therapeutic counseling at times with the client would benefit most. ICM was organized around six functions that form its core therapeutic process: (a) orientation and contracting, (b) assessment and monitoring, (c) solution planning, (d) referral, (e) orientation to transitional case management, and (f) client-directed case management (Hall et al., 2002).

Condition A (drug treatment agency) consisted of case management by two social workers who were employed

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by the study and who had their offices at the primary drug treatment facility. This condition was intended to test whether on-site case management, which is likely to be the predominant approach to case management, is more effective than off-site or other forms of case management not as closely linked with primary substance abuse treatment. These case managers participated in clinical meetings at MECCA and had much easier access to the clients while the clients were in residential treatment.

Condition B (social services agency) consisted of case management by two social workers who had their offices at a local social services agency. This condition was included to test if off-site case management is more effective than on-site case management. These case managers participated in the administrative organization of the social service agency and had more difficulty accessing clients while the clients were in residential treatment at the drug treatment agency. Because residential treatment lasted between 10 and 14 days usually, the inside case managers only had a theoretical advantage during that time when the client lived at the center.

Condition C (telecommunications) was included to compare the effectiveness of a telecommunications system, which is common in many managed-care organizations to face-to-face case management. In the telecommunications condition, a social worker was employed by the study and had an office in the administrative center for the study at the university. By design, this case manager met with clients in person while these clients were in drug treatment and subsequently provided most case management over a telecommunications system. Clients could leave messages on the system as needed and case managers coordinated care and performed other functions over the telephone. The telecommunication case manager worked with a double caseload of clients compared with case managers in Conditions A and B. This case manager met with patients in person at the primary treatment facility one to three times to complete some basic tasks and then provided most case management through a telecommunications system. Clients could leave messages on the system as needed and the case manager coordinated care and performed other functions over the telephone.

The case managers in Conditions A and B carried active case loads ranging from 16 to 20 clients and focused most of their primary interventions during the first 90 days following discharge from drug treatment. These four case managers carried less active case loads (those beyond the first 90 days after treatment) that ranged from 48 to 60 for up to 12 months following intake into drug treatment. As mentioned, the sole telecommunication case manager had a double case load (32 to 40 active, 96 to 120 less active) that could be handled, theoretically, more efficiently because of the technological features of our telecommunication system.

Measurement of Effectiveness

All individuals admitted to the treatment center during the time period of the study were administered several assessment instruments, including the addiction severity index (ASI). The ASI addresses seven domains including physical health, mental health, alcohol abuse, drug abuse, employment, family, and legal status. It has been used in numerous studies to measure outcomes of substance abuse treatment (Lyons, Howard, O'Mahoney, & Lish, 1997; McLellan et al., 1992). McLellan Luborsky, O'Brien, Woody, and Druley (1982) have developed summary composite scores covering each of these seven domains. The composite scores have been shown to be highly valid and reliable measures of clients' severity of functioning (McLellan Luborsky, Woody, & O'Brien, 1980; McLellan et al., 1982). However, these scores are not the most meaningful measures for use in cost-effectiveness analysis because they do not have a standard unit of measurement that can be used for financial analysis by clinicians or program administrators (Saleh et al., 2002).

One of the main criteria for judging the effectiveness of substance abuse treatment is the reduction in substance use (Mclellan et al., 1996). For the aims of this study, we selected client self-reported days of any substance use in the past month from the ASI to create the number of days of abstinence during the past month. The measure of substance use employed by researchers can range from amount of the substances used, to the number of days over a specific time period during which the client used a substance at least once, or its inverse, the number of days of abstinence over a specific number of days possible. The basic question is whether we use abstinence (a very conservative measure) as the desired outcome or do we focus on substance use with reduction in substance use as the desired outcome (a more realistic measure in some ways). Some studies measure sobriety as complete abstinence from substance abuse indefinitely (i.e., never relapsing again; Ouimette, Gima, Moos, & Finney, 1999; Walton, Castro, & Barrington, 1994). Others have looked at shorter abstinence periods ranging from 24 months abstinence (Zywiak et al., 1999) to an abstinence year (Shepard, Larson, & Hoffman, 1999a) to days of abstinence from substance abuse (Drake, Mercer-McFadden, Mueser, McHugo, & Bond, 1998). We decided that days

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of abstinence would be a reasonable measure of intervention effectiveness, mainly because we do not have evidence-based standards of acceptable substance use by those who have received drug treatment. To measure change over time, the ASI and other instruments were readministered to study participants at 3, 6, and 12 months following intake into drug treatment. In our overall research, researchers target several outcome variables that are related to the goals of the case management program.

Measurement of Costs

The primary costs considered in the cost-effectiveness analysis were the costs of treatment, case management staff salary and benefits, travel costs, and the cost of the telecommunication system. The costs of substance abuse treatment were added to those related to case management for two reasons. First, the model used in the project considers case management as a supplement to treatment and not as a replacement. Given that, it was important to consider both as one treatment package. Second, substance abuse treatment clients receiving case management are likely to have a different length of stay than clients who receive no case management services (Schwartz & Baker, 1997). It is therefore important to capture such differences in substance abuse treatment costs that otherwise would not be captured if the costs of case management are considered alone.

Costs of substance abuse treatment for all groups were obtained from the treatment facility. Case management labor and travel costs were estimated using data from the case management information system, a computerized database in which case managers log their activities and time spent with or on behalf of each client. Labor costs were estimated for each client based on the number of hours that case managers spent working with or on behalf of the client and the case managers' budgeted salaries and benefits. Travel costs were estimated based on the distance a case manager traveled in his or her case management activities. Telecommunication system costs were allocated based on the cost of the telecommunication system and its use by the case manager and the residential clients recruited in the project. Other costs, such as supplies, training, and overhead were not considered because of insufficient data. The social workers involved with the project were familiar with the case management model, which decreased training costs.

Two approaches to cost calculation were used: cumulative and add-on. In the cumulative method, costs were calculated from baseline to the respective periods (3, 6, and 12 months). The add-on method considered costs incurred between each of the follow-up assessments (i.e., 0 to 3 months, 3 to 6 months, and 6 to 12 months). The two estimation methods were used because of the high concentration of case management activities during the first 3 months. The first period after the initiation of the relationship involved a labor-intensive, rapport-building effort by the case manager. This period includes building a strong and respectful relationship with the client and identifying personal strengths, past successes, and both formal and informal resources in the client's life. The level of case management activities decreases over time and the amount of case manager time per client is considerably less in the later stages of the project. The use of the add-on cost calculation method allowed for the control for the initial high cost of case management.

Data Analysis Procedures

Analysis of variance was used to test the difference in the number of substance use–free days among the four groups. The Tukey studentized method was used for multiple comparisons. Age, gender, and severity of abuse at baseline were included as control variables.

Average costs for each of the condition groups were estimated from the sources described above (substance abuse treatment facility and case management information system) for each follow-up period. The cost-effectiveness ratios were calculated using the total costs for each group as the numerator and the number of substance abuse–free days per month as the denominator. Sensitivity analysis was conducted to assess the robustness of the results. For the sensitivity analysis, the number of substance abuse–free days during the three follow-up assessments was varied by using the average and the lower and upper 95% confidence intervals (CIs).

RESULTS AND DISCUSSION

Patient Characteristics

Client descriptive statistics are presented in Table 1. The average age of residential clients in the study was 33.5 ($SD = 8.8$), with most of the sample below 46 years of age. More males (59.1%) participated in the study groups than females (40.9%). More than four fifths of the sample (83.3%) was White, followed by African Americans (12.7%). A high percentage of clients (82.0%) had no significant other. The sample was roughly divided equally among the four study groups: the treatment agency group (25.2%), the social service agency group

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TABLE 1: ***Descriptive Statistics of the Sample Characteristics at Baseline for Residential Clients***

Characteristics	N	%
Age*	627	
18 to 25	136	21.7
26 to 35	227	36.2
36 to 45	202	32.2
46 to 55	58	9.3
< 55	4	0.6
Gender	643	
Male	380	59.1
Female	263	40.9
Race	654	
White	545	83.3
Black	83	12.7
Hispanic	8	1.2
Indian	10	1.6
Others	8	1.2
Significant other	655	
Has no significant other	537	82.0
Case management condition	662	
Treatment agency	167	25.2
Social service agency	160	24.2
Telecommunication	147	22.2
Control	188	28.4

*Mean age = 33.5, standard deviation = 8.8.

(24.2%), the telecommunications group (22.2%), and the control group (28.4%).

Substance abuse free days. At each of the three follow-up points, no significant difference was detected between the intervention groups and the control group on changes in substance abuse–free days (Table 2). One trend in client self-reports across all four study conditions was a higher average number of substance abuse–free days in earlier assessments than later assessments.

Cost-Effectiveness Analysis

Cumulative costs valuation. Table 3 presents the cumulative costs of case management and substance abuse treatment for each of the treatment conditions at each of the three periods. At 3 months, the case management conditions incurred more costs than the control group. As discussed, this was expected because of the time spent building up a relationship with the client. All three case management conditions had higher costs of treatment than the control group. Clients receiving case management through the treatment agency had the lowest average treatment costs compared to the other two case management conditions ($1,795 vs. $2,026.10 and $2,058.80). The treatment agency group also incurred the least total costs among the three case management conditions. Clients receiving case management through the social services agency incurred the highest labor costs and travel expenses.

At 6 months, the three case management conditions continued to incur more total costs than the control group. Clients receiving case management at the treatment agency remained the least expensive of the three intervention groups. However, at this point the total costs of the telecommunications group were less than the social service agency group. Labor and travel costs for the social service agency group were the highest among the case management conditions.

The 12-month estimated costs showed that two case management groups—the treatment agency group and the social service agency group—incurred treatment costs that were less than or very close to those of the control group. The telecommunications group incurred the most total costs among the four study groups.

Add-on costs valuation. Costs calculated incrementally (baseline to 3 months, 3 to 6 months, 6 to 12 months) for each of the four study groups are presented in Table 4. The 3-month results are the same as the cumulative results. For the 3- to 6-month interval, the results show that clients receiving case management in any of the three case management conditions incurred lower incremental treatment costs than the control group. Also two of the three case management conditions—the treatment agency group and the social service agency group—incurred lower total costs than the control group. In the 6- to 12-month interval the results reveal that the total incremental costs for each of the three case management conditions exceeded those of the control group. Clients receiving case management through the social service agency had significantly lower incremental treatment costs than the other groups but higher labor and travel costs.

Cost-effectiveness ratios. Table 5 presents the cost per substance abuse–free day for each of the study groups at the three follow-up assessments. None of the case management conditions was more cost-effective than the control group. Administering case management through the treatment agency was the most cost effective among the three case management conditions at the 3- and 6-month assessments. The cost per substance abuse–free day was $78.90 for the treatment agency group compared to $91.40 for the social service agency group and $99.40 for the telecommunications group. The difference in cost-effectiveness ratios between the treatment agency group and the telecommunications group widened at 6 months.

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TABLE 2: ***Substance Abuse–Free Days per Month by Treatment Group and Follow-up Point: Means, Confidence Intervals, and Sample Sizes***

	3 Months			*6 Months*			*12 Months*		
Period	M	*95% CI*	n	M	*95% CI*	n	M	*95% CI*	n
Treatment agency	25.2	22.9-27.4	65	24.0	21.9-26.1	82	23.9	21.8-26.1	68
Social service agency	25.8	23.9-27.7	73	23.5	21.2-25.8	80	25.3	23.2-27.4	67
Telecommunications	24.0	21.7-26.3	65	21.9	19.2-24.5	79	21.7	18.9-24.4	63
Control	25.1	23.1-27.0	80	24.0	22.2-25.9	92	22.6	20.0-25.1	72

$^{*}p < 0.05$.

TABLE 3: ***Average Cost of Substance Abuse Treatment and Case Management by Time Period and Treatment Condition***

	Treatment Agency	*Social Service Agency*	*Telecommunications*	*Control*
3 months				
Average cost of treatment	1795.0	2026.1	2058.8	1697.6
Labor ($ based on hours)	175.8	282.6	164.4	0.0
Travel expenses	16.5	49.5	16.5	0.0
Computer expenses	0.0	0.0	145.8	0.0
Total costs	1987.3	2358.2	2385.5	1697.6
6 months				
Average cost of treatment	2592.0	2655.2	2740.0	2597.0
Labor ($ based on hours)	247.0	347.2	246.8	0.0
Travel expenses	28.5	63.8	22.3	0.0
Computer expenses	0.0	0.0	291.6	0.0
Total costs	2867.5	3066.2	3300.7	2597.0
12 months				
Average cost of treatment	2785.6	2702.2	2902.6	2739.7
Labor ($ based on hours)	295.4	453.8	288.4	0.0
Travel expenses	43.6	103.3	23.4	0.0
Computer expenses	0.0	0.0	583.2	0.0
Total Costs	3124.6	3259.3	3797.6	2739.7

NOTE: Unless otherwise noted, figures are reported in 2001 US$.

TABLE 4: ***Average Add-on Cost of Substance Abuse Treatment and Case Management by Time Period and Treatment Condition***

	Treatment Agency	*Social Service Agency*	*Telecommunications*	*Control*
3 months				
Average cost of treatment	1795	2026.1	2058.8	1697.6
Labor ($ based on hours)	175.8	282.6	164.4	0.0
Travel expenses	16.5	49.5	16.5	0.0
Computer expenses	0.0	0.0	145.8	0.0
Total costs	1987.3	2358.2	2385.5	1697.6
6 months				
Average cost of treatment	797	629.1	681.2	899.4
Labor ($ based on hours)	71.2	64.6	82.4	0.0
Travel expenses	12	14.3	5.8	0.0
Computer expenses	0.0	0.0	145.8	0.0
Total costs	880.2	708	915.2	899.4
12 months				
Average cost of treatment	193.6	47.0	162.8	142.7
Labor ($ based on hours)	48.4	106.6	41.6	0.0
Travel expenses	15.1	39.5	1.1	0.0
Computer expenses	0.0	0.0	145.8	0.0
Total costs	257.1	193.1	351.1	142.7

NOTE: Unless otherwise noted, figures are reported in 2001 US$.

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TABLE 5: ***The Average Cost of a Substance Abuse–Free Day per Month by Treatment Condition and Time Period for Residential Clients***

Time Period: Intake to	*Treatment Agency*	*Social Service Agency*	*Telecommunications*	*Control*
3 months	78.9	91.4	99.4	67.6
6 months	119.5	130.5	155.7	108.2
12 months	130.7	128.8	179.1	121.2

NOTE: Figures are reported in 2001 US$.

TABLE 6: ***The Average Add-On Cost of a Substance Abuse–Free Day per Month by Treatment Condition and Time Period***

Time Period: Intake to	*The Treatment Agency*	*Social Service Agency*	*Telecommunications*	*Control*
3 months	78.9	91.4	99.4	67.6
6 months	36.7	30.1	43.2	37.5
12 months	10.8	7.6	16.6	6.3

NOTE: Figures are reported in 2001 US$.

The social service agency group cost $128.80 per substance abuse–free day at 12 months compared to $130.70 for the treatment agency group and a significantly higher $179.10 per substance abuse–free day for the telecommunications group.

Calculating the cost-effectiveness ratios using the add-on cost valuation is presented in Table 6. The two face-to-face case management groups achieved lower cost-effectiveness ratios than the control group (Table 6). The treatment agency group had a cost-effectiveness ratio of $36.70, and the social service agency's ratio was $30.10, compared to the control group's $37.50 per substance abuse–free day. The telecommunications group had the highest ratio ($43.20). The 12-month assessment showed that the control group was again the most cost-effective among the study groups, with an average $6.30 spent per substance abuse–free day. A close second was the social service agency group with a cost-effectiveness ratio of $7.60, followed by the treatment agency group ($10.80), and the telecommunications group ($16.60).

Sensitivity analysis. Sensitivity analysis was employed to assess the robustness of the results (Figures 1 & 2). The confidence in the ability to compare the four study groups will be reduced by the overlap that might exist between them because of the dispersion of variable values around the group means. Sensitivity analysis helps decrease the likelihood of inappropriate conclusions that are based on results with wide variation around group means. To examine the robustness of the results, the cost-effectiveness ratios for the four study groups were compared using the 95% CI boundaries of the number of substance abuse–free days. The results show some overlap in the cost-effectiveness ratios especially for cumulative cost estimation, which highlights the lack of major differences between the study groups when the inputs are changed.

CONCLUSIONS

The purpose of this study was to examine the cost-effectiveness of case management. Two methods of cost calculation were employed using cumulative and add-on averages. Based on our results using cumulative costs, the case management conditions were not more cost-effective than the control group. The results changed, however, when considering the add-on costs. Residential clients receiving case management through the treatment agency and social service agency had lower costs per substance abuse–free day at 6 months than the control group when add-on costs were considered. These lower costs can be partly explained by the dramatic drop in the case management costs compared to the high costs incurred in the first 3 months of client participation because of the extensive case management activities. These early efforts were essential to build a strong relationship with the client. In the cumulative cost analyses, the high initial costs were not offset by the difference in the number of abuse free days between the case management conditions and the control group. However, when costs were calculated as add-on, where the initial costs of case management were not included, the face-to-face case management conditions were more cost-effective than the control group (6 months) or had similar cost-effectiveness ratios (12 months).

As mentioned previously, few, if any, studies have examined the cost-effectiveness of case management in

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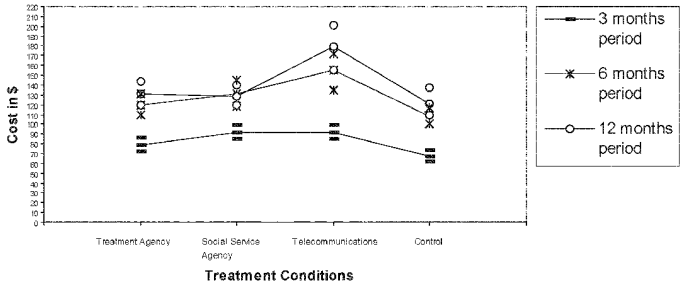

Figure 1: Sensitivity Analysis (Cumulative Cost Calculation)

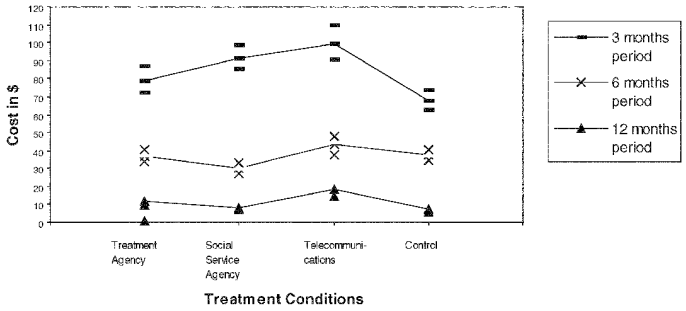

Figure 2: Sensitivity Analysis (Add-On Cost Calculation)

substance abuse treatment, let alone conducted a long-term assessment of its effects. Studies that have examined results of cost-benefits of alcohol and substance abuse treatment have reported that financial benefits begin to appear 2 to 4 years after treatment initiation (Holder, 1998). Because of the short-term follow-up of this study, conclusive evidence of the effects of case management could not be drawn. Case management is an intervention that introduces positive changes in the life of a substance abuser through the trusting and strong relationship built between the case manager and the client, changes that later help transform the client into an independent self-functioning individual. Such a transformation requires time to develop. One year might not be enough time to see the effects.

Another limitation of the study is the relatively low retention rate achieved in the follow-up assessments (Vaughn et al., 2002). The effects of low follow-up rates in introducing bias to study results have been addressed in the literature. Some investigators dismissed the concern

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over bias when having lower-than-usual follow-up rates (Hubbard et al., 1989). Others have argued that low retention affects study outcomes (Apsler & Harding, 1991; Stout, Brown, Longabaugh, & Noel, 1996).

So, where does this leave the question of the cost-effectiveness of case management with substance abuse clients? Obviously, our data do not support the cost-effectiveness of this case management model in this location. Future research could extend the length of time that these clients are followed to determine if the positive benefits of case management (outcomes related to costs) happen as in the Holder (1998) study. Second, other models of case management exist that do not include the intensity of this model (e.g., strengths-based counseling and outreach), and it may be that a less intense model (e.g., brokerage) would result in better results. Finally, similar cost-effectiveness studies need to be conducted in other settings including larger cities to determine if the rural Iowa setting was a negative factor (e.g., difficulty in tracking clients).

DISCUSSION AND APPLICATIONS TO SOCIAL WORK PRACTICE

Many social workers are required to perform a variety of case management responsibilities with their clients. Our assumption has usually been that case management should help clients improve their lives and reduce significant problems in their lives. This assumption is based on the person-in-environment model, which guides us to view problems within the context of the client and the environment.

A key factor in the delivery of social work services is cost. Our usual approach has been to address clinical efficacy and effectiveness and then recommend that cost-effectiveness be studied in future research. In the present study, we evaluated the costs of providing comprehensive case management with clients in residential drug treatment. Although our results did not support the hypothesis that case management would be cost-effective, other issues clouded these results. The primary confounding issue was the duration of the follow-up with our study participants. In Holder's work with patients treated for alcoholism, the savings in costs did not occur until the 3rd year—and these savings were for both the target patient and his or her families (Holder, 1998). Because our past follow-up point was 12 months following intake, we could not address this delayed benefit. We looked only at days without substance use. Some researchers, and social workers, argue that occasional use of some substances (e.g., alcohol or marijuana) is an acceptable outcome if clients' lives improve in other areas. Objectively measured areas might include reduced criminal activity, more days worked, or greater earned income. More subjective outcomes might include more positive self-esteem or improved family relations.

We recommend that social work practitioners desiring to use case management as part of their practice model first determine the appropriate case management model for their patient population and for the typical problems presented. Case management models can be compared and contrasted using the criteria found in Hall et al. (2002). The major models (from largest to smallest) are the assertive community treatment approach used mainly with mental health clients, the comprehensive approach that includes counseling and outreach, the brokerage model used mainly by public agencies (e.g., county social service offices), and the monitoring (gate keeping) approach used by the managed care and insurance industries. Models also vary by philosophy (problem or strengths focus), frequency of client contact, duration of contacts with clients and breadth of services (e.g., focus on many potential problems or on a few); but these dimensions can be measured through estimates of dosage (Huber, Sarrazin, Vaughn, & Hall, in press). Sometimes, comprehensive case management (which includes outreach and counseling) is necessary, but many times only brokerage case management can be supported financially by the organization. After selecting the most appropriate model of case management for their situation, we recommend that social work practitioners collect data on dosage (i.e., how much time it took to delivery services, the schedule for delivering these services, how long services were delivered, and specifically what kinds of services were delivered?) so that cost issues can be addressed by agency accountants and university researchers (Huber, Hall, & Vaughn, 2001; Huber, Sarrazin, Vaughn, & Hall, 2003). For social work practitioners, we must emphasize the use of evidence-based interventions with our clients whenever possible. Clinical wisdom can guide us when data are not available, but studies on effectiveness and cost-effectiveness should help us identify these evidence-based interventions and lead to better methods to evaluate these models. As public and private agency budgets respond to the changing goals of funding agencies, data on effectiveness and cost-effectiveness will become even more important and possibly required in the near future. However, it is important that studies highlight various other outcomes of social work in general and case management specifically in relation to quality of life and other outcomes that are not easily translated into dollar values.

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The Impact of a Caregiver Health Education Program on Health Care Costs
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The Impact of a Caregiver Health Education Program on Health Care Costs

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Objectives: This study examined health care cost outcomes resulting from a health education program (HEP), a social work intervention for spouse caregivers of frail older adults. Method: One-hundred five spouses were recruited and randomly assigned to HEP or usual care (UC). Health care utilization and cost data were collected from the HMO's management information system for both the spouse caregivers and care recipients in quarterly increments for a 30-month period. Results: The results indicate that HEP was cost-effective. Caregivers and care recipients who participated in HEP had significantly lower overall health care costs and significantly lower outpatient costs than those who participated in usual care. Conclusions: By 2 years, total cost savings for caregivers and care recipients who participated in HEP was $309,461.14. HEP is a cost-effective intervention for caregivers and care recipients receiving medical care from a staff-model HMO.

Keywords: *caregiver; support group intervention; randomized control intervention; health costs*

This article examines whether supporting caregivers of frail elderly through a health education program (HEP) can reduce health care costs incurred by both the caregivers and care recipients in an HMO setting. HEP is an intervention aimed at supporting and educating spouse caregivers of frail older persons with chronic illnesses. The demands of caregiving can have a negative impact on the emotional, physical, and social well-being of family caregivers (for a review, see Toseland, Smith, & McCallion, 2001). It has also been shown that caregiver support groups can have a positive impact on the well-being of caregivers (Bourgeois, Schulz, & Burgio, 1996; Schulz, 2000; Toseland et al., 2001; Toseland, Smith, & McCallion, 1995; Zarit, Gaugler, & Jarrott, 1999).

Much less is known, however, about whether support group interventions for caregivers can have an impact on health care costs. An extensive review for this study did not reveal any studies that examined whether participation in support groups has any impact on the health care utilization or health care costs incurred by caregivers. We were able to identify 10 randomized control design studies that examined the financial impact of caregiver support on care recipients, but these studies had limited cost data collection, small samples, and many were statistically nonsignificant.

The majority of previous studies have focused on whether caregiver interventions can delay the institutionalization of care recipients (Brodaty & Gresham, 1989; Brodaty, Gresham, & Luscombe, 1997; Brodaty, McGilchrist, Harris, & Peters, 1993; Brodaty & Peters, 1991; Chu, Edwards, Levin, & Thompson, 2000; Mittleman, Ferris, Shulman, Steinberg, & Levin, 1996; Mohide et al., 1990; Montgomery & Borgotta, 1989; Riordan & Bennett, 1998). These studies all indicated that various caregiver and care recipient support programs led to delayed institutionalization, therefore implying significant health care cost savings for care recipients. However, these implied savings were focused entirely on the care recipient. Data about the health care use of caregivers were not collected.

Other studies attempted to conduct economic evaluations of support programs for caregivers of the elderly. These studies had small samples, and the results were not statistically significant (Drummond et al. 1991; Miller, Hornbrook, Archbold, & Stewart, 1996; Weinberger et al., 1993). Although these interventions evaluated in the studies had a positive impact on psychosocial outcomes, no significant health care utilization or cost impact was found between intervention and control conditions. These studies indicated that additional research

Authors' Note: This study was funded by Grant No. R01 HSO8641 from the Agency for Health Care Policy and Research. A copy of the 70-page Telephone Support Group Trainer's Manual is available at cost from the first author. Correspondence concerning this article should be addressed to Tamara L. Smith, SUNY Albany, 217 Richardson Hall, Institute of Gerontology, 135 Western Avenue, Albany, NY 12222; e-mail: tsmith@albany.edu.

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was warranted to evaluate the economic impact of caregiver support.

Finally, one study found significant reductions in health care costs for some care recipients whose spouse caregivers had participated in support groups. In this study, care recipients in poor health whose spouses attended support groups had lower health care costs during a 1-year period than did control participants. This evaluation was limited because it only included care recipients. No cost analyses were performed on caregivers (Peak, Toseland, & Banks, 1995).

Taken together, these findings suggest that caregiver support programs may have a positive impact on the health care costs of care recipients. However, given both the limitations of the designs, sample sizes, and scope of the cost variables that were measured in most of these pioneering studies, and the fact that no data are available about cost savings for caregivers, additional research appears warranted.

The current article is the third in a series of articles about HEP. The first focused on the short-term psychosocial outcomes of HEP for both caregivers and their frail spouses (Toseland et al., 2001). Short-term results indicated that for caregivers, HEP was more effective than usual care (UC) in reducing depression, maintaining social integration, increasing effectiveness in solving pressing problems, increasing knowledge of community services and how to access them, and changing caregivers' feelings of competence and the way that they responded to the caregiving situation. No significant differences existed between care recipients whose spouses received either HEP or UC. The second focused on the long-term psychosocial outcomes for these dyads (Toseland, McCallion, & Smith, in press). Caregivers receiving HEP had significant long-term reductions in depression compared to UC, an increase in knowledge of community services and how to access them and a positive change in caregivers' feelings of competence and the way they respond to the caregiving situation compared to caregivers in UC. For care recipients, HEP was more effective than UC in preventing increases in symptoms of anxiety/insomnia and somatic symptoms. This article will focus on whether there were significant health cost savings for caregivers and care recipients who participated in HEP.

METHOD

Hypotheses

Compared with caregivers receiving UC, it was hypothesized that caregivers in HEP would experience significant ($p < .05$) reductions in outpatient costs at 6 months, 1 year, 18 months, and 2 years after baseline. It was also hypothesized that compared to care recipients whose spouses were in the UC condition, spouses of caregivers participating in HEP would experience significant ($p < .05$) reductions in outpatient, inpatient, and total costs at 6 months, 1 year, 18 months, and 2 years after baseline.

Participants

The study participants were all recruited from a staff model HMO. Five centers contained medical staff employed to serve the patients enrolled with the HMO. Recruitment strategies included referrals from HMO staff, direct mailings to married couples 55 and older, flyers distributed in the HMO, and referrals from physicians, nurses, and social workers in the HMO. Caregivers were eligible to participate in the study if they were 55 years of age or older and married to a spouse with a chronic illness who was also a member of the HMO. Care recipients had to be 55 years or older and suffering from a chronic illness. The Activities of Daily Living (ADL) section of the Older Americans Research and Services Center Instrument (OARS) was used to screen for the functional impairment of the care recipient. To be eligible for participation, care recipients had to have at least two ADL or IADL impairments as measured by the OARS instrument. The psychometric properties of the OARS ADL scales are well established (Fillenbaum, 1978).

To ensure that caregivers were sufficiently stressed to benefit from the intervention, they had to have a strain score of at least 7 on the Caregiver Strain Index (CSI) to participate. The 13-item CSI generates an overall caregiving strain score (range 0 to 13) and has good internal consistency ($r = .86$) (Robinson, 1983).

Caregivers and care recipients were screened for their cognitive functioning by using the Short Portable Mental Status Questionnaire (SPMSQ). This 10-item questionnaire has good test-retest reliability ($r = .81$), and its validity has been established (Pfeiffer, 1975). To ensure that caregivers could learn from the intervention, they had to score at least an 8 on the SPMSQ to remain in the study. Psychosocial outcome data from care recipients who scored less than 8 were excluded from data analyses, but their medical data were used in cost analyses.

The 105 caregiver–care recipient dyads that agreed to participate signed a consent form allowing the release of their medical cost data from 6 months prior to the intervention baseline to 2 years after baseline. The spouse couples also completed psychosocial measures at four time periods (baseline, 8 weeks, 1 year, and 2 years).

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TABLE 1: ***Caregiver Demographics***

Variable	Control Years	Intervention Years	Statistic
Age	69.9	68.7	$t = .791$
Total years married	41.2	39.6	$t = .597$
	%	%	
Gender			$\chi^2 = .210$
Female	70.8	66.7	
Male	29.2	33.3	
Race/ethnicity			$\chi^2 = 1.414$
White	93.8	89.5	
Black	4.2	3.5	
Other	2.1	7.0	
Employment status			$\chi^2 = 2.491$
Full-time	8.3	8.8	
Part-time	14.6	8.8	
Unemployed	2.1	1.8	
Retired	75.0	77.2	
Disabled	0.0	3.5	
Highest level of education			$\chi^2 = 13.48$
Less than 7 years	2.1	0.0	
Junior high school	2.1	5.3	
Some high school	18.8	3.5	
High school graduate	37.5	29.8	
Some college	31.3	33.3	
College graduate	4.2	14.0	
Graduate or professional	4.2	14.0	
Caregiving activities			
Help from others	25.5	24.6	$\chi^2 = .013$
Receiving other HMO help	6.3	12.3	$\chi^2 = 1.100$
Participating in support group	6.3	8.8	$\chi^2 = .235$
Hours per day caregiving	6.8	8.6	$t = -1.247$

TABLE 2: ***Care Recipient Demographics***

Variable	Control Years	Intervention Years	Statistic
Age	72.5	72.8	$t = .169$
	%	%	
Gender			$\chi^2 = .449$
Female	33.9	27.5	
Male	66.1	72.5	
Race/ethnicity			$\chi^2 = .119$
White	96.4	95.0	
Black	3.6	5.0	
Other	0.0	0.0	
Employment status			$\chi^2 = 4.462$
Full-time	5.4	0.0	
Part-time	3.6	0.0	
Unemployed	0.0	0.0	
Retired	76.5	77.5	
Disabled	14.3	22.5	
Highest level of education			$\chi^2 = 8.809$
Less than 7 years	1.8	7.5	
Junior high school	3.6	7.5	
Some high school	16.1	20.0	
High school graduate	28.6	22.5	
Some college	14.3	27.5	
College graduate	17.9	7.5	
Graduate or professional	17.9	7.5	
Activities of daily living score	17.8	18.8	$t = -.783$
Functional abilities			$\chi^2 = 5.989$
Very poor	6.3	7.0	
Poor	8.3	15.8	
Fair	39.6	29.8	
Good	37.5	26.3	
Very good	8.3	19.3	
Excellent	0.0	1.8	
Health			$\chi^2 = 12.902$
Very poor	0.0	7.0	
Poor	22.9	8.8	
Fair	35.4	42.1	
Good	35.4	22.8	
Very good	6.3	12.3	
Excellent	0.0	7.0	

Table 1 presents demographic data about the caregivers in the study. As can be seen in Table 1, the average caregiver age was 70 years old. The majority of caregivers were White, retired, and female. No significant differences on any of the demographic variables were found at baseline between caregivers in HEP and UC.

Table 2 presents demographic data about the care recipients. Table 2 shows that the average age of care recipients was 73 years old. Most care recipients were White males who were no longer working. As can be seen in Table 2, no significant differences on any of the demographic variables were found at baseline between care recipients in HEP and UC.

Design

Caregivers and their spouses were randomly assigned to receive HEP or UC. Each caregiver had an equal chance of being assigned to either arm of the study. Using an intention-to-treat methodology (Applegate & Curb, 1990), health costs for both groups were compared during the 30-month period from 6 months prior to baseline until 2 years after baseline.

Setting

The HMO from which participants were recruited was a staff model, closed-panel HMO that served 368,000 individuals in the Northeast. It operated with the basic concept of the primary care provider (PCP) as gatekeeper, most of whom were employed as staff by the HMO. PCPs in the system were physicians, nurse practitioners, or physicians' assistants practicing in the fields of internal medicine, family practice, or pediatrics. All specialty care, home care, inpatient care, and emergency room care

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TABLE 3: ***Description of HEP Weekly Meetings***

Meeting	*Description*
Meeting 1	Overview of major concepts of HEP, introduction of members to group, description of eight-step problem-solving model
Meeting 2	Identification and labeling of reactions to caregiving, discussion of effective and ineffective coping mechanisms, problem solving
Meeting 3	Importance of informal supports for caregivers, exercise on using existing family and friendship networks, problem solving
Meeting 4	Learning about formal community resources and services, problem solving
Meeting 5	Relaxation techniques introduced and practiced, problem solving
Meeting 6	Relaxation techniques practiced, problem solving
Meeting 7	Cognitive restructuring activities, problem solving
Meeting 8	Conclusion of weekly meetings, cognitive restructuring activities, problem solving

NOTE: HEP = health education program.

TABLE 4: ***Description of HEP Monthly Meetings***

Meeting	*Description*
Meeting 1	Effective communication with health care providers
Meeting 2	Safe and effective techniques for providing care within the home
Meeting 3	Prescription medicine, over-the-counter drugs, alternative medicine
Meeting 4	Safety in the home
Meeting 5	Nutrition
Meeting 6	Normal and abnormal aging processes
Meeting 7	Safe exercises and activities for care recipients
Meeting 8	Communication between the caregiver and the care recipient
Meeting 9	Legal issues pertaining to health care
Meeting 10	Preparing for the future, obtaining additional resources and help if needed, review of various skills and components of HEP.

NOTE: HEP = health education program.

had to be preauthorized. Two hundred eighty-six thousand were members of a traditional HMO, and 82,600 were enrolled in a point-of-service plan. Participation in this study was limited to members enrolled in the traditional HMO benefit package. The traditional HMO benefit package included a nominal visit fee (copayment) for each service, with coverage for well-care, unlimited inpatient care, home care in lieu of hospitalization, and 20 outpatient mental health visits annually. To control costs, employers had the ability to tailor copayments and benefits.

Intervention Conditions

HEP Condition

The HEP condition consisted of a group intervention led by a social worker. The groups contained between 5 and 8 caregivers. Each group met for 8 weekly, 2-hour sessions, followed by 10 monthly, 2-hour sessions. Table 3 describes the HEP weekly meetings. Table 4 provides a description of the monthly meetings.

The major components of HEP included (a) emotion-focused coping strategies, (b) education about caregiving and community resources, (c) problem-focused coping strategies, and (d) support. The first half of each weekly meeting centered on emotion-focused coping strategies. The second half of each weekly meeting focused on problem-focused coping strategies, using an eight-step problem-solving model. Throughout each meeting, participants were encouraged to bond with the other group members by sharing their experiences and problems and empathetically listening and responding. In this way, support was interwoven throughout each group meeting.

To illustrate the structure of the social work components interwoven throughout the HEP intervention, a case example will be used. This case example focuses on Sophia, a 73-year-old woman whose husband has Alzheimer's disease. Sophia's experience in the HEP group was enhanced by both her own participation, sharing strategies she'd used to cope, and the contributions of other group members, who helped her look at new approaches for caring for her husband while maintaining her own autonomy and sense of well-being.

During the first weekly meeting, Sophia introduced herself to the other group members and was given an overview of what to expect from the HEP. She described the impact that her husband's illness had on her and found it very comforting that other group members were going through similar situations. As a group exercise, the social

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worker presented the group with a list of pressing problems and asked the group members to think about what was most distressing to them about providing care. At the conclusion of the first meeting, Sophia was paired up with Rose, who became her "telephone buddy" for the rest of their time in HEP. Rose, like Sophia, also cared for a husband ill with Alzheimer's, and their pairing up allowed both women the chance to talk on a regular basis by telephone between meetings to someone else about the experiences of providing care to a frail spouse.

At the beginning of Meeting 2, the social worker asked each member to reveal their three most pressing problems. Prior to the group meeting, Sophia had identified three pressing problems that were causing her distress: her lack of help from other family members (primarily, her three children who all lived out of state), her feelings of isolation because of the all-encompassing role of being her husband's caregiver, and the communication problems she encountered with her husband. The social worker leading the group explained that one purpose of the group was to provide everyone with assistance with solving some of their pressing problems and that an eight-step problem-solving model would be used for this purpose. Sophia and the other caregivers then began to identify and label their reactions to caregiving. Frustration, sadness, and feeling alone were the three reactions that Sophia focused on. She also discussed some coping mechanisms that worked for her—for example, cooking as a release when she felt overwhelmed with frustration—and some that didn't work for her, such as yelling at her husband when he couldn't understand her directions. Meeting 2 concluded with a focus on Edward, another caregiver in the group. Edward presented his pressing problem, and the group worked together to provide him with some feedback and suggestions. Sophia suggested that Edward call some of his wife's friends for her to let them know she was having a difficult time. Prior to this suggestion, Edward did not think to include her friends in discussions of how his wife felt. Sophia left the group feeling that she was able to offer some help to someone else, and that feeling of empowerment left her more confident to continue caring for her husband. It had been an extremely long time since anyone had asked Sophia for any sort of advice.

The third weekly meeting focused on the importance of informal supports for caregivers. Members were encouraged to make use of existing family and friendship networks to help them to provide care and to gain support. Sophia brought up the fact that her children lived too far away to assist her. The other group members and the social worker suggested that she ask her church friends for help and that she ask her children for financial support to help hire a cleaning service.

The fourth meeting focused on learning about the formal community resources and services. Members were encouraged to describe their experiences with community services and the help and support these services provided. Sophia had never actually called the Alzheimer's Association and did not know about their respite care, phone support, or ID bracelets for wandering associated with the disease. The other group members were able to share their experiences with this organization, encouraging Sophia to call.

Relaxation techniques such as deep breathing, progressive muscle relaxation, and cognitive imagery were introduced during Meetings 5 and 6. Sophia was given a stress reduction audiotape to use between sessions. The audiotape included progressive muscle relaxation instructions and soothing cognitive imagery. The deep-breathing technique was used at the opening of each subsequent weekly and monthly meeting to practice this technique and to put members in a relaxed mood for the meetings. Sophia found that she enjoyed using the tapes between sessions and that they made it much easier for her to focus some time on her own needs.

During the 1st two weekly meetings, Sophia and the other group members focused on cognitive restructuring strategies, including self-talk, perspective-taking, and cognitive self-instruction strategies. Through her participation in the group, Sophia had learned several things she could do to help herself. She learned that by helping others in a similar situation, she was able to envision the other caregivers receiving help; these sessions helped her apply this same logic to her own situation. For example, instead of saying to herself, "I'm all alone," Sophia learned to list the people she could rely on, including her friends and her other HEP group members, especially her telephone buddy, Rose, and some members and staff of the Alzheimer's Association. She also realized that she, too, was a source of support for others, including her fellow HEP group members.

The 10 monthly meetings were divided into two parts: emotion-focused and problem-focused coping skills and health education. During the first half of each monthly meeting, the group leader reinforced the emotion-based and problem-based coping skills that were taught during the weekly sessions. Topics relevant to caretaking were presented by the leader or invited guest speakers during the second half of each monthly meeting.

During the first monthly meeting, Sophia learned about some new strategies for communicating with health care professionals. She learned that she had to be

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proactive in explaining to both her husband's doctors and her own doctors that she was the caregiver for a spouse with Alzheimer's disease. Instead of accepting doctors' advice without question, she learned to ask for clarification when she did not understand something and learned how to better document the progression of her husband's illness between appointments. The health education component of the meeting focused on effective communication with health care providers.

The 2nd monthly meeting taught Sophia some safe and effective techniques to help her husband maintain his independence within their home. She learned safety issues specific to dementia patients, such as locking the outside doors to prohibit wandering, labeling her husband's clothes in case he did wander, and providing simple instructions on electric appliances so that he would be able to use things safely.

During the 3rd monthly meeting, Sophia learned about some of the prescription medicines available for Alzheimer's disease and which of them were appropriate for her husband. She also learned the importance of throwing out unused antibiotics and expired medicines.

Safety in the home was the focus of the fourth meeting. Sophia learned about some new poison control information and learned how to provide a safer environment for her and her husband by taping down scatter rugs and other strategies.

The 5th monthly meeting concentrated on nutrition. Sophia reviewed what types of meals she was cooking, and attention was given to the sugar and carbohydrate contents of foods. She learned what foods produce greater levels of energy and what foods cause stomach distress.

The 6th monthly meeting described the difference between normal and abnormal aging processes. This was particularly important for Sophia, because she had assumed that several of the symptoms of dementia her husband was showing were actually just effects of aging. This helped her to understand her husband better, and it helped to reduce her fears of going through a similar experience.

During Meeting 7, Sophia was encouraged to begin walking daily with her husband, following a simple route so that he did not get too disoriented. She also vowed to take more time to do her morning yoga, which she had neglected throughout the past year.

During Meeting 8, Sophia learned how to communicate with her husband without the level of frustration and anger she sometimes experienced. By speaking in shorter sentences, talking slower, and repeating her words, she found that her husband understood things more clearly. Some other strategies she learned during the session are presented in *Maintaining Communication With Persons With Dementia* (Toseland & McCallion, 1998).

Monthly Meeting 9 was important for Sophia because she received counsel on how much her husband was legally able to speak for himself because of his disease. Luckily, she had already been assigned his health proxy, but this meeting provided Sophia with vital information concerning their financial matters, power of attorney, and whether it was too late in his disease progression for her husband to create a living will.

The final monthly meeting provided Sophia with a chance to discuss what her future possibilities were as her husband's disease progressed. She learned about housing options, such as Continuum of Care Retirement Centers, which she had never known existed. She also learned about what hospice offers and what nursing homes exist in the region. During this final meeting, she let the group know how much she had learned during their time together and how much confidence she had gained in dealing with her husband's illness.

UC Condition

Caregivers not randomly assigned to the intervention condition were provided the UC they received from the HMO. Caregivers in both conditions were free to seek any additional community or HMO supports that they needed, including medical, social, or psychological support services.

Group Leaders

Three group leaders were hired to conduct HEP. Each leader conducted three groups. All group leaders held an M.S.W. degree and had previous experience with group social work interventions. The principle investigator trained the leaders prior to their leading any group. A 70-page leader's manual has been developed and was used for training. In addition, the group sessions were audiotaped to provide quality assurance. The principle investigator listened to each tape after the session and provided consultation and supervision to the group leaders throughout the study.

Measurement

The HMO costs were adjusted to fit the 1998 Medicare Fee Schedule. Approved billing was used for any claims not covered though Medicare, such as ancillary charges. Costs were coded into categories using the billing and

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site-of-care classifications. Health cost categories included outpatient costs, inpatient costs, emergency room costs, drug costs, and total costs. The data were then aggregated into semiannual (6-month) costs.

Outpatient costs included any charges that did not include an emergency room visit or an overnight stay in a hospital. These costs included medical procedures, outpatient surgery, diagnostic procedures, and ancillary care. Inpatient costs included any cost incurred during an overnight stay in a hospital, including medical procedures, surgery, diagnostic procedures, and ancillary care. Because nursing home care was only paid for by the HMO if the care was rehabilitative and required skilled nursing care, these charges were captured within inpatient costs. Emergency room costs included only those without a hospital admission. If the patient was admitted from the emergency room to the hospital, the HMO coded the entire incident as an inpatient episode. Drug costs covered by the HMO were included in the analysis, but these data had some limitations. Only costs associated with prescriptions filled at the HMO's pharmacy were included in the HMO cost database. Prescriptions filled at neighborhood pharmacies, by mail, and the like were not included. Also, some patients had a limit on the amount of prescription drugs allowed in a time period. Total costs included all inpatient, outpatient, emergency room, and drug costs for each patient.

There were other limitations of the cost data that we were able to collect. Dental costs were not considered for this analysis because few patients had dental care that was covered through the HMO. We attempted to collect health care costs not covered by the HMO. Each participant received monthly forms designed to record any non-HMO health care usage, but these forms were sporadically filled out, even with repeated reminders. Therefore, we do not have a measure of non-HMO costs for caregivers or care recipients.

Data Analyses

Baseline demographic variables for the HEP and UC groups were compared using Student's t and χ^2 tests. Cost data were transformed using square-root and log transformations. The effects of the intervention on health costs were analyzed using random effects regression models (RERMs) to test for the effects of condition, time, and Condition × Time interaction effects. There were two levels of intervention (HEP and UC). The time effect had two levels of measurement (prebaseline and postbaseline). RERMs offer several advantages over more traditional repeated-measures designs or nonparametric tests (Gibbons, Hedeker, & Elkin, 1993; Hedeker, 1995). Our RERMs included adjustments for the first-order autoregressive error terms that account for the higher correlations in data points that are contiguous. RERMs enable all participants to be included in the analyses, including those participants with partial cost data. Subject-to-subject differences were controlled for in the RERMs by using random subject effects.

Missing data were accounted for by either a missing data point or a zero fixed value. Because of the intention-to-treat design, a person was assigned a missing data point only for time points after the person was deceased or time points after the person officially dropped out of the HMO. All other missing data were given a zero fixed value.

Differential attrition from the groups for any reason, including ending coverage with the HMO, death, all-inclusive custodial nursing home care, or hospice, was measured through a time-to-event analysis using a Cox proportional hazards model. A survival analysis to determine whether there was a significant differential death rate between the HEP and UC was also performed using a Cox proportional hazards model.

As in previous studies (Engelhardt et al., 1996; Toseland et al., 1996), we found during data analysis that despite randomization, there were baseline differences in the health care costs of caregivers in the HEP versus those receiving UC. Therefore, all analyses that are reported in the Results section control for these baseline cost differences.

RESULTS

Table 5 indicates that there were significant interaction effects for total costs and outpatient costs for caregivers. The means in Table 5 show that total costs for caregivers receiving HEP steadily declined during the course of the study, whereas costs for the UC caregivers decreased initially and then increased.

Total cost differences can be attributed to significant differences in the outpatient care, rather than to significant differences in inpatient or emergency room care. Table 5 shows that although outpatient costs for the HEP group declined over time, outpatient costs for caregivers receiving UC dropped initially but then rose over time.

A significant time effect was seen for drug costs. Both groups had initial increases in drug costs followed by declines over time. No significant differences were found for inpatient or emergency room costs for the caregivers enrolled in the study.

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TABLE 5: ***Caregiver Health Costs***

	Pre-Intervention		Baseline–6 Months		6-12 Months		12-18 Months		18-24 Months		F		
	M	SD	M	SD	M	SD	M	SD	M	SD	Condition	Time	Interaction
Total costs											0.99	30.19	15.14***
HEP	2131.65	2037.99	944.78	771.48	988.72	794.71	869.12	744.66	769.94	1052.26			
Control	2620.64	3002.10	1743.28	2223.25	1444.68	1510.36	2189.42	2970.92	1467.24	1625.78			
Inpatient costs											1.44	1.24	3.51
HEP	309.52	698.04	143.58	511.73	70.42	283.63	113.12	352.72	292.26	981.88			
Control	788.50	2184.30	667.62	2066.25	332.66	1184.16	1138.90	2631.07	495.80	1223.86			
Outpatient costs											0.5	19.03	24.80***
HEP	1688.50	1912.75	561.20	458.58	669.12	654.18	609.56	549.23	509.86	370.76			
Control	1495.76	1487.59	699.08	448.53	694.36	521.30	859.40	757.84	1180.42	837.23			
Emergency room costs											1.65	1.85	1.19
HEP	59.30	217.77	14.22	41.14	5.52	12.70	9.30	14.44	12.38	22.20			
Control	29.58	84.31	28.16	78.51	16.68	33.43	34.34	124.65	10.04	24.06			
Drug costs											1.17	18.42***	0.21
HEP	283.48	175.05	320.94	202.37	321.24	173.14	360.86	229.36	374.94	271.10			
Control	485.62	283.69	468.78	279.25	501.42	269.98	631.92	458.89	451.66	296.04			

NOTE: HEP = health education program. ***$p < .001$.

TABLE 6: ***Care Recipient Health Costs***

	Pre-Intervention		Baseline–6 Months		6-12 Months		12-18 Months		18-24 Months		F		
	M	SD	M	SD	M	SD	M	SD	M	SD	Condition	Time	Interaction
Total costs											3.53	8.16	6.50**
HEP	3176.44	2976.06	4323.12	4867.74	3145.48	3324.38	3372.80	3532.73	2694.40	4636.31			
Control	1999.06	1519.64	3029.32	3069.16	4840.72	11075.71	3460.40	4521.21	1954.32	2510.83			
Inpatient costs											0.29	9.21**	0.03
HEP	1145.70	2386.44	1638.10	3947.36	1359.76	2954.81	1868.24	2982.92	1529.00	4864.44			
Control	223.46	490.43	1110.54	2131.94	3792.22	12430.09	2484.62	4628.14	529.08	1395.33			
Outpatient costs											4.13	1.5	12.76**
HEP	1616.80	1243.56	2317.80	1702.43	1498.32	985.14	1497.00	1046.40	1284.38	914.17			
Control	1686.32	1396.15	1962.88	1639.01	1805.62	2129.01	1793.28	1101.66	1942.60	2078.03			
Emergency room costs											0.43	0.12	0.06
HEP	21.82	46.76	19.26	47.30	26.10	50.04	18.02	32.30	16.44	59.19			
Control	35.26	53.24	8.66	20.83	125.52	510.97	27.16	41.93	37.02	84.95			
Drug costs											1.32	0	0.05
HEP	856.08	424.82	1057.28	694.28	1175.06	605.50	1039.56	742.59	1162.76	933.96			
Control	660.80	342.79	851.26	409.85	825.94	385.47	970.86	546.60	844.90	658.62			

NOTE: HEP = health education program. **$p < .01$. ***$p < .001$.

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Table 6 reveals that there were also significant interaction effects for total costs and outpatient costs for care recipients in the study. Total costs increased during the second time period after baseline for care recipients whose spouses were in HEP, but then they declined over time. In contrast, the total health care costs for care recipients with spouses receiving UC rose during both the second and the three time periods and did not decrease at the same rate as the health care costs care recipients whose spouses were in HEP during the remaining time periods.

Significant reductions in the total cost of health care for care recipients can be attributed to significant reductions in outpatient costs. As can be seen in Table 6, care recipients whose spouses were enrolled in HEP had significantly lower outpatient costs over time. In contrast, care recipients whose spouses were in the UC arm of the study saw a slight increase over time in their outpatient costs. There was a significant time effect for inpatient costs for care recipients enrolled in the study. Costs steadily rose over time for both groups. There were no significant effects for emergency room costs or drug costs.

Controlling for baseline cost differences, cost calculations indicate that caregivers in HEP had a total cost savings of $255,696.00, whereas total cost savings for caregivers in UC were $141,888.00. Therefore, participation in HEP saved the HMO $113,808.00 in caregiver costs. The HMO spent $1,529.89 less per person on caregivers in the HEP condition than on caregivers in UC during 2 years.

Controlling for baseline cost differences, cost calculations revealed that care recipients whose spouses were in HEP had cost increases of $80,830.06, whereas care recipients whose spouses were in UC cost the HMO $276,483.20. Therefore, participation in HEP saved the HMO $195,653.14. Care recipients whose spouses were in HEP cost the HMO an average of $1,418.07 per person, whereas care recipients whose spouses were in UC cost the HMO an average of $5,760.00 per person. Overall, by participating in HEP, caregivers and care recipients saved the HMO $309,461.14.

The Cox proportional hazards model revealed no significant differential attrition between the two groups of caregivers and care recipients. Also, no survival differences were found among caregivers or care recipients assigned to HEP or UC. Overall, HEP and UC caregivers had similar rates of attrition and very few deaths. The care recipients followed a similar pattern, with no significant differences between UC and HEP care recipients.

DISCUSSION AND APPLICATIONS TO PRACTICE

The HEP had a significant impact on total costs for both caregivers and care recipients. The data indicate that the significant impact on total costs was driven by significant reductions in outpatient costs for both caregivers and care recipients. Over time, participation in HEP by caregivers and care recipients saved the HMO $309,461.14. Group leaders were paid $150 to conduct each session. There were a total of 20 sessions for each of the nine groups that were conducted. Therefore, HEP cost the HMO $27,000 in leader costs. Even considering recruitment and overhead costs, these findings suggest that HEP was cost-effective for the HMO.

The findings for caregivers exceeded the hypotheses presented earlier in this article. We had hypothesized that caregivers in HEP would experience significant reductions in outpatient costs. Data from the study support this hypothesis. We did not expect, however, that this difference in outpatient cost would be so great that there would also be significant total cost savings.

The pattern over time of total costs for caregivers suggests that HEP had an immediate effect on health care costs. Table 5 shows that health care costs fell from $2,131.68 preintervention to $944.78 during the first period when HEP was implemented. Then, total health care costs dropped only slightly during the remaining time periods. This suggests that the 8 weekly sessions had an immediate impact on the health care costs incurred by caregivers. One can speculate that the emotion-focused and problem-focused coping strategies taught during weekly group meetings reduced caregivers' needs to make outpatient visits to the HMO. The emphasis on taking better care of oneself, taking time off from caregiving, and using the emotion- and problem-focused coping strategies to reduce stress, tension, and anger associated with caregiving appears to have reduced the need to seek outpatient services. HEP may have also reduced psychosomatic symptoms that lead to unnecessary outpatient visits. However, this study did not include a measure of psychosomatic symptoms. Future research may want to include measures of somatic complaints or other variables to help explain why outpatient visits would decline for caregivers. In any case, the findings of a significant reduction in outpatient costs for caregivers has important policy and program planning implications because it implies that a relatively low-cost program such as HEP can save health insurers money in a relatively short time period.

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Data about care recipients' health care costs did not support all of our hypotheses. We had expected significant interaction effects not only in total costs and outpatient costs but also with inpatient costs and drug costs. However, there was no significant interaction effect for inpatient costs or drug costs.

In contrast to caregivers, care recipients did not respond immediately to the HEP intervention. Total costs rose for HEP care recipients after baseline and then declined during the 6- to 12-month and 18- to 24-month time periods. One explanation for this finding is that HEP caregivers were made aware of medical conditions of the care recipient that required the attention of providers by participation in the group. At the same time, higher rates of health care utilization for these health conditions initially may have prevented health care use later in the study period. Another possible explanation is that changes in caregivers' well-being (less stress, taking better care of self, etc.) may have had a gradual salubrious effect on care recipients' well-being (better relationship with spouse, less stress in interactions with spouse, etc.), and this, in turn, may have led to less need for outpatient services over the long term.

There are a number of limitations to this study that should be considered when evaluating the results that were obtained. The HMO claims database did not include institutional costs, day care costs, respite care costs, or dental costs. Drug costs for study participants were only captured if purchased in the HMO pharmacy. Any prescriptions filled at neighborhood pharmacies or by mail were not included in this analysis. Drug costs were based on the actual rates paid by the HMO without any Medicare fee schedule adjustment. For all other procedures, the Medicare DME (durable medical equipment) schedule was used, except when no price was assigned from the Medicare DME schedule. No prices were assigned in certain cases because Medicare did not cover the fees. In these cases, we used the amount paid by the HMO for the claim. There were relatively few claims with no assigned Medicare DME schedule rate. Emergency room costs were lower than anticipated because the HMO coded an emergency room visit as an inpatient episode if the person was admitted to the hospital.

This article is one of the first to examine health costs for caregivers and care recipients participating in a caregiver support program. Most previous studies have been limited to examining costs associated with time to institutionalization. Only one study by Brodaty and Peters (1991) included total health care costs, and that study focused on costs for care recipients in Australia. Additional studies examining comprehensive costs for both caregivers and care recipients are needed. This article focused on a chronically ill older population with mixed diagnoses. Additional studies should be designed to examine health care costs among care recipients with specific diseases and care recipients with a high risk of being hospitalized or institutionalized.

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[Additional submissions for the record by Ms. Shea-Porter follow:]

CLINICAL SOCIAL WORK ASSOCIATION,
Seattle, WA, July 28, 2008.

Hon. CAROLYN MCCARTHY, *Chairwoman,*
Subcommittee on Healthy Families and Communities, U.S. House of Representatives, Washington, DC.

DEAR CHAIRWOMAN MCCARTHY: Thank you so much for the opportunity to provide information to the Subcommittee on Healthy Families and Communities on the current state of social work in America. The Clinical Social Work Association is pleased to offer the clinical social work perspective on this important topic. Clinical social work, an important subspecialty of social work, is one of the major providers of mental health treatment for families, especially in assisting families with the care of children and the elderly. Licensed clinical social workers (LCSWs), called licensed

independent clinical social workers (LICSWs) in some states, are the largest group of mental health professionals, providing services for mental health and chemical dependency disorders to all strata of society.

There are approximately 175,000-200,000 licensed clinical social workers across the country (ASWB, 2007), by far the single largest group of mental health clinicians (SAMHSA, 2001). Licensed clinical social workers have at least a Master's degree plus 2-3 years of supervised post-graduate training or roughly the same clinical training and experience as psychologists. The concept of biopsychosocial assessment, so crucial to understanding and treating mental health and chemical dependency disorders, was also an outgrowth of basic clinical social work concepts (Simpson, G., Segall, A., and Williams, J., "Social Work Education and Clinical Learning," Clinical Social Work Journal, March, 2007.) The clinical social worker's scope of practice includes diagnosis of mental health and chemical dependency disorders and provision of clinical treatment for these disorders, popularly known as "psychotherapy", "talk therapy", or "counseling". In addition, clinical social workers assist with problems in social functioning within a "person in environment". (Karls, J. and Wandrei, K.,1994, Person-in-Environment System: The PIE Classification System for Social Functioning Problems, NASW Publishing.)

According to a Consumer Reports survey of over 3000 participants who received help with emotional and chemical dependency disorders, "Talk therapy rivaled drug therapy in effectiveness. Respondents who said their therapy was 'mostly talk' and lasted at least 13 sessions had better outcomes than those whose therapy was 'mostly medication.' Therapy delivered by psychologists and clinical social workers was perceived as effective as that given by psychiatrists." (Consumer Reports, "Drugs vs. Talk Therapy," October, 2004.)

The CSWA membership can attest that LCSWs are providing talk therapy that works in a variety of modalities, i.e., to individuals, couples, families, in several different settings, i.e., offices, schools, hospitals, and skilled nursing facilities, among others. The capability and skills of clinical social workers to provide a wide array of services in a variety of settings is partly due to the training that all social workers receive in understanding internal and external systems. In rural areas, clinical social workers are often the only mental health providers available. Fortunately, most insurers, including Medicare and TriCare, accept LCSWs as reimbursable providers for mental health treatment.

The most difficult areas of social work practice are those where abuse is reported, which often include the vulnerable populations of children, the elderly, and/or the disabled. Domestic violence and addictions also generally contain multi-faceted difficulties. These situations, which include harm to self or others, are the most complex and most challenging to resolve, both in terms of impaired social functioning and mental health disorders. Licensed clinical social workers could be a valuable resource in the biopsychosocial assessment and treatment of these situations, but often this work is being conducted by caseworkers who have little or no social work education and experience, even though they are frequently called social workers.

Cases where abuse may be present should receive services from the most experienced well-trained licensed clinical social workers, in manageable caseloads, with a funding that is commensurate with the difficulty of this work, in the opinion of CSWA. Improving the standards of education and supervision for those who work with the abused and their families in public and private agencies, and specifically including clinical social workers in these jobs, would save lives, reduce harm, and cut down on anti-social behavior which can cause people to spiral into the corrections system.

In addition to cases which include abuse, there are three areas of practice which require more biopsychosocial assessment and psychotherapy. These areas are working with the elderly, children, and active military personnel/veterans. The services clinical social workers can provide in these areas are as follows:

- Working with the elderly involves understanding family dynamics and the impact of the aging process on individuals, their families, and their communities. Clinical social workers are trained to intervene effectively these areas.
- CSWA has a strong concern about the kinds of services being offered to children and adolescents with emotional disturbance. There is an increasing emphasis on medication alone, not talk therapy, to control behavioral problems in children. Children and adolescents who learn to identify their feelings and put them into words, as well as to engage others to help them function more effectively, are more likely to become adults who are able to avoid behavior that is hurtful or harmful to themselves or others. LCSWs are the trained professionals who, in many cases, help children who have not been able to manage their feelings find better ways to manage them.

• The problems faced by veterans themselves, including traumatic brain injuries, are the tip of the iceberg when it comes to addressing the myriad problems caused by the impact of deployment on the spouses, children, and other family members of those who have served their country in the military. The levels of domestic violence, emotional disturbance, and addiction disorders involving spouses, children and extended family of current or discharged members of the military are far above the national average (Center for the Study of Traumatic Stress, Overview for Practitioners, 2008, *http://www.centerforthestudyoftraumaticstress.org/downloads/CSTS%20Helping%20Service%20Members%20for%20Providers.pdf*). Licensed clinical social workers are qualified to provide the crucial services to treat these serious problems. As H.R. 5447 states, the need for clinical social workers to provide services in these critical areas is increasing, and there is an anticipated shortage of clinical social workers to serve these populations.

In addition to these crucial areas, there hundreds of thousands of clinical social workers providing effective psychotherapy and improved social functioning to our citizens at all economic levels and in a variety of settings, a major part of our mental health and social service delivery system.

CSWA is proud to help clarify the role of clinical social workers as the mental health professionals who treat problems in emotional and social functioning. We appreciate the efforts of the Subcommittee to understand the many ways that social workers contribute to our country's well-being and CSWA would be happy to assist your sub-committee further.

Sincerely,

KEVIN HOST, *President,*
Clinical Social Work Association.

The NASW Code of Ethics and State Licensing Laws

By SHERRI MORGAN, JD, MSW, NASW (c) June 2007

Development of the NASW Code of Ethics and Legal Regulations

The first formal code of ethics adopted by social workers was published in 1947 by the American Association of Social Workers (Reamer, 2006). Almost fifteen years later, in 1960, the National Association of Social Workers published its first Code of Ethics. It has evolved and been revised several times since then, in 1979, 1996 and 1999.

During the 1960s only seven states had passed some form of credentialing statutes for social workers (Biggerstaff, 1995). This number doubled in the 1970s, increased in the 1980s, and by the early 1990s some form of licensing, registration or certification for social workers was required in all states and the District of Columbia (Biggerstaff, 1995).

As the profession of social work evolved and gained statutory recognition among the states, the NASW Code of Ethics was used as a primary source for national ethics standards. In states where there was no regulation, the NASW Code of Ethics set the standard for ethical social work practice. Thus, until the last decade of the 20th century, state licensing did not cover all of the states, and the NASW Code of Ethics filled a critical role, unmet by other forms of professional governance.

As states developed rules of conduct for the discipline of social work licensees, they often relied on the standards of the NASW Code of Ethics as a guideline for acceptable professional behavior. NASW also promoted the creation of state social work licensing and regulation, publishing a model licensing law in 1970 (Models for licensing, registration, 1970). The relationship between professional association standards and the development of state-by-state regulation has necessarily been, and continues to be, an interactive one.

As the federal government has increasingly played a role in standardizing the privacy and security of client treatment records, the Department of Health and Human Services (HHS) has acknowledged the unique role of professional ethics standards. In its preamble to the Health Insurance Portability and Accountability Act (HIPAA) privacy standards, HHS stated, "We expect and encourage covered entities to exercise their judgment and professional ethics in using and disclosing health information, and to continue any current practices that provide privacy protections greater than those mandated in this regulation." (Standards for Privacy of Individually Identifiable Health Information, 2000). Although the current HIPAA privacy standards defer to more stringent state laws regarding disclosure of confidential client information, the need for uniform national standards is emerging as a critical and controversial issue in the development of electronic medical information systems. Traditional standards for the protection of client information that are common to

both the NASW Code of Ethics and social work licensing boards' codes of misconduct may be vulnerable to erosion from new data transfer standards.

Rationale for Incorporating the NASW Code of Ethics into State Law

Current legal research indicates that almost half the states are relying on the NASW Code of Ethics for some portion of the state's regulation of the social work profession. The use of the NASW Code in state social work licensing laws or regulations serves a number of purposes. Reference to a national standard for professional conduct in state law or regulation provides a touchstone to enhance local and regional recognition of social work as a profession. Since social workers in a particular state may come from many locations and out-of-state schools, incorporation of the NASW Code serves to reinforce the common underpinnings of professional social work values, education, and training, regardless of social workers' geographic backgrounds.

The NASW Code of Ethics is the longest-standing and most consistently developed set of standards that have been part of the social work professional culture for longer than any state law. Inclusion of the NASW Code of Ethics creates a uniform standard for all social workers subject to the state standard. Thus, NASW members and social worker non-members are all on notice that they need to understand and comply with national standards and to consider how to integrate the high standards of the NASW Code with other state and workplace requirements.

The NASW Code was developed by social workers for the social work profession with the interests of the public in mind. For states with composite or "multi-disciplinary" licensing boards, inclusion of the NASW Code of Ethics assists licensing board members to clarify the unique standards applied to social work licensees. Inclusion of the NASW Code in specific practice areas also assists in the recognition of social workers' unique role among other professionals, such as in the school setting, hospice or specialty clinics.

Social Work Licensing Boards' Treatment of the NASW Code of Ethics

Twenty-two states explicitly incorporate the NASW Code of Ethics into some portion of state law. In most of these states the NASW Code is referenced, incorporated or adopted as part of the state social work disciplinary standards. However, there are other applications as well. Interestingly, South Dakota makes the greatest number of multiple uses of the NASW Code of Ethics among all the states. South Dakota includes the NASW Code in both statute and regulation and relies on two separate versions of the Code, uses it in the definition of practice, as a rule of conduct, and requires a statement of adherence to the Code's principles for licensees and supervisors.

The NASW Code of Ethics in state social work law is used in several ways, including:

- As part of the definition of social work practice
- As a rule of conduct
- As a curriculum requirement for social work students
- As part of the continuing education requirement.

Clinical Social Work Definition

Rhode Island includes adherence to "the principles and values contained in the NASW Code of Ethics," as part of its definition of clinical social work practice, rather than as an explicit standard of misconduct. Thus, in that state only ethical practice falls within the scope of practice. Code R.I. R. § 15 050 001. South Dakota has a similar provision, S.D. Codified Laws Ann. § 36-26-45; however, it also includes the NASW Code of Ethics as a standard for evaluating misconduct, § 36-26-32. Minnesota includes the NASW Code of Ethics standards in its definition of "professional social work knowledge, skills, and values." Minn.Stat.Ann. § 148D.010.

School Social Work Only

California and Washington limit their application of the NASW Code of Ethics to school social workers. In California, the knowledge requirements for the specialization in School Social Work, include knowledge of the NASW Code of Ethics, and of the NASW Standards for Social Work Practice in the schools, and the joint policy statement of NASW and the National Education Association. It also includes the skill of applying the NASW Code of Ethics to school-site situations. Cal. Admin. Code tit. 5 § 80632.3.

The state of Washington requires school social work candidates to complete courses and/or receive experience where they will gain knowledge in relevant field of study including the NASW Code of Ethics and school social work guidelines for practice. Thus, the NASW Code of Ethics is used as a curriculum requirement, rather than as a standard for determining misconduct. Wash. Admin. Code 180-78A-270.

Hospital and Hospice Social Work Only

The Connecticut Public Health Code, applicable to hospitals and hospice, requires a written social work service plan with policies that incorporate "the current standards, guidelines, and code of ethics determined by the National Association of Social Workers." This provision helps to protect hospital and hospice social workers from ethical conflicts, as it provides leverage for social workers in those settings to advocate for ethical practice as a legal requirement. Public Health Code 2000, 19-13-D4b.

Composite Licensing Boards

The Wyoming board includes several mental health professions and adopted by reference the ethics and professional standards of several different professional organizations. For three levels of social work licensees the NASW Code of Ethics is incorporated into the rules as an appendix as "additional guidelines to ethical standards." Mental Health Profession Board, Rules, Ch. 11 (Professional Responsibility).

Mississippi has incorporated the standards of both the NASW Code of Ethics and the American Association for Marriage and Family Therapy, and does not distinguish between the professions as to whether to adhere to both sets of standards and only the one applicable to the specific profession. C. Miss. R. § 50 032 001.

The New Hampshire board licenses five mental health professions and requires licensees to adhere only to that set of ethical principles adopted by their professional association. The specific associations are listed. N.H. Code Admin. R. Psy. 501.02 (1993).

Ohio subscribes to both the code of ethics promulgated by NASW as well as the American Counseling Association, and does not distinguish that these shall apply to the professions separately, although a common sense interpretation would suggest that they should. Ohio Rev. Code § 4757-5-01 (1997).

Separate Code of Conduct Established and Inclusion of the NASW Code

Tennessee requires licensed social workers to conform to "professional standards promulgated by the board under its current statutes and rules and regulations," and adopts in its entirety the NASW Code of Ethics as well. Tenn. Comp. R. & Regs. 365-1-.13 (Unethical Conduct). Ohio and Oklahoma are similar. Ohio specifies that if there is a conflict between the board's rules and that of the professional association, the board's rules shall prevail.

Judicial Application of the NASW Code of Ethics

At least 30 reported cases in state and federal courts across the country refer to the NASW Code of Ethics. Some of these represent groundbreaking precedents, such as the creation of a federal psychotherapist-patient privilege by the U.S. Supreme Court in Jaffee v. Redmond, while others illustrate the common usage of the NASW Code in a variety of matters. These tend to fall within four broad categories:

- appeals of social work board licensure or disciplinary decisions,
- malpractice or personal injury complaints filed by former clients against the social worker, supervisor, or agency,
- employment cases involving social workers, and
- cases involving social work clients where the social worker is called as a witness or records custodian.

Practicing social workers and social work educators should be aware of how the NASW Code has been interpreted and applied by the courts in the state where they are practicing. The summary of cases provided as an Appendix provides a resource for social workers seeking such information.

Conclusions and Implications for the Future

The NASW Code of Ethics relies on principles and values as a basis for relationships between social workers and their clients and other professionals. It is broader, more universally accepted, and more well understood that the various social worker conduct codes among the fifty states. Almost half the states have relied on its provisions in some form for regulating social worker conduct. These uses of the NASW Code include definitions of social work practice, continuing education requirements, curriculum requirements, disciplinary standards, and affirmative statements of adherence to the Code as requirements for licensure.

State and federal courts have relied on the standards of the NASW Code of Ethics regardless of whether they are sitting in a jurisdiction that has incorporated the NASW Code into state law. The extent to which courts find the NASW Code of Ethics to be a controlling authority varies. The collected opinions referencing the NASW Code of Ethics indicate that courts are sensitive to the contours of professional social work ethics, and generally display the ability to review the NASW Code of Ethics in an effective manner and apply it to a wide variety of cases.

The incorporation of the NASW Code of Ethics as a disciplinary standard by state licensing boards raises important questions as to how the Code should be interpreted and by whom. The NASW Professional Review Process affords the opportunity for volunteer NASW leaders to interpret and apply the NASW Code of Ethics. As the organization that created the NASW Code, this is most appropriate. When used for Professional Review purposes, the NASW Code functions as a self-policing set of principles and standards for the profession, to avoid harm to the public, and to provide social workers the opportunity to improve their practice and professional relationships.

In states that have adopted the standards of the NASW Code of Ethics into state disciplinary laws, a finding by NASW of a violation of the NASW Code of Ethics, if reported to the state social work board, should trigger a review of the social worker's conduct by the state authority. More information as to the degree of concurrence by state boards with NASW Professional Review findings would be useful for future analysis.

In other situations, state social work boards are in the position of interpreting and applying the NASW Code of Ethics without the benefit of a prior finding by NASW. In some instances, social work boards may have little guidance as to the accepted contours of the NASW Code, especially for non-social worker members of a board. The broad principles stated in the Code may seem too vague for a concise application to the matter at hand or conflicts between provisions of the Code may create a confusing array of alternatives. Some state boards address this by requiring expert social worker testimony as to the ethical standard of care.

As Congress and the Executive agencies continue to carve out health privacy as the province of the federal government, rather than the states, conflicts with the NASW Code of Ethics are likely to increase. State boards can anticipate that state and federal legislatures and agencies will be involved in efforts to streamline the flow of health information and that these efforts may involve changes in traditional arenas of state regulatory power, in areas such as confidentiality and privilege for mental health records.

In many ways, future applications of the NASW Code of Ethics could be guided by forces and authorities external to NASW. It is important to identify ways in which the principles of the NASW Code of Ethics will continue to influence those external processes in order to retain the core values of the profession.

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Appendix: Court Decisions Referencing the NASW Code of Ethics

Readers should note that decisions listed as "Not Reported" do not have precedent-setting value in other cases. They are presented for purposes of illustration only.

Malpractice or Personal Injury Complaints

Carroll v. Casey Family Services, 32 Conn. L. Rptr. 297 (2002) (unpublished opinion) (Connecticut).

Cosgrove v. Lawrence, 214 N.J.Super. 670, 520 A.2d 844 (1986), affirmed, 215 N.J.Super. 561 (1987) (New Jersey).

Doe v. Samaritan Counseling Center, 791 P.2d 344 (1990) (Alaska).

Eckhardt v. Charter Hosp. of Albuquerque, Inc., 124 N.M. 549, 953 P.2d 722 (1997) (New Mexico).

Homer v. Long, 599 A.2d (1992) (Maryland).

Horak v. Biris, 474 N.E.2d 13 (1985) (Illinois).

Kara B. v. Dane County, Mikela R. v. Dane County, 542 N.W.2d 777 (1995) (Wisconsin).

Martino v. Family Service Agency of Adams County, 445 N.E.2d 6 (1983) (Illinois).

Roe v. Catholic Charities of the Diocese of Springfield, Illinois, 588 N.E.2d 354 (1992) (Illinois).

Social Worker as a Witness or Custodian of Records

In re: Grand Jury Subpoena, 748 A.2d 821 (2000) (Rhode Island).
Jaffee v. Redmond, 518 U.S. 1 (1996) (Illinois).
Kinsella v. Kinsella, 150 N.J. 276, 696 A.2d 556 (1997) (New Jersey).
People v. R.R., 12 Misc.3d 161 (2005) (New York).

Social Work Licensure Board Cases

Andrews v. Board of Social Worker Licensure, Not Reported in A.2d, 2005 WL 3338880 (2005) (Maine).
Connolly v. State, Not Reported in A.2d, 2003 WL 21387189 (2003) (Maine).
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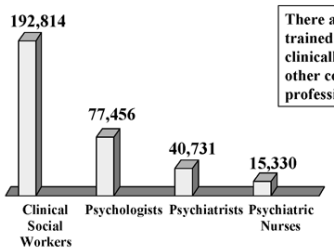
Social Workers are the Largest Group of Clinically Trained Mental Health Providers



There are more clinically trained social workers than clinically trained members of other core mental health professions combined.

Source: *Mental Health, United States 2002*
Published by the U.S. Department of Health and Human Services
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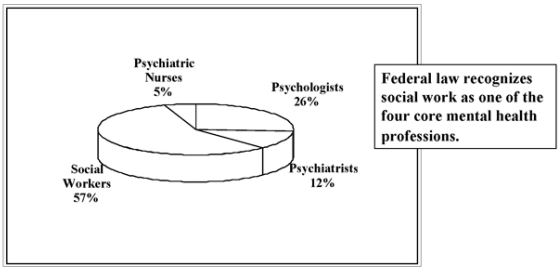

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Chairwoman MCCARTHY. Without objection, this hearing is adjourned.

With that, I would like to say thank you to Mr. Davis for being here with us. We appreciate his inputs. I thank you again, each and every one of you.

We are adjourned.

[Whereupon, at 4:40 p.m., the subcommittee was adjourned.]

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