corporations often place their factories in low-wage nations in the developing world, thereby eliminating jobs in the United States that might have employed some welfare recipients. In addition, corporations have often relocated their plants to suburban sites, making it difficult for inner-city residents to get to them. Corporations stand to benefit, moreover, from welfare reforms that force hundreds of thousands of people into the competition for jobs, allowing them to depress wages even further for relatively unskilled persons.

Analysts who use **medical or disease models** explore the physiological factors associated with specific problems.[19] Considerable numbers of welfare recipients are disabled or must care for children with disabilities. Medical or disease models dominate the medical and, increasingly, mental health fields, where physiological and pharmaceutical causes and solutions dominate.

Persons who emphasize **intrapsychic factors** explore personal and familial causes of social problems. Some researchers contend, for example, that teen pregnancy is often caused by a constellation of personal and familial dynamics, such as abusive parents, truancy, and poor school performance.

In a departure from traditional approaches, some persons adhere to **behavioral frameworks**, contending that certain social problems can be redressed by providing rewards and disincentives that make welfare less attractive than employment. Persons who favor disincentives advocate reducing the levels of welfare grants or requiring teen mothers to live with their parents except when they are abused by them. Persons who favor rewards often favor allowing recipients to retain some assistance from the government even after they leave welfare so that their post-welfare income will exceed their welfare income.

Some people emphasize **deterrent strategies** that penalize persons with social problems. Deterrents might include time limits for welfare or ending welfare altogether for certain groups of persons, such as legal immigrants.

These different approaches often cause vigorous debates among theorists, analysts, and researchers. Persons who implicate economic and environmental factors often contend that counseling is an ineffective strategy. Radicals contend that, without remedying the inequalities in American society and the stress that poverty causes, many social problems cannot be significantly alleviated. Contending groups often selectively cite research evidence to support specific remedies and attack the proposals of persons who use different paradigms.

These various frameworks and causal factors are not mutually exclusive, because various causes interact. Sophisticated policy practitioners and theorists believe that social problems are caused by an array of factors that combine the traditional approaches.[20] The risk of dependency increases when someone has not completed high school, has had no prior work experience, lives in a geographic area with high unemployment, has been subjected to parental abuse, and is sexually victimized by an older male. Theorists such as William Julius Wilson analyze these kinds of intersecting factors that shape complex phenomena such as welfare dependency.[21] Indeed, policy advocates should take leading roles in critiquing social policies that are premised on simplistic analyses of social problems.

Developing Interventions and Programs in Step 1

Having established a typology and analyzed causation, policy advocates devise interventions to solve specific social problems. They develop curative strategies and preventive programs, measure the prevalence of specific problems, and conduct research to locate persons with specific problems.

Some policy initiatives emphasize a deterrent approach, but many policy advocates favor a public health and radical approach. Single women have children for many reasons due to coerced sex, lack of knowledge of contraception, a desire for companionship, or desire to form a family unit. (In many cases, women believe that the father of the children will remain part of the family, only to find that he deserts, divorces, or fails to marry the mother of his children.) Research does not suggest that a diminution of welfare benefits markedly diminishes the number of single-headed families because women do not base childbirth decisions primarily on economic calculations.[22]

Once women do have children and once they are single heads of households, economic realities force them into poverty when they confront low-wage jobs and the sheer cost of day care, transportation, health care, and housing. Many of them realize from personal experience or from discussions with other women who have tried that they cannot support their families with income from low-wage jobs. So, many women stay on the rolls for extended periods or resort to on-and-off patterns as they enter and leave jobs that cannot finance their basic needs. Many women who cannot obtain sufficient money to support their families do not, or cannot, return to welfare because of lifetime limits in the TANF legislation. The decision to seek welfare in these economic circumstances is often a meritorious strategy used by women who care about their children enough to want them to have sufficient food, clothing, medical care, and housing.[23]

What is needed, then, is not deterrence but a constructive approach to make work pay enough to (at least) bring families to a specific standard. Conservatives, liberals, and radicals often differ about the level of this standard, whether at merely a poverty level or by giving people a "guaranteed income" at much higher levels. The specific standard can include not only cash but also in-kind help through free or subsidized day care, health care, and housing subsidies that continues as long as families remain below the poverty level. These in-kind subsidies need to be supplemented by direct income subsidies, such as an expanded earned income tax credit (EITC) that gives families tax rebates as long as they remain below the poverty level.

Programs that help people employed at low wages to upgrade their earning potential are also needed. Persons with minimal skills and limited education must be prepared for jobs that are geared to their abilities and must receive sophisticated job placement services. To the extent that their skills and education can be enhanced to improve their long-term prospects, they should receive extended services, education, and job training. Some recipients need help moving to areas with less unemployment and those with disabilities might need jobs geared to their capabilities.

Even these remedies, however, ignore the reality of growing inequality in the wage structure of the United States. Dramatic increases in the minimum wage, as well as an increase in the power of American trade unions, are needed to raise wage levels for low-wage workers whose economic status has been eclipsed by the dramatic growth of wages for highly skilled and educated workers. Many advocates participate in a movement to require "living wages" in jobs that flow from government contracts.

Another set of interventions must be directed to employers in the private and public sectors. It is tempting to portray private employers as villains, but it is understandable that they would try to fill specific slots with job seekers who already have the requisite skills and job experience, which many welfare recipients do not possess. Without economic incentives for employers to hire them, many welfare recipients will not get jobs except during booming economic periods, and they are likely to be the first persons laid off when the nation enters a recession.[24] Moreover, federal, state, and local governments must create large numbers of public service jobs and retain them as long as the private sector does not absorb welfare recipients. These public service positions are needed particularly by

recipients who are physically or mentally challenged. The government also ought to offer massive tax incentives to corporations that locate in low-wage areas, rather than the minor incentives offered under the current tax code.

Of course, booming economic growth will reduce the welfare rolls in some states even without these ameliorative policies. It will make deterrent strategies appear successful in the short term because employers, facing labor shortages, will hire many welfare recipients into low-wage jobs and will even promote some of them into moderate-paying ones. In the long term, however, the deterrent approach to welfare is not likely to be effective because it does not upgrade the skills and education of recipients; consequently, they will be vulnerable to layoffs when economic growth slows. Services and policies tailored to the needs of specific subgroups are needed rather than a single set of policies (see Policy Advocacy Challenge 7.6).

To protect the rights of single heads of households and safeguard their children, the welfare reforms of 1996 should have included a *bill of rights* for welfare recipients. If they participate in activities that prepare them for work, diligently seek employment, and secure employment, they should not fall beneath poverty standards or the combined AFDC, food stamp, housing, and health benefits that welfare recipients received just before the enactment of welfare reforms. The bill of rights is needed to prevent the victimization of recipients by states that push recipients into poverty by insisting they take low-wage jobs, while cutting off the child care, health, housing, and transportation. The need for this bill of rights was urgent during the Great Recession when many single mothers ended up on the streets with their children, resorted to selling blood to survive, and resumed relationships with men who had abused them.

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Designing Services for Homeless Children in Step 1

Anne Milder, MSW

When I learned, last December, that I, like every other first-year MSW student at the University of Southern California School of Social Work, would be required to advocate for a specific homeless population in Los Angeles or Orange counties, to do real policy analysis and advocacy, I complained and I complained loudly. This was not what I had signed up for when I enrolled in the program; I just wanted to be a practitioner, working with infants and toddlers and their mothers. How could I, a student, know enough to tackle a problem as large and seemingly unsolvable as homelessness? Besides, wasn't it obvious that the homeless just needed homes? I couldn't provide houses.... The task felt not only unrelated to the conceptualization of social work practice I held at the time, but, worse, it seemed like a futile exercise.

Given my ongoing interest in young children, from the prenatal stage through age five, and the crucial brain development that takes place at this juncture (and its interrelationship, at least according to the postulations of affective neurobiology, with attachments to primary caregivers), I chose homeless children under the age of five as my area of focus.

None of my roughly 250 fellow students were looking at the 0–5 age range, and, in my studies, I was surprised to discover the many ways in which the 0–5 age homeless population is commonly overlooked. For instance, at the time I began my analysis, I was told that First 5 LA, a public institution created by funds from Proposition 10 in Los Angeles County by a statewide ballot initiative designed to increase and improve for children 0–5, had not yet designed programs specifically for homeless children. Also, I was told that LAUP, the institution created by First 5 LA to promote universal preschool, was not yet specifically thinking

(Continued)

The Promise of Prevention We should make a distinction at the outset among primary, secondary, and tertiary prevention. We emphasize primary prevention in Figures 7.2 and 7.3 because it prevents persons from experiencing important problems in the first place. Were we to prevent some people from ever getting cancer by cutting use of pesticides, for example, we would achieve **primary prevention**. In **secondary prevention**, persons with a specific problem are given assistance in its early stages, thus averting a full blown or serious problem. When medical and mental health screening problems locate persons with early-stage cancer or early-stage depression, for example, they can avert life-threatening cancer and depression through early interventions, even though they failed to prevent cancer and depression altogether. **Tertiary prevention** aims to arrest a well-developed problem by using interventions that stop it from evolving further into a catastrophic condition. For example, the progression of clinical depression can often be stopped in persons treated with new medications as compared with persons who receive only counseling. (We can now update Figures 7.2 and 7.3 by noting that, although primary prevention occurs in the left-most circle, secondary and tertiary prevention occur in the middle circles of the diagram as persons are engaged with organized services or with community-based empowerment programs.)

Many preventive strategies have been shown to be effective at primary, secondary, and tertiary levels. With respect to primary prevention, for example, we know that lifestyle changes such as exercise, reduction of fat intake, reduction of alcohol consumption beneath certain thresholds, and weight control can markedly change health and mental health outcomes. We know that the requirement that automobile riders use seat belts and that bicycle and motorcycle riders use helmets have saved tens of thousands of lives. We have good evidence that Head Start improves school performance years after children have graduated from it. We know that educational credentials, such as a community college or a college degree, markedly increase earnings (and therefore reduce poverty) in succeeding years. With respect to secondary and tertiary prevention, we have good evidence that early treatment stops the progression of an array of medical, mental health, school, and job performance problems.

All these examples share certain characteristics. Research had established links between specific causal factors and specific problems. Prevention interventions could be targeted to persons with identifiable at-risk factors, such as obesity, sedentary lifestyles, poor diets, and lack of educational credentials, thus allowing society to focus its interventions on persons with these at-risk characteristics. Or, in the case of seat belts, society targeted everyone who rides in cars with clear evidence that the preventive intervention, seat belts, would increase the percentage of persons who survive car accidents. In each case, the cost of prevention was not so prohibitive that opponents could contend that society could not afford it.

Yet the promise of prevention is often unfulfilled. Certain interventions are poorly funded and implemented even when data suggest their effectiveness. Relatively few resources are devoted to helping persons make lifestyle changes, for example, even when sedentary lifestyles and obesity are strongly linked to various diseases and shortened life expectancy. We often invest too little money in programs that might prevent poverty, such as tutoring and preschool programs.

We lack good research on some preventive strategies, such as whether we can prevent many mental health problems from occurring in the first place. We do not yet know whether certain asset-building strategies actually work in the long term, such as helping low-income persons to establish savings accounts or own their own homes, though early results are promising. Therefore, we need to examine an array of factors that impede greater emphasis on prevention.

We can decrease economic dependency as well as poverty by enhancing income through a variety of income-enhancing programs as depicted in Box 7.2. The importance of these safety-net programs was illustrated by the economic hardships endured by tens of millions of Americans during the Great Recession of 2007–2009 and beyond—with the national unemployment rate remaining above 8 percent even at the end of 2012. (Unemployment rates were far high for vulnerable populations, including Latinos, African Americans, and persons with disabilities.) Many single mothers lost their employment or had their wages cut during this recession, forcing some of them on to TANF rolls or to take multiple jobs in a desperate effort to meet their family's survival needs.

Factors That Impede Prevention A series of barriers discourage prevention, including the problem of efficiency, difficulties in marshaling evidence of the effectiveness of preventive programs, the power of special interests, and competition with curative programs.

The Problem of Efficiency To understand the problem of efficiency, let us assume that we know precisely which persons will develop social problems, such as which teenage women will have out-of-wedlock births in high school and enter the welfare rolls. Our knowledge would be based on research about at-risk indicators, such as the various causes of welfare dependency listed in Box 7.1. Assume that this research allows us to predict with complete accuracy *true positives* (women who will join the rolls) and *true negatives* (women who will not join the rolls). Under these circumstances, we will direct our prevention efforts exclusively to the true positives, excluding true negatives from our project because we have accurately predicted that they will not join the welfare rolls. Were policy advocates able to predict accurately which women would become welfare recipients and which would not, they could develop a highly efficient prevention program that targeted its preventive services and resources only to true positives and provided no preventive services to true negatives.

BOX 7.2 An Array of Interventions to Increase the Resources of Low-Wage Earners

1. Direct economic assistance
2. Expanded EITC
3. In-kind economic assistance
4. Child-care, health, transportation, and housing subsidies
5. Food stamps
6. Indirect strategies to elevate wages for low-wage employees
7. Increases in the minimum wage and enactment of a living wage
8. Encouragement of trade unions
9. Job creation
10. Public subsidies of private wages
11. Public service jobs
12. Expanded tax concessions to industries that locate in areas with high unemployment
13. Encouragement of mobility
14. Relocation assistance to promote migration from areas of high unemployment
15. Tailoring of services to the needs of subgroups
16. A bill of rights for welfare recipients

In the real world, however, our ability to predict which people will develop a specific problem is imperfect.[25] Some women have characteristics that are frequently associated with pregnancy in high school, such as low school achievement, abusive parents, and sexual victimization by an older male, but defy the odds and do not become pregnant. These women are *false positives* because they do not become welfare recipients, even though they have at-risk characteristics. Conversely, some women do not have these at-risk characteristics and do become pregnant. These women are *false negatives*. To the extent that a prevention program makes incorrect predictions about who will develop a problem, it wrongly directs some of its resources to false positives and fails to direct its resources to some true positives. As it wastes resources in this manner, the prevention program's efficiency declines. (See Figure 7.4 for examples of a relatively inefficient prevention program, Program B, and a relatively efficient prevention program, Program A.)

Prevention programs further decline in efficiency, moreover, if they cannot help persons actually avert a problem. Assume, for example, that a program asks teenagers in a high school who the school staff believe are at high risk of becoming pregnant to take a pledge to be abstinent. Also assume that the staff later discovers that this intervention is relatively ineffective in averting teen pregnancy. Even if this program had correctly predicted which teens would become pregnant, it would be inefficient because its intervention, getting teens to pledge abstinence, is relatively ineffective in averting teen pregnancy. This situation is not unusual: Prevention programs must both direct resources to true positives *and* develop effective interventions.

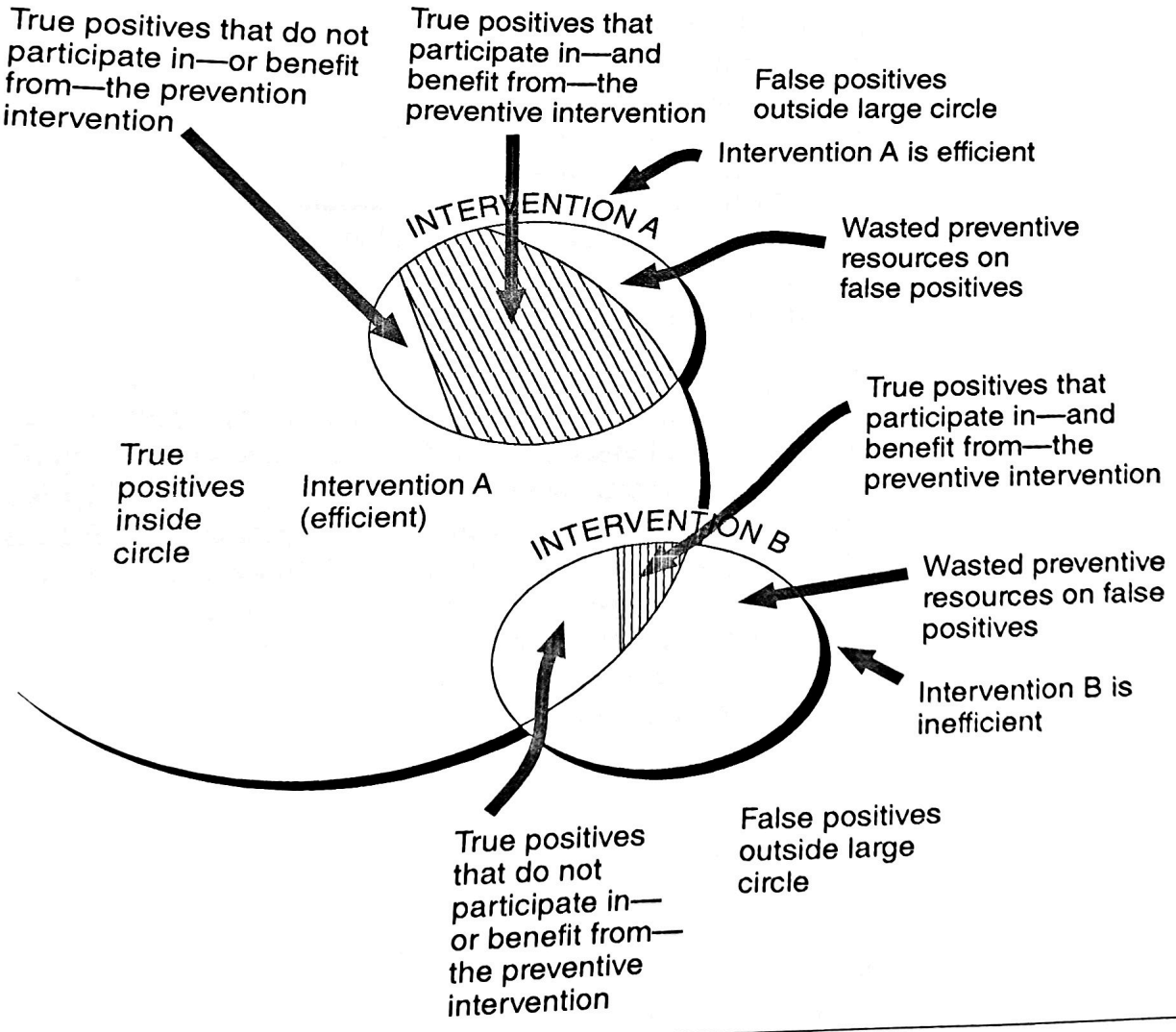

FIGURE 7.4 An Efficient and Inefficient Preventive Intervention

The Power of Special Interests Special interests often oppose meritorious prevention projects. Cigarette companies have successfully thwarted efforts to prevent teenagers from smoking because cigarette manufacturers consider teenagers a lucrative and growing market. Automobile manufacturers fought the installation of seat belts for years because of the cost. Right-to-life and moral majority groups have prevented many schools from providing effective sex education programs as well as birth control services. Professionals who are socialized to medical models tend to focus on curative rather than preventive remedies.

Yet determined reformers often overcome the power of special interests. Laws requiring the use of helmets by motorcyclists and bicyclists have saved thousands of lives, even though they were strenuously opposed by motorcyclists. Even cigarette companies, despite opposition, have been required to comply with many governmental regulations.

Competition Between Curative and Preventive Programs Preventive programs must compete for funds with programs that help people who already have specific problems. In the case of welfare programs, for example, states and localities must expend vast resources to sustain dependent families, by providing them with welfare benefits, helping them get jobs, subsidizing child care, or providing health care. Advocates who want significant resources to prevent teenage girls from joining the rolls have to convince legislators to divert scarce resources from curative to preventive programs.

We should not be deterred from developing preventive programs just because they are often inefficient, difficult to evaluate, or opposed by special interests or they compete with curative programs. To the extent that we can prevent problems, we not only forestall human suffering but also avoid future costs (see Policy Advocacy Challenge 7.7).

Developing a Prevention Program and Convincing Decision Makers to Adopt It

Bruce Jansson, Ph.D.

Try to develop an intervention program for an inner-city school that seeks to diminish teen pregnancy. As you plan the program, discuss whether it should do the following:

- Try to increase teenagers' self-esteem.
- Emphasize career and employment planning in hopes that teenagers who believe they have an economic future will be less likely to have children.
- Seek to change behaviors of teenagers or attempt to change behaviors of males, to the extent that teenagers become pregnant because they are raped or pressured to have sex by older men.
- Include the parents of teenagers in their project in hopes that improvements in family functioning will avert pregnancies.
- Provide birth control information and devices.

Assuming that you lack resources to provide your intervention to all teenagers in the school, what at-risk factors might you use to decide whom you would try to reach?

Once you have developed a tentative strategy, discuss what strategies you might use to persuade teenagers to participate in your intervention.

Discuss some problems you might face in trying to convince the local school board to adopt your intervention for the entire school district. Discuss the problem of efficiency in this context.

Measuring the Magnitude of Problems in Step 1

To measure the magnitude of welfare dependency among single women with children is relatively simple because public authorities issue data about the number of persons who receive welfare checks. Other problems, such as homelessness and substance abuse, are more difficult to measure because people who have these problems often do not seek public services. Policy advocates often have to demonstrate that specific problems are sufficiently important to merit the attention of agency staff, funders, government officials, and legislators.

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Legislators, funders, and agency executives are likely to invest scarce resources in programs that they believe address widespread problems. Rates, prevalence, and incidence are commonly used to measure the relative magnitude of social problems.[28] **Rates** (expressed as percentages), for example, measure the ratio of a group of persons, such as white males between the ages of 18 and 25 who were arrested for drunk driving in a specific year, to a larger reference group, such as the total number of white males in this age bracket in the population that year. **Incidence** (also expressed as percentages) measures the ratio of new cases, for example, the number of new arrests of white males aged 18–25 in 2001, to a larger reference group, such as the total number of white males in the population that year in that age bracket. **Prevalence** (again, expressed as percentages) measures the ratio of persons who are currently experiencing a social problem to the total population. A policy practitioner might want to compare the number of persons currently being prosecuted for drunk driving to the total number of drivers on a specific day. Each measure provides a somewhat different estimate of the problem's seriousness. These kinds of data are often available from city, county, state, or federal agencies or research literature in the social and health sciences.

Practitioners can use a variety of technical approaches when measuring the magnitude of social problems. When data are not available from government agencies or the research literature, policy practitioners measure social problems in other ways. Jonathan Bradshaw contrasts measures of felt need, expressed need, expert need, and comparative need.[29] **Felt need** measures persons' belief that they have a problem. An agency might interview a sample of working mothers with preschool children, for example, to assess their belief that they cannot afford day care. Of course, persons sometimes exaggerate their actual needs or, in the case of stigmatized conditions such as substance abuse, underreport them.

Expressed need measures persons' actual search for specific services. A policy practitioner might examine the length of the waiting lists at drug treatment centers, for example, or the number of calls that a hotline receives about substance abuse. Although the knowledge of clients' service-related behaviors is useful, these behaviors may not accurately reflect people's actual needs. Some persons do not seek services, for example, because they believe they cannot afford them, do not like social agencies, are unaware of the services, think they will receive ineffective services, fear they will be prosecuted, or fear they will be subjected to punitive services because of their stigmatized condition.

Policy advocates sometimes assess **expert needs** by asking experts, such as social scientists, social work practitioners, local agency executives, or government officials, for their estimates of the severity of specific problems. Experts can draw convincing evidence from current research, such as the extent of alcoholism among women. Of course, experts' biases and values may influence their position and credibility; someone who defines alcoholism as consuming many drinks each day will provide a lower estimate of the problem's seriousness than someone who uses a more stringent standard, such as consuming only a few drinks a day.

A **comparative need** approach measures unmet needs by comparing the services offered in different communities. Assume, for ex

caution, however, because they rely on inference rather than a direct measure of need. For example, a neighborhood with few drug treatment programs will appear to have a shortage of services when compared with those that have too many such programs.

Using several or all of these means of assessing needs helps us gauge the importance of specific social problems. If we were trying to promote drug treatment programs in a specific neighborhood, for example, we might look into the length of the existing programs' waiting lists (expressed need), ask high school students for their perceptions of the seriousness of adolescent substance abuse (felt need), discover whether similar neighborhoods have more programs (comparative need), and get information from selected experts (expert need).

Measurements of social problems become more dramatic when they include trend data suggesting that a specific problem is becoming more serious. Such data may come from felt-, expressed-, comparative-, or expert-need sources or from rising rates, prevalence, or incidence of specific problems. A dramatic increase in a community's substance abuse problems, for example, would be documented by a rising rate of deaths from overdose and longer waiting lists for drug treatment programs (felt need).

Policy decision makers, however, do not spring into action merely because policy advocates present them with data about the prevalence of a problem or the need for specific services. Legislators often ignore overwhelming data about a problem, particularly when they are not subjected to strong pressure by voters and interest groups or when powerful interests oppose ameliorating measures. Despite large numbers of deaths and injuries from guns in inner-city areas, for example, politicians in most jurisdictions have not enacted stringent measures to control guns because of opposition by the National Rifle Association. Politicians sometimes take action not when a problem is becoming more serious, but when the public believes it is becoming more important or when party leaders believe they can improve their political fortunes by taking action. In the case of welfare reform in 1996, for example, the cost of AFDC had risen from $15.5 billion in 1970 to $22.3 billion in 1993, not a marked increase after adjusting for inflation. Yet a welfare crisis was proclaimed, leading Congress and the president to rescind the AFDC program and devolve welfare assistance to the states.[30]

Locating Problems Spatially in Step 1

It does little good to determine that a problem is relatively widespread if we cannot locate and reach its victims or, in the case of preventive programs, its potential victims. Social science tools are one way to locate people with certain problems. The U.S. census, done every 10 years, does not collect data about social problems such as substance abuse and mental illness but instead states demographic, economic, and housing data in aggregate terms for specific geographic regions.[31] Nonetheless its data are important to social workers because social scientists have linked demographic and economic factors with social problems. For example, poor persons are more likely than affluent persons to experience specific medical problems, to be unemployed, to have poor housing, and to be pressured by dealers to use illegal drugs. Members of certain ethnic groups are more likely than others to have some medical conditions, such as sickle cell anemia and Tay-Sachs disease. Using economic, housing, demographic, and ethnic data, policy practitioners can infer high rates of certain social problems in specific geographic areas.