

# Advances in Social Work



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School of Social Work

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*Advances in Social Work* is committed to enhancing the linkage among social work practice, research, and education. Accordingly, the journal addresses current issues, challenges, and responses facing social work practice and education. The journal invites discussion and development of innovations in social work practice and their implications for social work research and education. *Advances in Social Work* seeks to publish empirical, conceptual, and theoretical articles that make substantial contributions to the field in all areas of social work including clinical practice, community organization, social administration, social policy, planning, and program evaluation.

The journal provides a forum for scholarly exchange of research findings and ideas that advance knowledge and inform social work practice. All relevant methods of inquiry are welcome.

*Advances in Social Work* is a peer-reviewed journal that publishes original work. Articles are accepted on the basis of appropriateness, clarity, sound methodology, and utility for social work practice, research, and education. Articles are indexed or abstracted in *Social Work Abstracts* and *Social Service Abstracts*.

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# Advances in Social Work

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## Editorial

Barry R. Cournoyer

**T**he Spring 2002 (Volume 3, Number 1) issue of *Advances in Social Work* marks the beginning of its third year of existence. The Editorial Board and I are extremely pleased with and proud of the journal's growth and development. We feel privileged to be associated with Indiana University School of Social Work and the prestigious cadre of consulting editors that provide such sage advice and consultation.

I personally wish to thank all members of the AISW team who have enabled me to serve as editor during these past two years. I could not possibly have produced these four issues without their hard work and scholarly input. This is my last issue as editor. I have truly enjoyed and valued this experience. I have been energized by my involvement with the many authors who have contributed their written work and have been inspired by the wonderful reviewers who have helped to improve the quality of both accepted manuscripts and those that were returned. I will miss this role but, at this time, I must turn my attention to other projects. However, we have the good fortune to have a new editor who will guide the journal's development toward an even more prominent future.

Dr. James G. Daley is Associate Professor, Indiana University School of Social Work. He is a prolific author, exceptional researcher, and a truly great social worker. Dr. Daley brings a multitude of strengths to the editor position. He has 24 years of clinical experience. He has served as the director of an inpatient alcoholism treatment program, the chief of a mental health clinic, and a policy analyst on mental health and family violence issues. He regularly conducts workshops nationally and internationally. He has published extensively and has served as a reviewer for several prominent journals. His areas of interest include families in crisis, international military social work, and family measurement issues. He is extraordinarily well-suited to shepherd AISW for the foreseeable future.

I feel special delight in introducing the contents of this issue. During the 2001-2002 year, we have celebrated the 90<sup>th</sup> anniversary of social work education at Indiana University. Formed in 1911 as a small department, the School of Social Work has grown into one of the nation's largest and most prestigious institutions. On April 12, 2002, the School sponsored a day-long symposium as part of the anniversary celebration. Several hundred participants joined as social work doctoral students presented research posters, experts led workshops and seminars, and all enjoyed various celebratory activities. The symposium's keynote address was delivered by Mr. Andrew Cuomo, former U.S. Secretary of Housing and Urban Development and current candidate for Governor, New York State. We are especially pleased to introduce this issue with a transcript of his remarks. His speech is funny, poignant, philosophical, spiritual, and, of course, political. He addresses issues dear to the hearts of social workers as he discusses housing and homelessness, social and political philosophy, and the potential impact of the tragic events of September 11, 2001.

Dr. Lisa S. Patchner's article "In the Belly of the Beast: A Case Study of Social Work in a Managed Care Organization" addresses the contemporary employment of social workers within managed care organizations. In particular, Dr. Patchner explores the nature and quality of social workers' service as case managers within a Medicaid



Health Maintenance Organization (HMO). Based upon semi-structured interviews, focus groups, and participant observations, she concludes that case management services were successful in helping HMO Medicaid clients address various bio-psychosocial needs. She also outlines the specialized knowledge and expertise required by social workers who practice within managed care organizations.

In "Evaluating Kinship Care Alternatives: A Comparison of a Private Initiative to Traditional State Services," Rodney Ellis, Gary Ellis, and Rochelle Galey explore the "new-old" practice of kinship care as an alternative to traditional foster care programs and approaches. Most social workers are painfully aware of the challenging state of the child welfare system and the increasing demands for placements for at-risk children. Kinship placements offer numerous advantages over non-familial foster care. This paper represents one of the first attempts to evaluate the effectiveness of kinship care by comparing the stability of placement outcomes obtained by two programs: an innovative, multi-service program operated by a private, not-for-profit organization and a more traditional program sponsored by a public state child welfare agency.

In their article "African Americans and Clinical Trials Research: Recommendations for Client Engagement," Sharon Moore and Wanda Lott Collins discuss the understandable suspicions that many African-Americans hold when invited to contribute as participants in research studies, particularly those involving clinical trials. Drs. Moore and Collins review some of the historical events and associated theories that lead to apprehension, fear, and sometimes rage among African-Americans whose brothers and sisters have been violated in various medical experiments. They identify significant health problems common among African-Americans, outline how and for whom participation in clinical trials might be safe and helpful, and suggest means and processes that researchers might adopt to recruit African-Americans as informed consenting participants in research studies.

Nancy P. Kropf and Mininder Tracey address the subject of service learning, an increasingly popular topic throughout university and professional settings. In "Service Learning as a Transition into Foundation Field," they distinguish the functions of service learning activities from those of professional internships and explore their use as a bridge to traditional field practicum experiences.

In "Student-Identified Strengths and Challenges of Using Blackboard™ for Group Projects in a Social Work Course," Melissa B. Littlefield discusses her study of students' experience in the use of a popular web-based educational tool that facilitates online communication and learning. Blackboard™ enables students and instructors to engage in real-time or asynchronous online discussion, transmit and receive e-mail messages, exchange computer files, and link to Internet resources. Most students reported that Blackboard™ was user-friendly and contributed to the success of their group project. The results suggest that online technology may contribute to group learning activities, increase efficiency, and enhance personal accountability among social work students.

The Editorial Board and I are pleased to present this issue of *Advances in Social Work* to the social work community. In this, my last editorial, I wish to express my gratitude to all members of the AISW team, the Indiana University School of Social Work community, the many authors and reviewers, and especially the social workers who conscientiously continue to read and think and learn from professional journals in order to provide the highest quality of social service to the people we call clients. Thank you for your service to the most vulnerable among us.

**Keynote Speech:  
90<sup>th</sup> Anniversary Symposium  
Indiana University School of Social Work**

**Andrew Cuomo**

**Abstract:** *In celebration of 90 years of social work education at Indiana University, the School of Social Work sponsored an Anniversary Symposium on April 12, 2002.*

*Andrew Cuomo, former U.S. Secretary of Housing and Urban Development and current candidate for New York State Governor, delivered the keynote address. In his address, Mr. Cuomo recognized the history and growth of Indiana University School of Social Work from its origin in 1911 to its current status as a state-wide, multi-campus enterprise. He discussed the formation of Project Help (Housing Enterprise for the Less Privileged) and shared some of his experiences as Secretary of HUD. He also explored several contemporary social, political, and philosophical issues, including the potential long-term effects of the tragic events of September 11, 2001.*

*Introduced by Ms. Jane Schlegel, M.S.W., Chair of the Indiana University School of Social Work Campaign Committee, Mr. Cuomo interspersed his prepared remarks with spontaneous reflections. His comments are presented here in unedited fashion.*

**Keywords:** *Andrew Cuomo, Indiana University School of Social Work, housing, social policy, homelessness*

**J**ane Schlegel: It's now my pleasure to introduce our guest for the day, who didn't even get lunch. He just got here, and it's one of those days when probably everything didn't go according to the plan, but we've all had those. So, we're very sympathetic to that.

I could immediately sense the energy Andrew Cuomo brings to his work, to his campaigning, and I'm sure to his family. I just want to touch on a few things. He has a website, which is <http://andrewcuomo.com>. If you want to read about his work and his campaign for the Governor of New York in more detail, you could go to the website.

In the meantime, I want to mention something that he did that I think as social workers is significant and reflects his energy and creativity. In 1986, as a young

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Indiana University School of Social Work.

attorney, he started a program called HELP. HELP stands for Housing Enterprise for the Less Privileged. This is a provider of transitional housing, and many of the wraparound services that go with helping people who have been homeless move to self-sufficiency. After he started that program, in 1991 he became head of the New York City Commission on the Homeless while continuing to operate HELP. In 1993, he came to Washington, D.C., first as Under Secretary of HUD, and he was determined from what I could tell from reading, to bring to the federal government the lessons he had learned at the city level. He developed a continuum of care strategy to help the homeless become self-supporting at HUD. At HUD he created a consolidated planning process that gave communities and their residents a greater role in determining how HUD money was used. Both his continuum of care project and his consolidated planning process won the Harvard Universities Kennedy School of Government Innovations in America Government Award. I think that's pretty impressive. We're always looking for innovations in government.

I want to quote David Osborne, who wrote a book that was actually the Bible of our former Mayor Steve Goldsmith, and that book is *Reinventing Government*. Some of you may have read it or heard of it. He wrote that Andrew Cuomo's management reform "represents one of the most ambitious, fundamental, and exciting reinvention plans in the recent history of Federal Government."

Andrew Cuomo was born in New York City. He became a lawyer. As you know, we've heard of his father who served as Governor of New York. Andrew Cuomo is now running for Governor of New York, himself. He is married to Kerry Kennedy Cuomo. They have three daughters, and I would predict as those daughters get a little older, he may wish he were back running HUD. It will probably look like a walk in the park.

**Andrew Cuomo:** Thank you very much. I'm going to leave the comment about the three daughters and running HUD alone, because I'm not sure what I could do with that that would work out well. Thank you for the kind introduction.

It's a true pleasure to be here today with all of you. I want to first thank Chancellor Bepko and Dean Patchner for the invitation. It's a pleasure to be with them. It's a pleasure to be back in Indianapolis. I did a lot of work here when I was the HUD Secretary. Mayor Goldsmith was mentioned, and Mayor Hudnut, who was a very creative fellow. We did a lot with Indianapolis, and it's a very beautiful city. One of the good things from my experience in Washington: I was all across the nation in literally every state, and I think Indianapolis really brings the best of all the different urban components together. It has a strong economy. It has an urban life, but it's a very livable city. It's a pleasant city, and it has a great population. So, it's a pleasure to be here.

I did work in Fort Wayne, and I did work in Gary. Whenever you think we're a success, and we've mastered the universe, you can always just take a ride to Gary and look at some of those neighborhoods. Then you know how much more work that we have to do. I've heard the slogan that was used in the other room. I heard it a little differently, though. Maybe it's an East Coast thing. I heard that great cities have great universities, and great universities have great schools of social work, and great schools of social work have great alumni and faculty. That's the way I heard that statement.

Congratulations on 90 years of great work! I believe that the School of Social Work truly does do the Lord's work. I believe it's going to be a growth business, and I'm going to speak to that in a moment. I'm sure we need it more and more than ever before. It is a tough field, but ultimately more rewarding, if not more challenging than dealing with buildings, or dealing with finance, or dealing with marketing. You're dealing with people. That's the beginning, and that is the end.

You heard about my experience at HELP from Jane. HELP was a not-for-profit organization that helped homeless families. Homeless families was a euphemism. Homelessness still is a euphemism. We don't want to admit exactly what it is, so we call it homeless. It sort of immunizes us from the pain of what it actually is.

When I was working with homeless families in New York in the late '80s, the number one cause of homelessness was domestic violence. Number two was substance abuse. Number three was mental health. We called it all homeless. We made it a housing problem, which made it almost simpler to deal with, less painful. If you ever had to admit the problem we have with domestic violence, and admit that we have a problem where men abuse women in our society physically and with frequency, that this is not an issue that is isolated to any economic group, but is pervasive, that would be difficult for us. So, we call it homeless.

I started working with the homeless and formed an organization called HELP. Fifteen years later it's the largest provider for the homeless in the nation. Seventy-five thousand people have gone through it. To this day, I believe it's the greatest thing that I've done with my life thus far. It got difficult, and that's why I say your work is so challenging. Primarily, we were a social service organization that provided housing, but only as a place for the delivery of services. We worked with social workers, who basically ran the operations. We went from two employees to 500 employees over a number of years. I did it for five years, and at the end of five years I couldn't take it anymore. The day-in, the day-out, the human trauma that you deal with. For every one success, you have two stories where you take a step back. Ultimately, I couldn't take it. It was too much of a toll. I fled help for the safety of the bureaucracy. I became a paper pusher in Washington, DC. It was nice. There was no human contact. I dealt with the Congress, and I didn't consider that human contact. I was one of the youngest cabinet secretaries in history as you heard from the Chancellor.

Bobby Kennedy, who would have been my father-in-law, was younger when he was named Attorney General by his brother. That was nepotism, so I don't count that as competition. I was appointed, and I was 39 years old. I was head of HUD. I left four years later, but those were a long four years. Those were the Clinton administration four years. We experienced all sorts of things in those four years. Those were long days, and those were long nights. Four years later I left, and I was 67 years old. That's why I look the way I do. HUD was a difficult post. I got HUD basically because everyone else was too smart to go there. It was the enemy of the Republican Congress. They wanted one thing. They wanted to blow up HUD. That was their main point. They wanted to eliminate it, and God bless them, they were not shy. They told you exactly how they felt.

I remember when I was nominated for HUD. The President can nominate you, but only the Senate can confirm you. These are very different concepts, and the



Senate wants to make sure that you understand this, that the President only nominates, but they confirm, so, therefore, you work for the Senate, and therefore you are responsive to them. So, they hold your life in their hands for a period of time. They call it the Senate Confirmation Process, but really they just take you by a string, and they dangle you over a flame for a period of time until you pay the amount of appropriate respect due to the United States Senate and Congress, and then they either release you to four years of pain, or just drop you directly into the flame. So, I ran the gauntlet that was the Senate Confirmation process, and I was going through the hearings, and one of the Senators, who was from down South, and who was a big enemy of HUD and everything that HUD did, because HUD helped those poor people in those poor places with those funky problems that shouldn't exist in the first place, and we were going through the process, and the Senator looked at me and said, "Now, boy, you don't have to bother unpacking when you come down because you're not going to be here that long," but I was, and we saved HUD.

I turned out to be a successful HUD Secretary, successful HUD Secretary being defined as a HUD Secretary who's not indicted by the end of his tenure, and I did that. We actually made some changes, and we did some good things. We did good things on the areas that you work in. We did a lot of work on the homeless. We doubled the budget. When I got to HUD, the budget for homelessness was about \$300 million. It was still seen basically as a housing physical problem, the continuum of care, but as a social service model to helping the homeless, and we brought the budget up to over a billion dollars, and we brought not-for-profits in all across the nation to work on the issue. We bought home ownership to its highest level in history, 67%, and we fought discrimination. We did a lot of good work, and if I took any lesson, it was how much needs to be done, but yet what a great potential we have to do great things. Those are the points I want to touch on today.

I want to start with one quick story that sums up the point to me. That's the story of the farmer and the flood, which sort of brings it all home to me. The story of the farmer in the rural part of the county. It had been raining for a number of days. The county officials were concerned about the rain, and they called up the county, and they found out that the river was starting to swell, and that there was going to be a flood. The county officials got in a large truck, and they went out to the rural part of the county and went to the farmhouse. They said to the farmer, "You see all this rain? Actually the river's swelling, and there's going to be a flood, but we have some time. We have a big truck outside. We're going to take you and your belongings to safety." The farmer looked at the county official and said, "No, I'm a God fearing man. I go to church every Sunday, and the Lord will take care of me." The county official said, "All right, but we have the truck, so let's go ahead and get in the truck." The farmer said, "No," and they were back and forth a little bit. Then the county officials left disgusted. The rain kept coming and kept coming, and a few days later there was six feet of water. The county officials, being industrious as they were—good government employees, they now had a boat. They got in the boat, and they went back to the farmhouse. They said to the farmer, "We told you that it was raining. We told you that they said it was going to flood, and now you have six feet of water, but don't worry we have a boat outside. We're going to bring you to safety in the boat." The farmer looked at them, and said, "No, I'm a God fearing man. I go to

church every Sunday, and the Lord will take care of me." They said, "We know. You said that last time, and look where we are now in six feet water. Get in the boat now while we still have time!" The farmer said, "No, the Lord's going to be there for me. I'm sure of it! I'm sure of it!" They said, "Come on, we'll get in the boat, and we'll take care of the Lord later." He still said, "No," and they went back and forth, and they argued. Eventually, the farmer insisted that they get back in the boat, and they leave. The rain keeps coming, and keeps coming, and now the farmer is standing on the roof of the farmhouse, and the water is up to the farmer's neck. Only his head is above the water. He has his head above the water, and he's looking up. As he's looking up, he hears a great rumbling sound, and the clouds start to part, and there's a loud noise as the clouds are parting, and it gets windy. Then there's a helicopter. It's the county officials that are in the helicopter. They throw down a rope and they say, "Grab the rope! It's us, the county officials. We can still save you. Grab the rope, and we'll pull you up to safety." The farmer said, "No, I'm a God fearing man. I go to church every Sunday, and the Lord..." They said, "Grab the rope before it's too late!" In the next scene, the farmer's at the pearly gates. He meets our maker, and the Lord says, "Hello, welcome to heaven." The farmers says, "It's nice to be here. I guess it's better than the alternative, but, Lord, I'm confused. I went to church every Sunday. I thought you were going to be there for me. What happened?" Our Lord looked back at the farmer and said, "You're confused? I'm confused. I sent a truck, a boat, and a helicopter. What happened?"

The point to me is that in the final analysis, it is up to us. It is our action. It is our initiative that will decide destiny and decide fate. Nothing happens. What happens is what we make happen, and it starts with us. I think that's an important lesson for today, because we are at a crossroads. I think the Chancellor is exactly right. I think this nation is at a point that it can go in different directions, and we're working through that right now, but we are truly at a crossroads. As they say Indiana is at a crossroads, we are at a crossroads today for a number of reasons. Number one, the economy is basically good. It's not great, but it's basically good, and we don't have to be preoccupied with the economy. When the economy is bad, it becomes the entire subject of the day. When the economy is good, we're not worried about our immediate economic wealth.

We have a 1996 welfare reform act that has given us a totally different program model of how we're going to help millions of people across the United States. We are more diverse as a nation than ever before. By the year 2050, we will be a majority minority. You go all over the United States and you meet new immigrants. Immigration and diversity is now not just a function of the coasts. They're in Minneapolis. There are new immigration patterns all across the United States, and that is changing us. We are younger. The baby boomers are moving on. There is a new generation. Generation X, generation Y, and I'm not part of it, but they see the world totally differently. A different set of values, different stimuli, and they're now taking their place.

Most importantly, I think, and what's going to be most transformative is the 9/11 experience. I think one day they will talk about 9/11 the way they talked about the John F. Kennedy assassination, or World War I, or World War II, or being a Depression baby. This is going to be individually formative, and formative of the

nation. I think we're still working through it, and I don't think we've determined yet what it has meant. I think we're still processing the feelings, but you can see two very different options, and you can see that we're at a fork. One option is that we can take the 9/11 incident, and we can take that fear, and we can close down. We can constrict. In some ways it's almost the natural response. When you get startled, (remember) the startled reflex with a child... when you're afraid, you constrict. Your body says, "Pull within. Close down. Cover your vulnerable parts. Reduce your vulnerability." You can almost see us doing that as a people. Closing down, building walls, getting suspicious, getting afraid. You're different than I am. You have a different skin color. You have a different tone. Maybe you're a terrorist. Let me see your papers. Let me pull you off the line. Getting afraid and getting tight is an option for us individually, and for us as a nation. You can't trust anyone. Become nationalistic, close out borders, close out boundaries, and get tight.

The second option is to go the exact opposite way. Yes, we are vulnerable. Yes, we can be hurt, but the solution is not to close down, but to open up, and be liberated by the vulnerability. Not to be restricted by it. Let's learn why, understand why, and let's become more protective and more secure certainly, but let's reach out and form alliances, and form connections, and become safe in the whole, rather than individualized and isolated. That is a less natural response. It is a more intellectual, more intelligent response, and I believe long-term a more productive response, but not a natural one.

I believe in government. I'm running for Governor. Why? Because I believe in government. Forget all the politics and all the bologna. Government is purely the vehicle that says we will operate as a collective. If you choose the fork that says, "We should be community. We should be together," then the vehicle that does together, that does community, is government! It gets too complicated with all these TV shows, all these program numbers, and all this federal mumbo jumbo. All government is is when we decide we're going to do something together, the committee we form is called government, and it does what we can't do as individuals.

We need the military defense. Not everyone can defend the country. Okay, we'll have a committee do it. We need to protect ourselves domestically. We'll have a police force. We can't do it individually. Okay, we'll form a committee. That committee becomes government. If you believe in the collective rather than the individual, and you need an implementation vehicle, that then is government. So, yes, I believe in government. Yes, I'm running for governor, and yes, I was at HUD, but only because I believe in the collective. Not because I have any great need to amass pension benefits as a government employee, only because I believe in the collective. I believe that the vehicle has to work. I believe that the vehicle has to be credible, and I believe we have a lot of reform to do in that way, because the government vehicle doesn't work today.

Only 18% of the new generation that's coming on vote. Why? Because government doesn't work. Government isn't inspirational. They didn't have a John F. Kennedy, a Bobby Kennedy, or a Martin Luther King. They had none of that. Their main interaction with government is the Department of Motor Vehicles, when they get a license, and the Internal Revenue Service, when they decide to make some money. These are not inspiring interactions where you say, "I want to be with

them. I want to be that clerk in the DMV." They don't have that same feeling. You have to make it work.

First, the politics, the political paradigm we have today is outdated. When I was in Washington, one of the marbles I had was whatever the issue was before the United States Congress; the vote was always by party line. Democrats always voted for Democrats, and Republicans always voted for Republicans on whatever the issue. Should we cut down trees under six feet tall in the Midwest? Democrats all have one opinion, and Republicans all have one opinion. How can it be? The loyalty was to the party label rather than the public interest in public service. It had become more about your party affiliation than your popular sentiment. They didn't bring the independent judgment that was suppose to be representative of government that Jefferson and Madison talked to us about where you're going to represent the people and bring your skills and abilities. They said, "What's the call on this one boss?" "We vote against the trees that are six feet tall." It constantly was that sort, and that doesn't work. The traditional definitions don't even work. The Democrats want to have a simplistic view that says, "The private sector is bad, and we need government to control the private sector." That doesn't work. Maybe you have that fear coming out of the depression, where you saw the private sector victimize women and children, but that was decades ago.

The Republican view is that government is bad. If you just let the private sector work, life will be all rosy. Go look at Gary and Deanna after eight years of the strongest economy in history, and tell me how well the private sector does lifting all votes. Gary was anchored if that was your theory that it lifts all votes. The traditional paradigm doesn't work. Also the operating model of government doesn't work. It is where the corporate sector was 30-40 years ago.

The best analogy I have is the analogy of the bank in the '60s. Remember what a bank was about in the '60s. The power was in the bank. The power was in the corporate institution, and you were just a consumer. You were just a customer. You had no power. You were just a person. They were the corporate entity. The bank was always on the corner of every city. Big granite building with big columns that made the statement, "I am the bank and you are a mere person." You would go to the bank, but you would go to the bank on the bank's terms. The bank closed at 3 o'clock in the afternoon. Why? Who could get there by 3 o'clock in the afternoon? It didn't matter. If you wanted your money, you figured out how to come. They laid a reform, and then they were actually open on Saturday mornings as a convenience. You'd have your little pass book, and you'd go up to the teller and say, "May I please have my money back?" "Well do you have your pass book? Let me see if the paper is in order?" "I forgot my pass book." "Then, no money for you today!" The power was with the bank. The power was with the institution. We've gone 180 degrees from there. Now I have my ATM card. If I have to move more than 10 feet in any direction to find an ATM teller, I'm going to get a new bank because that's just unacceptable. I have the power. I am the customer. I am the consumer. I don't care. The power is not in the institution. The power is me.

Government is still in the '60s model. They think they are the institution, and you must come to them. It doesn't work that way. The whole service delivering mechanism doesn't work. The whole organization doesn't work. The stovepipe approach doesn't work.

I was in the Department of Housing. Then there's the Department of Health and Human Services. What if you had a health problem and a housing problem? Then you come to me, and I'll give you an apartment. Then you have to go next door and see Donna Shalala, and she'll give you health needs, but the problems aren't presented that way. Homelessness, domestic violence, substance abuse, it doesn't happen that way. It doesn't happen in the stovepipes, but that's the way the government is organized, and if you don't present the problem the way the government is organized, they don't recognize the problem. None of these things work top down anymore. All of the solutions are bottom up. All of them are comprehensive solutions on a community basis.

Government as a service deliverer doesn't work. The not-for-profits are much better. Make the government work. Change the political paradigm, get out of the old labels, change the operating methodology, make it perform, and make it work. Then you'll start to have the credibility to actually address the new problems.

Once you have government working, the two priorities in my opinion, first of all, the public education system. You can go to any city in this nation, and there are two education systems. You can go to the rich side of town. They will show you the schools on the rich side of town, either public or private, and they will be state-of-the-art. You go to the first grade, and you see first graders on a Pentium processor. You go to school on the poor side of town, and it's the exact opposite. The most sophisticated piece of electronic equipment they will have is the metal detector that you walk through on the way to the classroom. Two different education systems.

What was supposed to be the great equalizer for American society, the education system, now has become the great discriminator. It was the great equalizer. It said, "I don't care what color your skin, where you came from, what your accent is, what your country of origin, or how much money your parents have in the bank, you can become the president of the United States based just on the public education system." That was the American experiment, and that was American democracy. We'll invest in you. We'll grow you, and you'll help all of us. We did that through the public education system. That was it. No handouts. Nobody ever asked for a hand-out, but we'll give you an education, the public education system. Now it does the exact opposite. And now you have a real fear that if your child goes to the wrong school, the child will never catch up. If your child goes there seven, eight, or nine years, he or she may be left behind for the rest of their lives and not be able to catch up. That is job one.

Job two is going to be the issue of race. The outside threats have gone for this nation. The internal threat is more dangerous and more insidious. Racism is alive and well. We don't even want to admit it. We don't even want to talk about it, let alone solve it. It's almost like homelessness and domestic violence. We don't want to say domestic violence. Why? Because it hurts us. It's too painful to admit the problem we have. Race is the same thing. We don't even want to talk about it, but it is there across the board. It is just as ugly as it was in the '60s and the '50s. That same brutal, physical kind of ugliness and racism.

They dragged a black man, Mr. Bird, to his death in Texas only because he was African-American. I did a case in Pennsylvania when I was at HUD. We sued the Ku Klux Klan. Why? Because the Ku Klux Klan targeted a woman who was biracial. She



had an African-American father and a white mother. This was a biracial girl. The KKK's fear was that you may not know that she was biracial, because she was very light skinned. This is a great fear for the KKK that you're going to mix blood, and you may not know that this woman is African-American. So, what they did as a public service was they put her picture and her identification on their website. They would track her whereabouts, so everybody would know exactly where she was. So, if you went into an establishment, and someone happened to meet her, you would know she's black. God forbid you would be on notice. The family ultimately moves from Pennsylvania. Thank God for the Internet, because the KKK could track the family. The family moves five times in two years, trying to get away from the KKK. We sued the KKK. That was the first time the KKK had ever been sued, and the Grand Marshall of the KKK of the State of Pennsylvania. That was two and one-half years ago. Discrimination has also become a little more subtle, and a little more intellectual and institutionalized. It is inherent in our banking system, our housing system, and our insurance system.

We used to do discrimination testing at HUD. Take the same financial form, every number and every statistic the same. We'd give it to an African-American, and give it to a white person. They would both go into the bank. The same exact life history, everything exactly the same, just the color of the skin different. The white would get the loan, and the African-American wouldn't. That's in the year 2000, and we don't even want to talk about it, but we're becoming more and more diverse. The problem's not going to go away on its own. Don't worry, it will go away. No, it's going to get worse, and it's not just black/white. It's black, white, brown, yellow, Asian. Seventy-five different languages in the New York City public school system. One-hundred and ten different languages in the L.A. public school system. Learn how to deal with this, or it will defeat you, I am convinced, because the whole experiment was, "Don't worry, we can take people from different places and bring them together, and they'll forge one nation." The differences will be a source of strength and not weakness. That's not where it is now. We have to have the courage to speak about this issue and address it.

God blessed Bill Clinton. He talked about a one America race dialogue. He said, "Let's have this discussion in every church, in every temple, in every school, and every kitchen table all across the nation," and understand why we get afraid when a person is different. What does it say to us? When a person has a different skin color or a different accent, why does it challenge me? Why does it threaten me? What does it say to me that makes me angry and makes me fearful? Understand the problem. Then secondly, say to this nation, "It is not just wrong discrimination, it is illegal." By the current laws today, it is illegal. We don't enforce the laws, but it is illegal. Enforce those laws with the same vengeance that you enforce the drug laws, that you enforce the tax laws. Say to the people in this nation, "No, we will not tolerate discrimination, and we're going to enforce it," and take the enforcement agencies and those laws, and make them work. Not that the EEOC is a joke.

In my state, the State of New York, Division of Human Rights, you make a complaint, it takes seven years to hear the case. You know what that means? The case is never heard because Justus delayed is Justus denied. You can't make a case after seven years. What are we really saying? We know what goes on, and it's going to be a subtle admission. Public education and race relations are going to be the top two

priorities, and we have to do it now. I believe in the fork in the road and the cross-roads. I believe we're going to take the right fork. I believe that the 9/11 experience is going to wind up having a silver lining. I don't think we're there yet. I think we're still processing it, but I think that's where it's going to come out. Maybe I have a different perspective coming from New York, where this is a much more intense response, but I think it is formative, and I think there is a silver lining, and I think this is the silver lining.

On 9/11, the first image was the plane hitting the building. That image is etched in our memory, in our heart, and in our soul. That image will never leave us. That is an image of fear, cowardliness, and pain. That is there. The second frame is the ground floor, with policeman and firefighters running into the building and showing a courage that we have never seen before. Then, people coming out of the building and being embraced by New Yorkers. Not a place known for love and charity. New Yorkers were there together in a way they had never been before. Nothing I had seen in my 44 years was anything like this. A sense of giving, a sense of charity, a sense of unity, where literally there is nothing that you could have asked that they wouldn't have done one for the other. Where they literally gave the shirt off of their backs, the blood out of their veins, the money out of their pockets. One for another, and we were one. We were one! We were united! We didn't look one to the other and say, "Oh, you're a different color skin than I am. I'm nervous of you!" We said the opposite. We didn't see the differences. We saw the similarities. We saw the commonalities. We saw the humanity. We saw the brotherhood. We held one another. We cried for one another. We looked to one another with hope, with love, and with openness, and not just within New York, the entire nation saw this. The entire nation responded the same way. From California to all across the country, they said, "We're there with you! We're all one! We're Americans! You're not a different city, a different state, you are one of us! We're united in this moment. This event has been transcended, and has brought us together." This event has created such an energy that it has gotten past all the bramble and all the weeds, and it's taken us to a higher place. It said we are connected. The Chancellor said we are a fabric. We've heard for so many years that we are a fabric. We felt it. We felt that there's a cord that connects me to you, to you, to you, and to you, and maybe the cord's been invisible, but we felt the fabric that that cord weaves, and we understood that when one goes up, we all go up. When one comes down, we all come down. We got it that day. We felt it, and that was a beautiful feeling. It's like love. Once you feel it, you want it again and again and again. Love is stronger than fear. That togetherness, that joining, that union is such a powerful feeling that we want it again and again and again. If you had it once, you can have it again. If you weren't afraid of the other person once, maybe you can be together again. If you could be united as a nation once, maybe you could be united as a nation again. That is a very powerful feeling, and we had it. It's not an intellectual concept. It's not a religious concept. We tasted it. It's not in the history book, community, from the Latin *communis* of the common. We were the common. It was Matthew 25. We were brothers. We were sisters. We felt it, and it was a great feeling. If you did it once, you can do it again. It comes back to the farmer and the flood. It's up to you! No one else is going to do it. Someone has to start the pattern. Someone has to start the cycle. Someone has to be the first person to put his or her hand out, and say, "I'm

with you. I'm not afraid of you. I'm here for you. I'm vulnerable, yes. Maybe you can hurt me, but we're all vulnerable, and I'm going to take the chance because love is greater than fear. We can do so much more together than we can do alone, and we're really together in the first place." Thank you and God Bless.

### QUESTIONS AND ANSWERS

Any of the difficult questions I will give to the Dean and the Chancellor.

*When are you running for President?*

At this rate, I'm going to be running for cover soon.

*What do you think about welfare reform reauthorization, the limited resources for welfare, and the time limits for welfare recipients?*

I think welfare reform was a great opportunity, and in some ways a good thing, but in most ways a bad thing. I was on the welfare reform task force that President Clinton put together. The welfare reform that he put in had nothing to do with the welfare reform that came out. To do real welfare reform, it would have cost more money short-term, not less money. Welfare reform was not about saving money to do it intelligently. I think it came up with a false construct. The construct for welfare reform became shouldn't we make people work. The answer is obviously yes. If you can work, you should work, and welfare reform then said, "Well then you must work!" Yes, except that was never the issue in the first place. I've been in every poor community in this country. I never once had someone say, "Mr. Cuomo, do me a favor. Can you help me get a welfare check?" Never once. Instead "Help me get transportation. Help me get education. Can you help me get child care?" Never once, "Can you help me get a welfare check?" The trick was getting the person through the transition to the job. Getting from here to there is often a chasm, and resolving those issues, which are expensive and often long-term. We haven't felt the pain of this because we were in a very strong economy. The economy was going so strong that it just inhaled everyone into the job market, and the government had a lot of money, and the welfare reform plan block granted all of that money down to the cities and states, and the states gave it to the cities. So, whatever welfare burden there was could be paid. I'm afraid now the economy slows, the money that was block granted is now gone. If Indiana has a welfare problem now, and the feds say, "Well use the money I gave you four years ago," they're going to say, "That money's gone." They're giving away tax cuts. There's going to be no money, and now we're going to have a major problem. If the economy slows, the first person laid off will be the same people. They'll become the unemployment roles. They'll be very expensive. There will be no money. That's the fear. The only good news, because I was in Washington for eight years, so you had to be an optimist otherwise life was very long, the good news was politically it's not the same issue that it was. The politics of this afforded conservatives an opportunity to beat the progressives over the head with the welfare reform stick. It was quite effective for them. It's no longer a political issue to use against the progressive community. That's the good news.

*How can government do a better job and use technological innovations to improve services?*

(We're beginning) to see local governments getting this. I talked about the DMV. The wealthier and more advanced communities will now have web-based DMV systems, which is their way of saying, "We're starting to get this." The government needs to perform the way the bank does, and the way any institution in the country that you're going to contract with does, and they're not there yet. Local governments are starting, states with income, the federal government will come. In some ways, the more removed from the person the government is, the more entrenched it tends to be in its own bureaucracy.

When I was at HUD, I went to a web-based system. I went to kiosks in shopping malls, so that government goes where you are. You're not supposed to come to the government. The government should go where you are. Government should be convenient. It's the ATM, 10 feet here and 10 feet there. Government should speak your language. When I worked at HUD, they have a whole language of their own there at HUD. It had nothing to do with the English language. I remember the first day I walked in, they would say, "Hi, I'm working at CDBG now, and I'm going to put out a NOFA, and we're going to do a Section 8 certificate for the new com plan, so we're excited you're here." I'd say, "That's great. I'm really happy I'm here now, too." That's how they talked to people. Like you were supposed to know their language, otherwise, you were unintelligent. That is changing slowly. I think you'll see local governments start to get it first because you will demand it of local government, or they will no longer be in office. Then, it will rip them up.

*What do you think about the eviction from public housing of family members of those persons convicted of drug offenses?*

This was passed when I was there. This is, if you are convicted of a drug offense in public housing, it's the family associated or a tenant associated with that person that gets evicted. The most common case is when a grandmother has the lease, and the grandson is convicted of drugs, so the grandmother gets evicted. I believe this was an overreaction. We tend to work in pendulum swings. We had a problem in public housing. We had a problem with drugs, and public housing had gotten out of control. It was out of control, the Chicago housing authority. The children sleep in bathtubs because the mothers are afraid of stray bullets. The Chicago housing authority would drive the children across a courtyard in a vehicle with armor-plated glass because they're afraid to let the child walk across the courtyard to go to a school. It was out of control. Dramatic response, over-response. Anyone who was associated with a person who does any drugs is a victim. I think that's what the first strike was, but it's been upheld by the Supreme Court, and it's going to be the law. It will have, no doubt, some effect, a chilling effect, on the behavior in public housing. That's the good news. The bad news is a lot of innocent people are going to be evicted because of it, and we're going to pay a very high price. My guess is that the pendulum will swing back, but it's going to take a couple of years, and sometimes the pendulum comes back very slowly. The analogy that I'm working on now. . . New York has something called the Rockefeller drug laws. They were passed by Governor Rockefeller. This was in the '60s when you had high drug crimes. They passed a law for a very small amount of drugs. You have a minimum sentence, mandatory minimum, 10 years or 15 years. So, you have kids who would get busted with a small amount of drugs, and bang, you go away. Mandatory min-

imum. It doesn't matter what the judge says. It doesn't matter what the specific facts are. You go away. We had a tremendous increase in the prison population. All young, almost all minorities, males, small-drug related. Now, I'm trying to talk about alternatives to incarceration substance abuse for minor offenders. A prison cell costs about \$30,000 in change in New York. Residential substance abuse can be \$16,000-\$17,000. It's less expensive. It's about half the cost, plus you also redeem a person rather than paying for them forever, but change comes slowly.

*What role do you see universities playing in your vision of a united, compassionate, and caring society?*

I think it's going to be a key role because it is not the natural response of people. I believe the natural response is to constrict. It's almost biological. It's almost chemical. It's the startled response. You hear the noise and you close down. The alternative is an educated, informed, disciplined, intellectual response. With the universities, it is much more taught than instinctive.

Your school of social work, definitely what you're doing, the skills you've learned, will inform not just you, but you can bring this message to others. Also, universities on a practical level. Universities are great assets in a community and for most community development (and) urban development. I started a program at HUD, the University Partnership Program. Build off of the university. Make the university part of the community. It's not a fortress isolated onto itself. It is a great asset in the community. Breakdown those university walls, and let the university open itself onto the community, and let the community open itself onto the university. I had a lot of success with that program, both in concept and in practice. So, I think it works on both levels.

*You said after 9/11 that people in New York united. So, what do you think about gays and lesbians getting the equal opportunity to receive the same compensation that heterosexual couples receive?*

I agree with that. I'm 100% in favor of that. There's a law in the United States in the state of Vermont that's called Civet Union, which says essentially that a civet union partnership has all legal rights as if you were husband and spouse. Vermont is the only state that has that law. I would propose it in the State of New York. I would like to see the State of New York be first, but I'll settle for being second with that law.

*You spoke about the (9/11 tragedy) in New York of bringing people together, and how this is the way we really should be within the nation. What seems to happen in America's past is that it seems to be a tragic situation or something very significant where we all see each other as one, but at some time after that it reciprocates. What do you see are the roles that individual non-profit government can play to sustain that and really make it a part of American life as opposed to (a transient phenomenon)?*

That's an excellent question. I'm working through that now. I don't have a really specific answer for you, but I don't know that it's going to be that fleeting. You had generations that came home from World War I and World War II, and boy, they were Americans, and they understood the flag. They were united, and they felt a sense of camaraderie that no one has felt since. Certainly in my 44 years, I've never had any galvanizing experience in my lifetime. So, I don't know that it's necessarily that



fleeting for that reason, and also I don't know that the threat goes away. I don't know that 9/11 will have been a one shot, pardon the pun, I think the fear is going to be lingering because the first image of the plane in the building is going to be lingering. You turn on the TV and you hear about the Middle East and its suicide bombers and cafes and buses. After 9/11, this means it brings it home here to you, also. If you turned on the TV and you saw what's happening in the Middle East on 9/10, you would have said, "Well that's the Middle East. That could never happen here. This is America." You turn on the TV and you see that on 9/12 and you say, "That could be here."

I was in the Middle East the week before last as a sign of solidarity during this period. I went to Israel, and they live with it every day. I think that may very well be what happens here. I would love to be able to say, "Oh, don't worry, that's never going to happen again," but I don't believe it's true. I believe in some ways that 9/11 was a precedent in that it said to the world, "You can do this." Why didn't this happen before? Well, because you couldn't do it. Why not? Because it's the United States. We have all the security. They're very powerful. They're very smart. You could never do this. Nobody could ever get away with it. Now it's sort of a given. 9/11 says it's not a given. You could be a terrorist organization, not the most sophisticated, and you could actually do this. By the way, you can hit the giant in the jaw, and the giant's knees buckle, and you could take the entire United States of America and bring it down with one terrorist act. We've informed the globe of that, and I'm afraid it became self-fulfilling.

When I was in the federal government, after the Oklahoma City Bombing, the FBI said, "Be careful, because there's now going to be a rash of bombings." I said, "Why?" They said, "Because these types of fanatics see one incident, and then says to them gives them license." If you can do it once, I can do it also. I can do it again. After Oklahoma City, I don't know if they were publicized, but we had a rash of bombings. Not bombings, literally, but domestic type terrorist activities, and I think that's very much going to happen here. So, I don't know that it's fleeting for those reasons. There are going to be plenty of reminders. I also think some of this is going to be that we will remember it because it was nice. There was an element of nice here. I don't think we can say that yet. To talk this way in New York, it's almost incongruous, but there was a sweetness to New York. There was a sweetness that you've never felt in New York. It is enticing, and it is appealing. Once you taste it, you want it again. You want that sweetness back. I think that's probably the greatest reason that we'll follow that fork. It felt right, and it felt good. It felt nice, and we were just in a good place on that plane in life, and I want to go back there.

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## In the Belly of the Beast: A Case Study of Social Work in a Managed Care Organization

Lisa S. Patchner

**Abstract:** *The employment of social workers within managed care organizations is a new phenomenon. As such, this case study utilized an exploratory-descriptive design that assessed social workers as case managers within a Medicaid HMO. The semi-structured interviews, focus groups, and participant observation suggested that the use of case management services, delivered primarily by social workers, was effective in addressing the bio-psychosocial needs of Medicaid consumers within a provider-driven HMO. Study findings recommend specific knowledge and skills that social workers need in order to prepare for practice within managed care environments.*

**Keywords:** *Managed care; Medicaid; case management; HMO, health care policy*

As managed care more completely penetrates the health care and public service delivery markets, the industry can expect to enroll increased numbers of high-risk populations. With advances in medicine, coupled with the aging of the population, there are increased numbers of individuals with chronic illnesses and complex psychosocial concerns that require long-term health and community-based services (U.S. General Accounting Office, 1996). The managed care industry, familiar with the provision of a lower-cost alternative to traditional indemnity insurance for healthy populations, has limited experience serving high-risk populations (Kaiser Commission, 1995). As Kelly (1997) reported, most managed care companies are inexperienced in the supply of community support services (i.e., psychosocial services, outreach, case management, and transportation) needed to manage health care and promote wellness among high-risk populations. With the increased privatization of Medicaid, leading to managed care arrangements, the industry has had to hasten delivery systems to meet the health and social service needs of a growing, heterogeneous population.

Even though managed care continues to grow at a rapid pace, there have been no empirical studies of social workers' involvement in private managed care organizations. This study represents a beginning attempt at understanding professional social work involvement in the evolving managed health care delivery system by examining social workers employed in a Medicaid managed care organization. Specifically, this case study investigated the role and functions of social workers in a

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Medicaid managed care organization, and determined the structure and function of case management services offered by these social workers. Implications are drawn for social work's involvement in managed care organizations and for the education of future professional social workers for case management positions within managed health care organizations.

## **BACKGROUND**

Managed care will increase its penetration into the continuum of care in order to demonstrate efficient and cost-effective health improvement for large, chronically ill populations (Goldsmith, Goran & Nackel, 1995). Expansion into the provision of community services alters the treatment focus from acute care to chronic care, and highlights the need for cost-effective, long-term care management of the chronically ill and other high-risk consumers (Moore-Greene, 2000).

Social work case management models have traditionally been applied in the coordination and linkage of service components within the service delivery continuum. In providing case management services, social workers transition high-risk clients with chronic illnesses to appropriate levels of care in order to increase desired health outcomes and decrease inappropriate utilization of services. Traditionally found within community service settings, case management services have begun to emerge as an important component of insurance utilization management. Managed care systems have begun to integrate case management strategies into their organizational processes in order to coordinate acute and chronic care services for increased Medicaid enrollments (Kaiser Commission, 1995). As Medicaid managed care systems provide the consumer with a primary care provider and facilitate the coordination of integrated services through case management services, better population health outcomes should emerge.

According to a recent Health Care Financing Administration (HCFA) Press Office Fact Sheet on Managed Care in Medicare and Medicaid (U.S. Dept. of Health and Human Services, 1997), enrollment in managed care plans has experienced unprecedented growth. In 1999, more than half (55.59%) of the national Medicaid population was enrolled in a managed health care plan (U.S. Dept. of Health and Human Services, 2000). The accelerated growth of Medicaid managed care systems, which serves the most vulnerable populations, is the result of a failure to agree upon a national health policy, increased fiscal deficits, and inequalities of access to primary medical care.

Most states have focused their managed care enrollments on low-income families, which constituted approximately 73% of the Medicaid population in 1994 (U.S. General Accounting Office, 1996). As states initiate mandated managed care for their entire Medicaid populations, individuals with disabilities, who represented approximately 15% of the 1994 Medicaid population and account for more than one-third of Medicaid expenditures, will also challenge states to provide quality health care to a diverse population. Additionally, the prevalence of chronic illnesses and disabilities among children enrolled in the former AFDC and current TANF programs is approximately twice that of children from the general population (Meyers, Lukemeyer & Smeeding, 1998). According to a recent study (Shatin, Levin, Ireys & Haller, 1998), children with selected chronic health conditions are enrolled at a higher

rate in Medicaid managed care plans than in private managed care plans, and those enrolled in Medicaid managed care plans require more services than children with similar conditions who are enrolled in private managed care plans. Due to the heterogeneity of chronic disabling conditions and demographic trends, individuals with chronic illnesses and disabilities will need a well-designed service delivery continuum (The Institute for the Future, 2000). Somers and Martin (1997) state:

Health plans entering the Medicaid marketplace must adapt their health care delivery systems to serve the disabled and aged populations. Purely medical-model health care delivery systems must become social-model organizations able to coordinate both medical care and social services. (p. 2)

A series of recommendations is beginning to emerge from advocacy, research, government, and industry experts indicating that a refined and informed approach to meeting the unique health care needs of high-risk populations, including those with chronic health care needs, is urgently needed. The Kaiser Commission (1995) asserts that the special needs, ethnic characteristics, and other unique features of the Medicaid population must be addressed when designing effective managed care systems for low-income consumers. Their report further indicates that such services as case management and care coordination have the potential to improve health delivery by modifying managed care services to address unique health concerns.

The Pew Commission (1995) predicts that the future American health care system will be more concerned with disease prevention, health promotion, and care management, and less focused on specific medical treatments. The Commission recommends that health professionals broaden their understanding of the psycho-social-behavioral sciences, population health promotion strategies, and health management sciences in order to better meet national health needs. The Pew Commission also asserts that the newly emerging demand-driven health care system warrants consumer-focused and culturally-sensitive health care delivery.

Preister (1996) recommends a new model of consumer-focused delivery that incorporates four characteristics: community-based human services; flexible and holistic services; family-centered services; and professional services that reflect accountability. Additionally, Preister (1996) stresses that families need to partner with case managers to design consumer-focused interventions.

McManus, Fox, and Newacheck (1996) acknowledge the important contributions of case management services to families of children with special health needs. According to Nicolaysen (1996), the need for case management within managed care will continue to grow as wellness among high-risk populations is promoted, thus indirectly reducing costs and contributing to cost containment. Harris (1992) anticipates that in addition to educating consumers about health prevention, there will be more emphasis on improved health outcomes by better management of clinical interventions. Others predict that managed care will focus more upon managing health outcomes of high-risk populations (Goldsmith, et al., 1995; U.S. GAO, 1996).

As managed care better adapts its service delivery systems to address the needs of high-risk populations, increased opportunities for professional case managers

will emerge. Although various professions have provided case management services, social workers continue to be most commonly associated with case management, especially at the community level. The National Association of Social Workers (1992) defines social work case management as:

A method of providing services whereby a professional social worker assesses the needs of the client and the client's family, when appropriate, and arranges, coordinates, monitors, evaluates, and advocates for a package of multiple services to meet the specific client's complex needs. (p.5)

Long familiar to social workers, case management has grown in importance in health care due to the changing health needs of the population and the resulting changes in health delivery systems. Landgarten (1988) argues that the growth of case management services reveals the fragmentation and inefficiencies throughout the health care delivery system. He asserts that case management attempts to reintegrate the fragmented health delivery system to meet the convergent needs of the consumer, payers, and providers.

As the U.S. population is increasingly covered under managed health and welfare services, the expertise of social work case managers in serving high-risk populations will be sought out by the private managed care sector. Social workers are specifically trained to utilize tested interventions from community-based programming and adapt these to managed care settings in order to deal with problems of access to services, continuity of care, and chronic care management (Hughes, 1999). Despite these opportunities, social workers have generally avoided working for managed care organizations even though their knowledge, skills, and values could greatly benefit persons served by these plans. Reluctance on the part of professional social workers to seek employment in managed care systems is due, in part, to an historical aversion to participate in the for-profit sector of the economy. In addition, the ethical issues surrounding cost-containment measures implemented by these systems have made them suspect to the profession. However, due to their specific skills and training, social workers can make significant contributions to the availability, accessibility, and quality of services provided through managed care arrangements.

## METHODOLOGY

This case study examined social workers in a Medicaid managed care system and described the unique applications of social work case management services in this environment. Specifically, the study had two major foci. The first was to analyze the role and functions of social workers in a Medicaid managed care organization serving the western region of a Middle Atlantic state. The second was to describe the structure and function of case management within a Medicaid managed care system.

### Setting

A for-profit, managed care organization that delivers an HMO product specifically designed for the Medicaid population served as the setting for the study. The health plan began in November 1992, when an Agreement and Plan of Limited Partnership was signed by three major health care organizations. Two of the three partners are not-for-profit organizations and the third is for-profit. The health plan



began enrolling Medicaid recipients in July 1993 with a start-up population of 111, and at the time of this study, covered more than 102,000 beneficiaries. The health plan began serving one county and expanded to a 16-county area. As a network model HMO, the health plan concentrated on developing a quality provider network with a strong internal utilization management structure during its early development. As membership increased, attention to both the external and internal delivery process led to further refinement of health services, specialized case management, quality improvement techniques, and utilization management. Incrementally, health improvement strategies utilizing disease prevention programs (i.e., asthma program, maternal health program), member education, and targeted case management were implemented. This particular Medicaid managed care organization was selected for study because they had a unique Case Management Unit where social workers played an integral part in the delivery of case management services to a high-risk Medicaid population.

### **Design**

Given the complexity of case management, several data collection methods were employed. These included interviews with case managers and the MSW Manager of the Unit, focus groups with consumers, and participant observation.

Face-to-face interviews were held with eight case managers. Five were MSW-level social workers, two were BSN-level nurses, and one was a MS-level Rehabilitation Counselor. The interviews focused on assessing their specific roles and functions and ascertaining the model of intervention that they employed. Semi-structured interviews allowed for in-depth questioning about the case managers' specific roles and functions, and their use of case management interventions. Each interview occurred at the case manager's workstation and took approximately 45 minutes to complete.

In addition, this investigator engaged in participant observations of the operations of the Case Management Unit. These day-long observations occurred one-to-two days a week for a 15-month period. The purpose of these observations was to gain a comprehensive understanding of the structure, function, and practices of the Case Management Unit at the health plan. This research was authorized by the Managed Care Organization for the purpose of sharing information regarding their Social Case Management Model with other stakeholders. The researcher was not monetarily subsidized by the Managed Care Organization for this research.

During the 15-month period, the investigator interacted with a variety of staff within the Medicaid health plan and attended departmental staff and other corporate meetings that addressed case-management related activities. The researcher was given a cubicle, limited access to the management information system, and a telephone within the Case Management Unit to better assess the operations and processes of the department and to participate more fully with the staff. The researcher signed a confidentiality statement pledging not to disclose identifying information about any of the cases. Staff routinely shared case situations with the researcher. Observations were noted either in writing through daily field notes or mentally. Daily field notes included the activities of the investigator and impressions of the observations being made, such as how case management was conceptualized and carried out.

Two focus groups were held with consumers who had recently received case management services to evaluate their satisfaction with those services and their perceptions of their health status. The focus groups were designed in such a manner that those individuals who directly interfaced with a case manager (i.e., they had telephone or face-to-face contact with a case manager) were invited to one group (Focus Group A) and those who did not interface with a case manager (i.e., case management services were provided, but the individual had no direct contact with the case manager) were invited to the other (Focus Group B). All focus group members were chosen from a systematic random sample of recently closed case management cases. Two other selection criteria for participation in the focus groups were residency in the primary county served by the health plan and current membership in the health plan. Application of these criteria resulted in a pool of 36 potential participants for Focus Group A and a pool of 26 for Focus Group B. Attempts were made to phone all of the eligible members to invite them to participate in the focus groups. Those contacted were assured that their participation was voluntary and that their anonymity was guaranteed. Those who were unable to participate indicated a variety of reasons including: work schedules, child care issues and not wanting to participate. Approximately one-third of the eligible focus group members were unable to be reached by phone. Letters inviting participation in the focus groups were sent to all eligible focus group members, except those who declined to participate. Seventeen people accepted the written invitations and participated in the process: 12 participated in Focus Group A and five in Focus Group B.

Free transportation to and from the focus group meetings was provided to any participant who needed it, and each participant was given \$20.00 for participating in the focus group. Focus groups were held at the corporate office of the health plan and lasted for two hours each. The following areas of inquiry were addressed: the consumers' views of the health plan, case management services, case managers, medical services provided, and past and present health status.

## **FINDINGS**

### **Case Management Process**

By its very function of providing and coordinating services to consumers, social work case management within health care delivery uses a client-driven approach to meet consumer health needs. Case management services at this health plan accomplished this by focusing their interventions on client-centered needs by coordinating services, communicating health concerns, educating consumers about health promotion, advocating for necessary services, assessing health needs, and informing consumers about care options.

The traditional case management model that uses a client-driven approach is in sharp contrast to the provider-driven approach which has increased in recent decades due to accountability and profitability factors. At this health plan, a very structured, client-driven approach was in operation within the Case Management Unit, where individual consumer health care needs were the primary focus of the case manager's intervention.

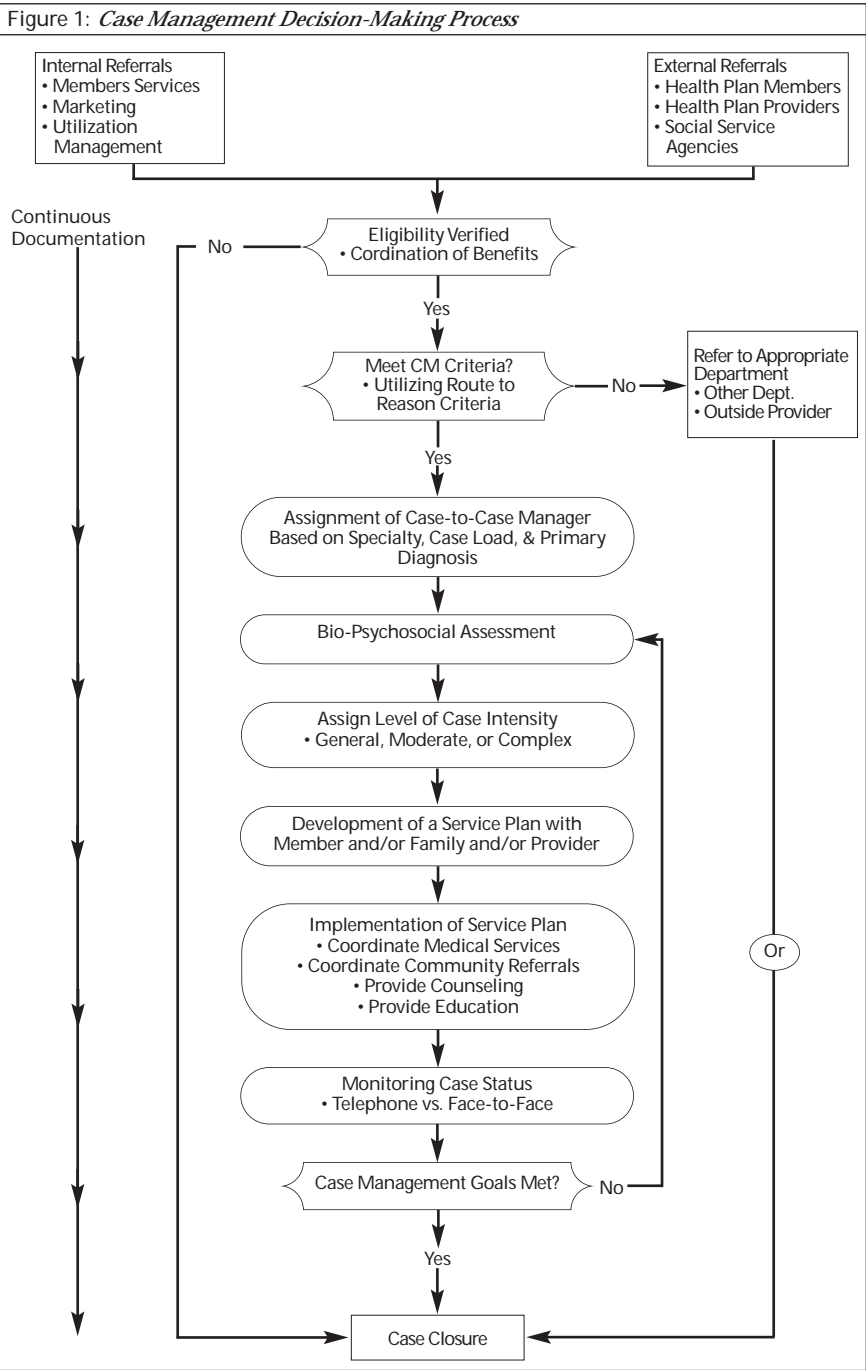
To bridge the client-driven and provider-driven approaches to case management services, the Case Management Unit adapted a practice model developed by the Case Management Society of America (CMSA) (Smith, 1995). This model places the case manager as the central figure who addresses the various concerns and desires of client, provider, and payer in order to develop effective services. The CMSA model directed case management practice, interventions, and services to meet consumer needs within the managed care health delivery environment, where mediation between the payer, provider, and client occurs. Advocacy, assessment, collaboration, communication, coordination, empowerment, evaluation, facilitation, planning, and problem solving are utilized by the case manager to broker resources for the member of the health plan.

Case management services focused on intervening with complex, catastrophic cases that benefited from increased coordination of medical and community-based services. Using a bio-psychosocial assessment to determine medically necessary care, case managers assisted the members in accessing health and social services through advocacy, coordination, monitoring, counseling, and education functions. The case management process consisted of referrals, screening, assessment, intervention, and quality monitoring (see Figure 1: Case Management Decision-Making Process).

High-risk cases were routed by utilization nurses, customer services, marketing, providers, members directly, and community-based services to the Case Management Unit. The referral process was accomplished through the management information system, which allowed internal routing of cases on-line rather than on paper. Cases with specific psychosocial and medical indicators were automatically referred to the Case Management Unit for assessment and, if necessary, intervention.

When personnel within the health plan, community providers, or the health plan members themselves identified a psychosocial need, cases were routed to the Case Management Unit for intervention. Certain illnesses or conditions, such as mental illness or substance abuse, automatically triggered a referral. When a referral was made to the Case Management Unit, the member was assigned to a specific case manager who provided the necessary intervention. The case managers were assigned to specific cases where their expertise in behavioral health, high-risk pregnancy, geriatrics, rehabilitation, developmental disabilities, cancer, or HIV/AIDS was needed.

Once a referral was received, a screening was performed to assess health plan eligibility, case management criteria eligibility, and member's willingness to participate with case management. An assignment of the member, based on diagnosis and caseload, was made to a specific case manager. The BSW Intake Coordinator, in consultation with the Manager of the Case Management Unit, made these assignments. Next, the case manager completed a bio-psychosocial assessment. The assessment was done in narrative format on-line. The case manager then assigned a level of case intensity—general, moderate, or complex. These case intensity levels depended upon the amount of time and effort that the case manager would be involved with the case. A plan of care was then developed in conjunction with the health plan member, the family, and/or the provider.



The case manager coordinated the implementation of the interventions specified in the plan of care. This required a variety of contacts with medical and community services and the member and the family. Throughout this process, the case manager strived for the self-determination of the member through education and counseling of the member regarding service alternatives. On-going monitoring of cases to determine whether treatment goals had been met was an integral component when implementing interventions.

Regardless of the professional orientation of the case manager, services were initiated when there was an onset of chronic or catastrophic illness or injury that required coordination of multiple medical and psychosocial needs. It was essential that the case manager focus on an individual treatment plan that was cost-effective, satisfying to the consumer, and guided by professional standards. Complex medical referrals of consumers were routed into the Case Management Unit for individualized attention and action by a case manager who addressed the multiple psychosocial needs that impeded medical treatment. Due to the complexity of health care delivery, case management services had grown into a powerful tool for managing the health needs of high-risk populations that exhibited multiple bio-psychosocial needs.

Quality monitoring was a continuous process where case reviews on intensive cases were presented within the department or discussed with the manager of the Case Management Unit. Case management activity was monitored weekly through the management information system documentation to determine the case manager's workload and efficiency in processing the cases. Monitoring of phone calls for quality assurance purposes and adherence to corporate standards were available to managerial staff. An audit, conducted quarterly, was designed by case management staff to assess the quality of the case manager's interventions and documentation through peer and supervisory review.

### **Consumers Served by Case Management**

At the time of this study, the health plan served more than 102,000 individuals within a 16-county network. Since the inception of case management MIS data collection capability, the Case Management Unit received 16,713 referrals, which included 3,502 separate individuals. These individuals accounted for 3.5% of the membership in the health plan. Of those served by the Case Management Unit, 70.2% were female and 29.8% were male. Their ages ranged from newborn through 95 years of age, with a median age of 25.6 years and a mean age of 28.9 years. For their primary care physicians, 42.6% of the members who utilized case management services chose family practice physicians, 40.4% chose internal medicine physicians, and 17.0% chose pediatricians. These health plan members, all of whom were Medicaid recipients, fell into 45 Medical Assistance categories. These include 33.2% AFDC—Cash Medicaid, 20.1% SSI—Disabled, 8.1% Disabled Elderly, 7.0% General Assistance or Chronically Needy, 6.9% AFDC—Medicaid No Grant, 1.4% SSI—Aged, 16.3% Not Classified, and 7.0% that were dispersed among the remaining categories.

Of the 16,713 referrals, 69.9% came from the health plan Utilization Management Unit, 11.4% from the Behavioral Health Unit, 4.0% from community agencies, 3.7% from the health plan maternity program, and 2.5% from a self-

referral or a referral of a family member. The remaining 8.5% came from social workers in hospitals, rehabilitation units, nursing homes, and home health agencies, OB Clinics, Primary Care Physicians, member services within the health plan, and several other sources.

Each time a member was routed for services, the member's diagnosis was recorded for each specific episode of care. A member's diagnosis could vary each time the Case Management Unit was involved. For example, a member could receive case management services because of a behavioral health problem on one referral into case management, and, on the next referral, the same member could receive case management services due to a bone fracture. Thus, each time an individual received case management services, the primary diagnosis might be retained, as might typically be the case for a chronic illness, or could change due to a change in condition for each episode of care.

The primary diagnoses of the 16,713 referrals that received case management services fell into 921 unique classifications utilizing the International Classification of Diseases (ICD-9) (Practice Management Information Corporation, 1996), thus demonstrating that the Case Management Unit handled consumers with a wide variety of presenting diagnoses and resulting psychosocial problems.

The ICD-9 classification system is elaborate and specific. For example, among the 921 diagnoses of consumers who used services of the Case Management Unit, there were nine different codes for bipolar disorders, 22 for substance abuse, 10 for high-risk pregnancies, and 14 for diabetes. For analyses purposes, these 921 unique diagnoses were reclassified into 11 general categories and an "other" category for those diagnoses that did not fit into one of the 11 categories. The 12 reclassified categories included: 1) AIDS/HIV, 2) Bipolar Disorders, 3) Depression, 4) Alcohol/Drug Abuse, 5) Asthma, 6) Diabetes, Injury/Trauma/Fractures, 8) High-Risk Pregnancy, 9) Normal Pregnancy, 10) Congenital Anomalies, 11) Neurological Diagnosis/Cerebrovascular Disease, and 12) Other. When reclassified, the distribution of diagnoses addressed through case management services revealed that High-Risk Pregnancy accounted for 10.7% of the diagnoses, Injury/Trauma/Fractures accounted for 6.8 %, Normal Pregnancy accounted for 6.7%, Depression accounted for 5.4 %, Neurological Diagnoses/Cerebrovascular Disease accounted for 5.1%, Asthma accounted for 5.0%, Alcohol/Drug Abuse accounted for 2.7%, Diabetes accounted for 2.6%, Congenital Anomalies accounted for 1.8%, AIDS/HIV accounted for 1.6%, Bipolar Disorders accounted for 1.1%, and Other accounted for the remaining 50.6% of the diagnoses. The "Other" category is quite high because it included several hundred diagnoses. However, each one accounted for less than one percent of the total diagnoses.

### **Social Work Case Management Roles and Functions**

The working environment at the managed care organization reflected an integration of aspects of both social welfare and business paradigms. The public mandate to serve the Medicaid consumer was a priority within the Case Management Unit. On the other hand, the corporate mandate to be efficient and cost-effective was also routinely evident. Usually, the two mandates could be accomplished by staff within the Unit without any professional conflict of interest. When the public man-



date and the corporate mandate conflicted, however, the Case Management staff conferred with other co-workers in this interdisciplinary unit and with supervisors, including the Unit manager and the health plan medical director. They weighed the benefits and costs to the individual consumers before making any decisions. This allowed for a more informed decision-making process and facilitated a collaborative approach to conflict resolution. An example of such a conflict would be in a case where a prescribed medication that the primary physician had ordered was not included in the organization's drug formulary. For a special needs consumer, the task of case managers would be to advocate for a waiver to permit the consumer to receive the prescribed medication. Case managers reported that their advocacy efforts were usually successful.

When asked to describe their duties, roles, and responsibilities as case managers, all eight individuals identified coordination of services and service as a resource specialist for members. Four of the case managers considered themselves member advocates, with one case manager describing empowerment of members as a key job function. Other job functions described by case managers included: consultation with providers, crisis management, development and monitoring of treatment plans, education of the member, promotion of good health practices, and service as a liaison between the member and community services. One case manager described her function as "assisting members in getting appropriate, cost-effective care in a timely fashion." Irrespective of their professional identification as a social worker, nurse, or rehabilitation counselor, all eight case managers responded by identifying job functions performed by professional case managers and not necessarily those of their individual professions.

The Case Management Unit used a social case management model staffed primarily with social workers. However, as the department expanded, it developed an interdisciplinary approach to case management by adding the other professional disciplines of nursing and rehabilitation counseling. All but one of the case managers interviewed felt that this interdisciplinary approach influenced what they did as case managers. The case managers generally felt that the collaboration and consultation among staff from different disciplines allowed them to become better informed and more efficient in decision-making.

There was a high level of comfort among the social workers that functioned within an interdisciplinary approach while utilizing their specialized discipline specific skills to address individual consumer needs. There were few value conflicts or professional conflicts observed or reported among Unit staff. Social work case managers reported performing similar functions to those used by social workers in the community setting (i.e., advocacy, counseling, coordination, brokering, program development). Generally, they did not view their telephone interventions with consumers and providers as problematic. According to all case management staff, providing services through community providers also appeared to work well when the consumer and provider had developed a good working relationship.

There were instances where case managers had to advocate for members' needs that were not covered by the health plan. Some of these advocacy efforts (such as a member needing supplies or medications) may have cost the health plan more in the short-run, but in the long-run was considered preventative and cost-effective.

tive in nature. Staff indicated that they were comfortable working within this corporate setting, and it appeared that they were well respected by other units throughout the managed care company.

As a profession, social work has been lukewarm regarding its role in providing services within corporate managed care settings primarily because of our unfamiliarity with managed care, lack of direct access to the managed care policymaking process, and the desire to adhere to the profession's ethics and values (Epstein & Aldredge, 2000). In contrast, case management staff within this Managed Care Organization possessed a clear understanding of the organization's role in providing health care delivery, their role as advocates and facilitators in securing necessary and appropriate services, and their potential to impact organizational policies and procedures that affected the overall health of consumers.

Benefits of interdisciplinary case management included the convergence of perspectives, more in-depth assessment, and a more holistic approach to service. None of the workers could identify any specific weaknesses with the interdisciplinary approach. One suggested that "the informal nature of their professional collaboration might need to be formalized in the future should the department grow significantly." When asked what other disciplines should be added to the Case Management Unit, all but one of the case managers suggested that additional staff should have a background in the area of developmental disabilities. Other suggested areas of expertise for new staff were in benefits and funding, early intervention and education, behavioral health, community outreach, home health, and rehabilitation and orthotics. One worker felt that until the needs of the growing membership could be determined, it was premature to anticipate what additional areas of expertise would be needed within the Case Management Unit.

Staff indicated their concern that communication among unit case managers might be challenged as additional professionals are added to the unit and new procedures for addressing larger numbers of high-risk populations emerge. Staff indicated that the interdisciplinary approach was well-integrated into daily operations of the Case Management Unit. Utilizing a quality improvement mechanism to address staffing loads, communication patterns, case management policies and procedures, documentation of case findings, and consumer outcome measures could enhance successful future growth of the Case Management Unit.

### **Consumer Satisfaction**

In general, members who participated in the focus groups were very positive about the health plan and the case management services they received. Members who interfaced with case management were much more favorable than those who had not. Indicative of the enthusiasm demonstrated by members who had interfaced with case management staff, some described the health plan as "Miracle Insurance" and a "Thank You Health Plan." Members who interfaced with case managers reported that the case manager listened and responded to their needs, remembered who they were, indicated genuine concern for their unique health concerns, had good communication skills, and were knowledgeable about resources. Members generally noted prompt follow-up by case managers following hospitalizations and member-initiated calls to the Unit. Of significant help was the

brokering role of case management, where case managers linked members to other health plan services, such as a high-risk maternity program, or to community agencies providing services for alcohol or drug problems, mental health issues, special needs children, and the like. Members noted the tangible services they received, such as assistance with alcohol rehabilitation assistance, transportation, rehabilitation therapies, maternity outreach assistance, medical equipment, information on available services, and coordination of services prior to and after hospitalization. They were particularly pleased that case managers understood their needs, were kind and respectful, and were resourceful. They acknowledged the efficient manner in which the Case Management Unit appeared to operate.

Some members who did not have direct contact with the health plan case managers did receive case management services from providers and vendors who served them following an illness or injury. Members of this group generally felt pleased with the services they received from the providers and vendors who assisted them in the home. These services, many of which were arranged by the case managers, included home health assistance with insulin training, high-risk pregnancy bed rest with home health and homemaker assistance, and orthotics with follow-up physical therapy. Generally, these members were pleased with the prompt arrangements for services, the effectiveness of the service, and the quality of the personnel providing the services. One member indicated that "I wouldn't change if I had the choice."

Although members were quite satisfied with case management services, both groups of members—those who had interfaced with case management and those who had not—provided suggestions for the improvement of services. Some suggestions that related to case management interventions included: assistance with prescriptions not covered under the health plan, education of procedures for emergency room visits and ambulance transport, assistance in obtaining respite help and parenting skills in dealing with challenged children, and assistance in locating providers within the health plan network for their unique family needs. Suggestions related to overall services provided both in the home and for follow-up of chronic conditions included: the need for information on continuity of care decisions, future involvement of the member in the decision-making process on services, education of procedures for emergency room visits, a desire to have one primary provider and not multiple providers at a PCP site, and referrals to specialists for chronic care problems.

## **CONCLUSIONS AND IMPLICATIONS**

The utilization of social workers within managed care organizations is a recent development. This case study represents an effort to describe this phenomenon. An exploratory-descriptive design permitted a broad assessment of social workers utilizing case management services at a specific health plan and demonstrated the perceived effectiveness of case management in delivering Medicaid HMO services to vulnerable high-risk populations. The findings of the semi-structured interviews, the focus groups, and the participant observation indicated that the use of case management services, delivered primarily by social workers, were effective in addressing bio-psychosocial needs of Medicaid consumers within a provider-driven managed care system.

This case study demonstrated that social workers utilizing case management skills are highly effective in a managed care organization, suggesting that other managed care organizations can employ social workers to improve the quality of services. However, individualized attention to client needs is essential to effective case management. In this case study, the interdisciplinary approach to the delivery of case management services maximized the capabilities and unique talents of personnel in the Case Management Unit. Other managed care organizations interested in emulating this model should consider having social workers at the core of such a unit. Successful delivery of case management services included formal linkages with community-based organizations that were maintained through ongoing quality assessment and improvement activities. Consequently, other managed care organizations employing this case management model would be wise to develop strong linkages and relationships with community-based organizations.

Social workers interested in seeking careers in managed care organizations need to garner specific skills for such practice. In studying the growth of managed care and its effect on the training of professional social workers, Strom-Gottfried (1997); Strom-Gottfried, et al. (1998); and Jarman-Rohde, McFall, Kolar, and Strom (1997) recommended additional training of social workers and social work students in managed care. Black (1997) identified several competencies for emerging professionals in managed care that will be needed within the near future. These include familiarity with the systems' perspective, familiarity with multidisciplinary teams both within and across organizations, computer literacy, data analysis skills, familiarity with management techniques, knowledge of case management, familiarity with epidemiological research techniques, and interpersonal skills that assist the consumer and the community (Black, 1997). Professional skills for practice need to be focused in three areas: basic professional skills, population-specific skills, and autonomy-building skills (New York Academy of Medicine, 2000). There may be a growing gap between the training given social work students and the real-life needs of health care consumers (CSWE, 1998; The New York Academy of Medicine, 2000). If so, emerging professionals will benefit from specific training on the actual mechanics of managed care systems and how they operate. Such specialized training might include coverage of health care delivery systems, health care policy issues and analysis, medical terminology, outcomes measurement research and program evaluation techniques, accountability techniques, development of individual treatment plans, and health promotion and disease prevention strategies. As social workers serve as both primary care providers and function in a variety of case management roles within managed care settings, a thorough understanding of the managed care environment is essential (National Association of Social Workers, 2000). In the future, case management will increasingly be applied to chronic disease care management (The Institute for the Future, 2000). Educators need to examine their curricula and field placement options to ascertain how they relate to the competencies and skills demanded from managed care organizations. Social work educators will need to enlighten policymakers on the state and local level of the value and need for professional social workers within managed care systems. Future health care delivery systems will provide new employment opportunities for social workers and other allied health professionals. As managed care systems employ a wide variety of disciplines and profession-

als to staff this growing field, research conducted with managed care systems will strengthen pre-employment training. On-site participant observation can be highly valuable in developing foundation knowledge about emerging service delivery environments such as managed care.

While much has been learned about the utilization of case management at a Medicaid managed care organization, a major limitation is that only one Case Management Unit at one Medicaid managed care organization was examined. Therefore, the findings of this case study are limited in their generalizability. Nonetheless, the implementation of a social case management model with high-risk populations may prove to be as effective in other locations where similar populations are served by managed care organizations committed to providing quality services.

A possible confounding factor in this study is that of social desirability. Even though the interviews with the case managers appeared to be balanced and objective, there may have been a bias with presenting information in a manner that would positively reflect upon the Case Management Unit and the health plan. Similarly, and perhaps even more of a factor could be the responses by the consumers in the focus groups. Historical recall of the services received was difficult for a few consumers, and some may have been reluctant to mention service delivery problems even though confidentiality was assured. Some consumers might have felt intimidated when participating in the study or even fearful of sharing any negative experiences. These factors could have contributed to the high regard that the consumers held for the Case Management Unit and the health plan. Nonetheless, the perceptions of the consumers allowed for an understanding of their basic health care needs. These perceptions provided a basis for understanding the primary impact of social work case management services upon high-risk consumers.

Subsequent replication of this study should be conducted in other Medicaid settings and in the private, commercial, managed care arena with larger populations. Such replication would be prudent in light of continued scrutiny of managed care arrangements by policymakers and consumer groups. Additionally, continued research and examination of best practices will assist stakeholders to modify and improve Medicaid managed care in order to safeguard particular populations. In particular, the delivery of social work case management to vulnerable high-risk populations should receive increased attention due to the aging of the population and the subsequent increase in related bio-psychosocial needs. This case study indicated high consumer satisfaction by high-risk populations with case management services. Further research is needed to ascertain future consumer satisfaction as more heterogeneous high-risk populations enroll in managed care arrangements. Research comparing customer satisfaction and health perceptions for those high-risk populations under traditional fee-for-service and Medicaid HMO arrangements would enlighten policymakers in addressing the challenging and unique needs of this population. Replication of this case study within other Medicaid HMOs serving similar high-risk populations in other states would be beneficial to policymakers as they implement mandatory managed care for Medicaid recipients as part of welfare reform initiatives.

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## Evaluating Kinship Care Alternatives: A Comparison of a Private Initiative to Traditional State Services

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**Abstract:** *Multiple stressors on the child welfare system have forced innovative solutions to the overburdened foster care program. A promising alternative is kinship care, in which children are placed with biological relatives. Proponents cite the opportunity to place the child in familiar surroundings, the natural access to additional family resources, and the degree to which it is sensitive to the norms and values of non-dominant cultural groups. Various models of kinship care have been implemented in several jurisdictions, yet little or no research has been done to determine which alternatives are the most effective. This paper addresses that deficit. It reports the results of a study that compares stability of placement outcomes between a program operated by a private, not-for-profit organization (n=60) and a more traditional program (n=79) operated by a state child welfare agency. Results support the use of the private alternative over the more traditional state-operated program.*

**Keywords:** *Kinship care, child welfare, foster care, at-risk children, children's services, placement*

The child welfare system in the United States has recently experienced a myriad of stressors. The number of children in care has skyrocketed, as has the number of children with special needs (Courtney, 1996; United States Department of Health and Human Services, 1996). Experts cite large numbers of children with special education or mental health issues (Chernoff, Combs-Orme, Risley-Curtiss & Heisler, 1994), an influx of substance-exposed infants (Ross, 1995), and children with serious health problems (Bilaver, Jaudes, Koepke & Goerge, 1999). Increasing numbers of minorities have entered the system (Scannapieco & Jackson, 1996), raising questions about the appropriateness of traditional programs. The system, never rich in resources, has been hard-pressed to respond.

Kinship care, the placement of at-risk children with biological relatives, has been lauded as a partial, yet effective response (National Adoption Information Clearinghouse [NAIC], 1997). Relatives provide a familiar, comfortable environ-

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ment, lessening the trauma children experience from forced relocation (Ingram, 1996). Family members may know of others who can help with transportation, supervision, or financial needs. Placement with relatives may help to address cultural issues, allowing the child to remain in a culturally similar environment (Child Welfare League of America, 1994). Perhaps most important to the overburdened system, a diligent search for relatives can help to generate placement alternatives, directing children away from the traditional system.

Kinship care is not a new concept. Children in need of protection have been removed from their homes and placed with relatives throughout the history of child welfare. What is new, however, are the kinds of resources directed to caregivers (Gleeson, 1999; Ingram, 1996). Some programs are exploring alternative management processes, such as family mediation (Scannapieco, 1999; Wilhelmus, 1998). Others use family meetings for decision-making and support long-term care as an alternative to adoption. Many offer a variety of new resources, such as financial assistance, caregiver support groups, and parenting courses (Scannapieco, 1999).

Despite the enthusiasm with which new approaches to kinship care have been greeted, few researchers have compared the effectiveness of various program alternatives. This paper reports the results of different outcomes of two kinship programs. Both operated in Davidson County, Tennessee (Nashville). One program, herein identified as "public," served children placed in the temporary custody of the Tennessee Department of Children's Services, which then encouraged relatives to provide care and seek permanent custody of the children. This program offered a more traditional style of supervision, including case management, emergency financial support, clothing, and transportation. The second program ("private") was operated by a partnership among three private agencies, the Court Appointed Special Advocate program (CASA), the Vanderbilt Legal Clinic, and Family and Children's Services. The privately sponsored Relative Caregiver Program offered the same basic services as did the public program, but also included a broader range of services, including linkage to CASA volunteers (provided by CASA), weekly support group meetings, therapeutic activity groups, family and individual counseling, educational training (provided by Family and Children's Services), and legal representation (provided by the Vanderbilt Legal Clinic).

## **LITERATURE REVIEW**

The kinship literature features a variety of publication types, including: 1) studies of children, caregivers, and biological parents, 2) program descriptions, and 3) outcome evaluations. Because of their value in conceptualizing this study, the literature in each of these categories is reviewed here. In addition, potential outcome variables are identified.

### **Descriptive Studies**

Several studies have examined the characteristics of children in relative care, their caregivers, and the parents whose children are placed with kin. Children's studies have focused on demographics, medical conditions, and behavioral or psychoso-

cial problems (Berrick, Barth, & Needell, 1994; Dubowitz, Tepper, Feigelman, Sawyer & Davidson, 1990; Gabel, 1992; Iglehart, 1994; Task Force on Permanency Planning for Foster Children [TFPPFC], 1990). Caregiver studies have reviewed demographics, commitment to caregiving, and willingness to comply with traditional permanency alternatives (Berrick, et al., 1994; Dubowitz, et al., 1990; Gabel, 1992; Iglehart, 1994; TFPPFC, 1990). Research regarding biological parents has been primarily limited to demographics (Berrick, et al., 1994; Dubowitz, et al., 1990; Gabel, 1992; Iglehart, 1994; TFPPFC, 1990; Thornton, 1991; Wulczyn & Goerge, 1990).

The mean age of children in kinship care is seven to eight years (Berrick, et al., 1994; Dubowitz, et al., 1990; Iglehart, 1994; TFPPFC, 1990). They are predominantly African-American (Berrick, et al., 1994; Iglehart, 1994). Distribution by gender appears to be equal (Berrick, et al., 1994; Dubowitz, et al., 1990). Most of the children are in custody due to neglect or parental substance abuse (Berrick, et al., 1994; Gabel, 1992; TFPPFC, 1990). Often, the substance abuse has resulted in pre-natal exposure for the child (Berrick, et al., 1994; Gabel, 1992; TFPPFC, 1990; Thornton, 1991).

Regarding psychosocial issues, conclusions have been inconsistent. In the area of physical health, Berrick, et al. (1994) found that most children were free from significant physical problems. Dubowitz, et al. (1992), however, found that only 10% of the children they studied were free from medical problems. Scannapieco, Hegar and McAlpine (1997) suggest that results may vary because of different sources of assessment data.

Several researchers have identified behavioral problems. Dubowitz, et al. (1990) found that 35 percent of the children in kinship care scored in the clinical range on the Child Behavior Checklist. Berrick, et al. (1994) concluded that children in relative care scored more than one standard deviation above the norm on the Behavior Problem Index. However, both Berrick, et al. (1994) and Iglehart (1994) found fewer problems among children in kinship care than among those in foster care. In school, 60 percent of the children in kinship care behaved satisfactorily (Berrick, et al., 1994; Dubowitz, et al., 1990; Iglehart, 1994), but between 36 and 50 percent performed below grade level in academic performance (Dubowitz, et al., 1990; Iglehart, 1994).

Caregivers have been primarily African-American, about 50 years old, and female (Berrick, et al., 1994; Dubowitz, et al., 1990; Gabel, 1992; TFPPFC, 1990). Most have been maternal grandmothers (over 50%) and aunts (up to 33%) (Dubowitz, et al., 1990; Gabel, 1992; TFPPFC, 1990; Thornton, 1991). Most have been single, and high school graduates (Berrick, et al., 1994; Dubowitz, et al., 1990; Gabel, 1992). Many were employed, yet lived at or below the poverty line (Berrick, et al., 1994; Dubowitz, et al., 1990). Regarding willingness to comply with child welfare goals, many caregivers were willing to provide long-term care (Berrick, et al., 1994; Dubowitz, et al., 1990; Thornton, 1991) but were reluctant to adopt or assume legal guardianship (Berrick, et al., 1994; Iglehart, 1994; Thornton, 1991).

Biological parents were predominantly African-American, with a mean age of 27 years. Their primary income was from income maintenance programs. Many could not be located when their children were taken into custody (Gabel, 1992;

TFFPFC, 1990). Although different reasons were cited for removal of children, the primary reason was neglect, often compounded by parental substance abuse (Berrick, et al., 1994; Gabel, 1992; Iglehart, 1994; Thornton, 1991; Wulczyn & Goerge, 1990).

### **Program Descriptions**

The literature regarding kinship program descriptions has been summarized by Scannapieco (1999). She identifies two categories of programs, one distinguished by funding source and a second defined by continuum of service. Similar typologies will be needed to facilitate outcome comparisons of models. Review of the current literature suggests at least four programmatic dimensions. They include: 1) formal vs. informal programs, 2) types and ranges of services, 3) identity of service providers, and 4) program goals and philosophies.

#### *Formal Versus Informal Programs*

Placement with relatives has long been an alternative. In some cases, placements have been arranged without court involvement or state supervision. These placements have been termed informal (NAIC, 1997). In other cases, children have been placed by court order, and ongoing state supervision has been mandated (NAIC, 1977). These arrangements are considered formal. Generally, when professionals refer to kinship care programs, they mean formal programs where judicial order and state responsibility are present.

#### *Types and Range of Services*

Programs offer a range of services. They may include a monthly stipend, case management, emergency financial relief, support groups, counseling services, parenting classes, educational services, and others (Wilson, 1999). For example, Scannapieco, et al. (1997) identified the services offered to Baltimore kinship homes as medical and mental health, education, transportation, in-home aid, housing, crisis intervention, and parent education. Service delivery models ranged from directive case management to mediation (Wilhelmus, 1998).

The variability of service availability among programs raises the question of the contribution of each to outcome. In multi-faceted interventions, it is critical to know which components are effective and which are ineffective. For example, stipends may enable families with limited resources to accept a child when it might not otherwise be possible. Similarly, programs that include support groups may help caregivers deal with stressors that might otherwise disrupt the placement.

#### *Identity of Service Providers*

Another important dimension is the identity of the service provider. In some programs, the primary service-delivery organization is a government agency. In others, it is private (Wilson, 1999). The primary agency may directly offer a broad range of services or may broker most services among a network of agencies. Similarly, some may provide the majority of services through a case manager, while others may serve primarily as a source of referrals.

### *Program Philosophies and Goals*

Program philosophies and goals differ among programs. Philosophical bases include family preservation, diversion from out-of-home care, or out-of-home care (Scannapieco, 1999; Scannapieco & Hegar, 1996). Goals may include reunification with parents, long-term placement with relatives, overall placement stability, preservation of family ties, adoption, independent living, reduction of the trauma generated by removal, and ongoing contact with the child's natural culture (Gleeson & Craig, 1994; Hegar, 1999; Ingram, 1996; Scannapieco, 1999).

### **Outcome Evaluations**

Few kinship outcome evaluations have been published. Most have defined success in terms of duration and stability of placement (Scannapieco, et al., 1997). These measures are closely related to program goals such as placement stability, preservation of family relationships, adoption, trauma reduction, and cultural sensitivity. Previous research has compared placement stability in kinship homes to that in traditional foster homes. Kinship placements have been more stable than traditional placements (Berrick, et al., 1994; Dubowitz, et al., 1990; Gabel, 1992; TFPPFC, 1990; Wulczyn & Goerge, 1990). The current researchers were unable to locate any studies reporting the results of outcomes between kinship care models.

Kinship care is likely to be a permanent child welfare strategy (Scannapieco, 1999). This makes comparisons between kinship and traditional programs far less relevant. In fact, Dubowitz (1994) observed that, "rather than asking whether kinship care is good or bad, the important policy-relevant question is what factors influence the success or failure of kinship placements" (p. 562). This suggests that future research should examine effectiveness among program alternatives as well as the elements of successful programs.

A single outcome study focused on quality of care. Berrick (1997) found that children in kinship settings were less safe than children in traditional settings (based on such factors as the presence of a first-aid kit, caretaker knowledge of CPR, and the physical environment of the home and community). However, kinship homes ranked higher in terms of both presence of and quality of a relationship with the mother.

### **Identification of Outcome Variables**

The literature suggests that a broad selection of outcome variables is relevant. Dimensions from which variables might be selected include: 1) characteristics of children (such as psychosocial functioning, quality of care [Berrick, 1997], medical and behavioral conditions [Bilaver, et al., 1999]); 2) conditions of the family (relationships [Berrick, 1997; Ingram, 1996], contact with biological parent [Berrick, 1997]); and 3) conditions of the placement (safety [Berrick, 1997], stability of placement [Berrick, 1997; Henry, 1999; Gleeson & Craig, 1994]). Ideally, evaluations should include a combination of these variables, but the nature of the data and sample size often inhibit choice. Stability of placement is itself a valuable measure, and may serve as a proxy for others, such as psychosocial functioning, quality of care, and family relationships. Evidence of its suitability as a proxy can be found in



studies that have shown placement disruption can have a negative effect on the psychological, emotional, and intellectual development of children (Ainsworth, Blehar, Waters & Wall, 1978; Fahlberg, 1979; Goldstein, Freud & Solnit, 1973; Verschueren, Marcoen & Schoefs, 1996).

## METHODOLOGY

### Sample

The data were abstracted from the private program files and Davidson County Juvenile Court records. Data collectors were trained in abstraction techniques and closely supervised to minimize the probability of problems with inter-rater reliability. Training techniques included: 1) a thorough review of the document containing the original data, 2) trial efforts in data collection using fabricated data, and 3) a discussion of how discrepancies in the original data should be handled. Supervisory techniques involved the presence of the same supervisor during each data collection period. The supervisor answered questions and reviewed random data collection forms for clarity and accuracy. Some inconsistencies may have existed in the way in which data were originally collected by workers from the private program or the juvenile court.

The sample consisted of 148 children between infancy and age 18. Nine children who had received services from both the *private* and the *public* programs were excluded from the analysis. Each of the participants represented a distinct kinship placement, that is, neither group's total included settings in which siblings were placed together in the home of a relative. Table 1 reports distribution by age for the 139 participants. Seventy-five (54%) were female and 64 (46%) were male (see Table 2). They were predominantly African-American ( $n=113$ , 81.3%), and included 23 Caucasians (16.5%), one Native American/Alaska Native (.7%), one who self-identified as Multi-racial (.7%), and one who self-identified as Other (.7%). Distribution by race is reported in Table 3. All were residents of the Metropolitan Davidson County (Nashville) area. The *private* group ( $n=79$ ) included all children who participated in the program between August, 1997 and February, 1999. The *public* group ( $n=60$ ) consisted of a randomly selected sample of children who received services from that program during the same period. Outcome data were collected through May 2000.

### Variable Selection, Research Design, and Hypothesis

Since randomization was not possible, the researchers selected three variables to determine group equivalency. Age, sex, and race were used for comparison. Age was continuous, including children from infancy to 18 years. Sex was, of course, dichotomous. Race was categorical, the categories having been determined by program documents. Categories included Asian, Native American or Alaska Native, Black, Hispanic, Hawaiian or Pacific Islander, Multiracial, Caucasian, and Other.

Positive outcome was defined as stability of placement. Stability of placement was defined as remaining consistently within the same home without permanent removal to an alternative setting. Disruption for any reason other than return to a biological parent was regarded as unsuccessful. The dependent variable was,

Table 1: <i>Distribution of the Sample by Age</i>						
Age	PRIVATE		PUBLIC		Total	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
1	3.8	3	1.7	1	2.9	4
2	6.3	5	6.7	4	6.5	9
3	6.3	5	3.3	2	5.0	7
4	5.1	4	1.7	1	3.6	5
5	1.3	1	11.7	7	5.8	8
6	5.1	4	5.0	3	5.0	7
7	8.9	7	5.0	3	7.2	10
8	6.3	5	6.7	4	6.5	9
9	11.4	9	11.7	7	11.5	16
10	10.1	8	11.7	7	10.8	15
11	11.4	9	10.0	6	10.8	15
12	1.3	1	6.7	4	3.6	5
13	10.1	8	0	0	5.8	8
14	7.6	6	10.0	6	8.6	12
15	5.1	4	1.7	1	3.6	5
16	0	0	5.0	3	2.2	3
17	0	0	0	0	0	0
18	0	0	1.7	1	.7	1
Total	100.0	79	100.0	60	100.0	139

Table 2: <i>Distribution of the Sample by Gender</i>						
	PRIVATE		PUBLIC		Total	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
Female	28.1	39	26.6	36	54	75
Male	28.1	40	17.3	24	46	64
Total	56.9	79	43.1	60	100.0	139

therefore, dichotomous, representing either continuous residence with the kinship caregiver or removal to a setting other than the biological parent. The independent variable was treatment, consisting of the categories *private* and *public*. A retrospective cohort design was used to test the hypothesis that children from the *private* group would experience greater stability of placement than those from the *public*.

**Statistical Method**

The groups were compared on three variables: age, sex, and race. Ages were compared using a *t*-test. Chi-square analysis was used for both sex and race. To compare outcomes between groups, placement stability was cross-tabulated with treatment and the hypothesis was tested using the chi-square distribution.

Table 3: *Distribution of the Sample by Race*

Race	PRIVATE		PUBLIC		Total	
Black	77.2	61	86.7	52	81.3	113
White	20.0	16	11.7	7	16.5	23
Native American	1.3	1	0	0	.7	1
Multiracial	1.3	1	0	0	.7	1
Other	0	0	1.3	1	.7	1
<b>Total</b>	<b>100.0</b>	<b>79</b>	<b>100.0</b>	<b>60</b>	<b>100.0</b>	<b>139</b>

RESULTS

Analysis of the demographic variables showed little indication of difference between the groups. The mean age of participants in the *private* (8.63 years) and the *public* groups (8.95 years) did not differ significantly and, perhaps more importantly, the squared point bi-serial correlation revealed that only .2% of the variance in age could be explained by group membership ( $t=-.456$ ,  $p=.649$ ,  $r_{pb}=.039$ ). No significant relationship between group membership and gender was observed and the relationship between these two variables was also quite weak ( $\chi^2=1.367$ ,  $p=.242$ ,  $\Phi=.100$ ). The groups also did not differ significantly by racial composition ( $\chi^2=1.889$ ,  $p=.169$ , Cramer's  $V=.118$ ). The sample was thus similar to those from other studies where children were seven to eight years old, evenly distributed between the genders, and predominantly African-American.

On the outcome placement stability variable, 69 of the 78 private participants (88.5%) remained in kinship care at the end of the study period. In comparison, 42 of the 54 *public* participants remained with relatives, a total of 77.8% (Table 4). Seven participants were excluded because of missing data. The results were significant at the .10 level ( $\chi^2=2.723$ ,  $p=.10$ ,  $\Phi=.144$ ).

Table 4: *Stability of Placement by Program*

	PRIVATE		PUBLIC	
	N	%	N	%
No Disruption	69	88.5	42	77.8
Disruption	9	11.5	12	22.2

$\chi^2 = 2.723$ ,  $p = .10$ ,  $\Phi = .144$

The  $p=.10$  alpha level was selected over the traditional  $p<.05$  criterion to offset the probability of a Type II error. Stevens (1999, p. 135) suggests that alpha levels of .10 or even .15 may be appropriate in certain contexts. As Stevens points out, small and medium effect sizes are very common in social science research. Failure to reject null hypotheses based on stringent alpha levels may thus dissuade researchers from engaging in inquiry in new areas of research that may ultimately prove fertile (Stevens, 1999, p. 126). As such, relatively liberal alpha levels are often appropriate for studies that represent initial inquiries into new research problems.

It is also instructive to consider the practical significance of this finding in the context of power versus risk reduction (Stevens, 1999, p. 135). Given that costs of the two programs under consideration in this study are similar, power should take precedence over the risk of falsely rejecting a null hypothesis. Rejecting a true null hypothesis would only lend support to a program of similar cost, which also produced a somewhat more positive outcome in the sample data. If, indeed, the more than 10% improvement is supported in future studies with larger samples, this could make an important difference for many children in state custody. In a group of 50,000 (not unrealistic to imagine in the future given today's escalating child welfare population), conditions for 5,000 would be improved. This suggests that proper program selection could have a substantial positive effect for thousands of children.

## DISCUSSION

This study supports the efficacy of the *private* over the *public* program. This suggests that child welfare practitioners should be actively involved in developing and evaluating kinship programs. Research should focus on outcomes between models and the elements of those models. For example, it may be that the weekly support groups offered to caregivers in the *private* program were critical to their ability to cope with stress and make effective family management decisions. Alternatively, it is likely that the legal consultation and representation offered by the program helped participants make sound decisions while navigating the court system, enhancing the probability of placement stability.

The success of kinship programs does not mean that practitioners should expect placement with a relative to ensure success. The programs in this study provide intensive, specialized support. These supportive conditions often do not exist where specialized programs are not in place. Although practitioners should always consider kinship placements, they should not assume results such as those in this study.

Practitioners should develop initiatives using models and concepts that have been effective elsewhere. Outcomes should be evaluated and results disseminated. Advocacy efforts will need to include special funding allocations, policy accommodations, and some restructuring of service delivery systems.

Researchers should conduct evaluations using larger samples, more sophisticated designs, more informative statistical methods, and more comprehensive variables that use higher levels of measurement. Additional questions need to be answered regarding family assessment techniques, referral patterns, service utilization patterns, and service delivery systems.

Protocols for program comparison should be developed and used across studies. An example would be a table of program characteristics that includes a typology such as the one suggested by Scannapieco (1999) and developed in this article. The table could serve as a basis for program comparison. An example, *Protocol for Model Comparison* (PMC), is included in Table 5.

The PMC illustrates program differences in the current study. In the first dimension, formality/informality, both programs are formal. The programs offer different services (dimension 2). One consists of state workers (*public*) and the other of private

employees (*private*) (dimension 3). Comparisons could not be made in the fourth dimension because one program lacked a clear statement of philosophy. Future studies could help to determine characteristics that are most crucial to outcome.

*Table 5: Protocol for Model Comparison*

- |   |
|---|
| <p>Dimension I- Formality/Informality</p> <p><input type="checkbox"/> Formal</p> <p><input type="checkbox"/> Informal</p> <p>Dimension II- Source of Funding</p> <p><input type="checkbox"/> Federal and state foster care funds</p> <p><input type="checkbox"/> State funds only</p> <p><input type="checkbox"/> TANF funds</p> <p><input type="checkbox"/> Other</p> <p>Dimension III- Types and Range of Services</p> <p><input type="checkbox"/> Monthly stipend</p> <p><input type="checkbox"/> Case management</p> <p><input type="checkbox"/> Emergency financial relief</p> <p><input type="checkbox"/> Support groups</p> <p><input type="checkbox"/> Counseling services</p> <p><input type="checkbox"/> Parenting classes</p> <p><input type="checkbox"/> Educational services</p> <p><input type="checkbox"/> Medical services</p> <p><input type="checkbox"/> Mental health services</p> <p><input type="checkbox"/> Education</p> <p><input type="checkbox"/> Transportation</p> <p><input type="checkbox"/> In-home aid, housing</p> <p><input type="checkbox"/> Crisis intervention</p> <p><input type="checkbox"/> Parent education</p> <p><input type="checkbox"/> Clothing</p> <p><input type="checkbox"/> Linkage to CASA volunteers</p> <p><input type="checkbox"/> Therapeutic activity groups for children</p> <p><input type="checkbox"/> Family and individual counseling</p> <p><input type="checkbox"/> Educational training</p> <p>Dimension IV- Identities of Service Providers</p> <p><input type="checkbox"/> Government agencies</p> <p><input type="checkbox"/> Private, not-for-profit</p> <p><input type="checkbox"/> Private, for profit</p> <p>Dimension V- Program Philosophies and Goals</p> <p>Philosophies</p> <p><input type="checkbox"/> Family preservation</p> <p><input type="checkbox"/> Diversion from out-of- home care</p> <p><input type="checkbox"/> Out-of-home care</p> <p>Goals</p> <p><input type="checkbox"/> Reunification with parents</p> <p><input type="checkbox"/> Long-term placement with relatives</p> <p><input type="checkbox"/> Overall placement stability</p> <p><input type="checkbox"/> Preservation of family ties</p> <p><input type="checkbox"/> Adoption</p> <p><input type="checkbox"/> Reduction of the trauma generated by removal</p> <p><input type="checkbox"/> Ongoing contact with the child's natural culture</p> |
|---|

## LIMITATIONS

The study was limited in a number of ways. It would have been desirable, for example, to include data from a traditional foster care group. Unfortunately, the structure of the record-keeping system between the juvenile court and the state child welfare department prevented the researchers from accessing foster care data.

Next, archival data limited the selection of variables and predetermined the level of measurement. This precluded the use of more complex statistical methods and restricted access to information that might have been available with higher levels of measurement.

Another limitation was the manner in which original data were collected. Study staff received extensive training to assure consistency in data collection. Various workers from different sources collected the original data, introducing the possibility of inter-rater reliability problems.

The outcome variable was also limited. The assumption that relocation of a child into a setting other than the care of a biological parent is detrimental may not be accurate. For example, a move to a more restrictive placement may be desirable when the services available are necessary to improve the child's condition. Furthermore, it cannot be assumed that return to the biological parents is always desirable.

A final limitation involved the referral process into the programs. Some children ( $n=3$ ) in the *public* program had originally been referred to the *private*, but either their families had elected not to participate, or the children were screened out because they failed to meet selection criteria. Criteria included a continuum of conditions, ranging from families showing no need for specialized intervention, to being in an extreme state of crisis. Depending on the number of children who did not participate in the *private* program for any of these reasons, outcomes might have been affected.

Despite the limitations of this study, it provides valuable information in an area characterized by its paucity, constituting a valuable foundation for future research. Different designs, such as experimental or single-subject, may provide additional insight into effectiveness. Future studies should use live data sources with levels of measurement chosen to provide optimal conditions. Researchers should use multiple outcome measures, including placement stability, psychosocial functioning, and family adjustment. Within the models of care, treatment integrity and patterns of service utilization should be examined. Differential effects should be considered among ethnic groups, genders, age groups, and groups of children with special needs.

## SUMMARY

Kinship care is a promising, although partial, response to the growing pressure on the child welfare system. Placing children with relatives can help to minimize the trauma of removal, maintain supportive family relationships, and preserve consistency of cultural experience. It is a desirable alternative for children, families, and child welfare providers.



There are various kinship care models, ranging from informal, unfunded arrangements to highly structured, well-funded interventions. Additional research is needed to identify effective models and their critical components. The current study supports the effectiveness of the *private* over the *public* program. These findings argue for continued research into program alternatives.

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## African-Americans and Clinical Trials Research: Recommendations for Client Engagement

Sharon E. Moore  
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**Abstract:** *African-Americans have, without their knowledge and consent, been used as human guinea pigs in scientific and medical experiments by private and governmental organizations. As a result many African-Americans approach the health care industry with caution and apprehension. African-Americans are admonished to remember the atrocities they once experienced and to approach participation in clinical studies with skepticism. This paper presents an historical overview of conspiracy theories, discusses various health issues that affect African-Americans, identifies for whom participation in clinical trials could prove beneficial, and recommends methods that can be used to attract African-American clients as active participants in clinical studies.*

**Keywords:** *African-Americans, conspiracy theories, clinical trials, research, patient rights*

Many African-Americans approach the health care industry and especially medical researchers with caution and apprehension. Reese and Ahern (1999) found that many African-Americans fear they will "end up being a guinea pig in one of their experiments" (p. 554). Various conspiracy theories contribute to their trepidation

Although not all of the common conspiracy theories are rooted in fact, some are. Perhaps the most notable of these violations of human dignity occurred during the Tuskegee Syphilis Study. During this United States Public Health Service sponsored experiment, 107 of the 400 men who were involved died because they went untreated, even though penicillin had been proven to be effective in curing the disease (Fairchild & Bayer, 1999). They had been lured to participate in the experiment under the promise that they would receive free medical care to cure a variety of medical ailments from which they suffered. Tuskegee is symbolic of unjust practices of the medical community, unethical practices in human research, and government mistreatment of African-American people. It has caused many African-Americans to be suspicious of the medical and public health authorities and is a major factor in low participation among African-Americans in human research (Gamble, 1997).

Another incident of unethical research involving African-Americans occurred in the 1970s. This well-publicized experiment was funded by the National Institute

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of Health. In that study, blood samples were taken without parental consent from 7,000 young, underprivileged boys from the Baltimore area. They thought they were being tested for anemia (Washington, 1994). In actuality, they were screened to determine who among them had an extra "Y" chromosome, under the assumption that individuals with an extra "Y" chromosome were foreseeable criminal types. Many of these young men were later labeled criminals. These are two of many examples of deceptive research practices that have contributed to the "healthy paranoia" that exists among many African-Americans. The term healthy paranoia refers to a positive defense mechanism use by African-Americans in recognizing that racism exists and that white people must be approached cautiously until they prove that they are trustworthy (Grier & Cobbs, 1968).

### **BELIEF IN CONSPIRACY THEORIES**

Many of these theories assert negative actions by the government against African-Americans. Turner (1993) indicates that theories of government conspiracy fall into two main categories: malicious intent, in which the government purposefully causes or increases social problems with African-Americans, and benign neglect, whereby the government takes a nonchalant attitude to addressing social problems. Other concerns focus on contamination theories that maintain that efforts are made to harm the health of African-Americans in various ways.

#### **Pervasiveness of Conspiracy Beliefs**

In a survey of 2,000 African American residents from Philadelphia and Charlotte, North Carolina, Turner and Darity (1973) found that up to 62% of the respondents believed that the U.S. government was trying to decrease the African American population. Parsons, Simmons, Shinhoster & Kilburn (1999) conducted the first comprehensive empirical study of the beliefs of African-Americans on a number of theories that asserted governmental wrong doings. They found that of the 1,104 African-Americans questioned, most believed in conspiracy theories, particularly those involving government plots that target African-Americans. More than half responded that the government directs genocidal efforts towards African-Americans. These beliefs are as common among African- American professionals as they are among nonprofessionals (Parsons, et al., 1999).

Among the common conspiracy theories held by African-Americans are that:

1. AIDS was developed by white scientists to be used as a form of African-American genocide (Parsons, et al., 1999).
2. The National Centers for Disease Control was involved in the Atlanta child murders as part of an experiment to extract the cancer drug interferon from the tops of Black boys' penises (Harris, 1996).
3. The Ku Klux Klan has economic ties to Troop Sportsweat, Church's Fried Chicken, and Tropical Fantasy fruit drink (Turner, 1993).
4. Illicit drugs are planted in the African-American community by the U.S. government for economic profit and as a form of racial genocide (Parsons, et al., 1999; McWhorter, 2000).

5. The U.S. government purposefully investigates African-American elected officials in an effort to discredit them "in a way it doesn't do with white officials" (Ruffins, 1998, p. 27).
6. Norplant implants are a mechanism to permanently sterilize African-American women (Turner, 1993).
7. The Sickle Cell Anemia screening program of the 1970s was a form of government directed genocide (Wilkinson, 1974).

### **The Development of Conspiracy Theories**

What is known about these theories is that they began in response to the racism and mistreatment that African-Americans suffered during slavery. The Tuskegee Study brought to light unethical research practices that had occurred for centuries.

During slavery, both slaves and free African-Americans were routinely exploited by the medical profession. Their bodies were often used without consent for dissections and medical experimentation (Savitt, 1982). Following emancipation, stories of "night doctors" were common in the African-American community. Night doctor was the term applied to medical students who allegedly stole cadavers for training purposes and to professional thieves who sold living and dead African-Americans to doctors who used them for medical research. In 1882, it was exposed that African-American cemeteries were frequently pillaged by grave robbers who later sold the corpses to Philadelphia medical schools (Thomas & Quinn, 1993).

Hence, conspiracy theories have become a part of the collective consciousness of African-Americans and have been orally passed down through the informal grapevine for generations. Many African-Americans believe that they are targeted for human experimentation because of their race. Subsequently, many African-Americans understandably approach the medical community with considerable apprehension. Belief in these theories is not necessarily pathological. Indeed, they may serve to solidify the community and move it toward social action. Being encouraged to approach participation in research with skepticism and as a conscientious consumer is positive because it is empowering. Alternatively, a negative consequence of this belief system is that African-Americans do not benefit from legitimate research in areas such as mental health and medicine (Dhooper & Moore, 2000).

Due in part to conspiracy beliefs, many African-Americans delay or postpone seeking medical treatment, which often has dire consequences for them. Numerous health problems disproportionately affect African-Americans. Effective treatment strategies for many of these conditions could be developed through clinical trials research that included African-American participants.

### **HEALTH PROBLEMS AND AFRICAN-AMERICANS**

There are approximately 35.5 million African-Americans. They represent about 13% of the United States population (U.S. Bureau of the Census, 2001). On average, African-Americans live six fewer years than whites (Thompson & Chambers, 2000). Nearly 75 million of all Americans aged 12 and above report using illegal drugs at least once during their lifetimes (National Institute of Drug Abuse, 1998). Approximately 10% of these are African American. However, African-Americans make up approximately

36% of U.S. citizens who are drug dependent (National Institute of Drug Abuse, 1998). African-American women, more than others, have disproportionately higher rates of death from diabetes, cancer, cardiovascular diseases, and breast cancer. They are also more likely to struggle with substance abuse, addiction, HIV, and AIDS. AIDS is now the leading cause of death among African-American women between the ages of 25 and 44 years, representing a rate that is 12 times higher than that of their white counterparts (Kumanyika, Morssink & Nestle, 2001; Phillips, 1997,). Generally, when they do present themselves for treatment, they are in more advanced stages of the disease and have more symptoms. Cultural beliefs, such as conspiracy theories, coupled with socioeconomic variables are responsible for late diagnosis (Kumanyika, Morssink & Nestle, 2001; Raveis & Siegel, 1998).

### **Gender Specific Problems**

African American men are 76 times more likely than white men to die of a stroke related to high blood pressure (Dwyer, 1995). They have more problems with physical mobility after age 65 due to chronic diseases and have a 50% higher rate of prostate cancer than white males (Herbert, Hurley, Olendzki, Teas, et al., 1998; Thompson & Chambers, 2000). There are 2.8 million African-Americans over the age of 65 (U.S. Bureau of the Census, 2000). Although African-American elderly are living longer, they are more likely to be infirm, have chronic diseases at earlier ages, and be more physically limited in these illnesses (Allen-Kelsey, 1998).

Clinical trials are vital in health research and the development of medical knowledge. They are the measure by which new therapies are investigated. "They allow investigators to test biological hypothesis in living patients and they have the potential to change the standards of care" (Davidoff, et al., 2001, p. 854). Before 1994, most studies on the health of Americans conducted through academic medical facilities using human subjects that were middle-class, white male, or married. African-Americans were only minimally represented in these studies (Flaskerud & Nyamathi, 2000). When they did participate, they were sometimes injected with cancerous cells and cancer-producing substances, subjected to lobotomies, or injected with hazardous materials (Dhooper & Moore, 2000). As a result of limited, homogenous samples, research findings were sometimes erroneously generalized to the entire population without considering that cultural variables are important in diagnosing and treating health-related disorders in minority populations. Additionally, African-Americans are more susceptible to an increase in mortality and a decrease in quality of life when they are not included in health-intervention research. Current controls that exist to minimize past abuses include the National Research Act of 1974, which was passed after the Tuskegee study became public. This legislation established guidelines whereby all federally-funded research that involves human subjects requires prior approval from an institutional review board and a data monitoring committee that expeditiously identifies evidence of benefit or harm to research participants (Lilford, Braunholtz, Edwards & Stevens, 2001). Other controls include the development of the Patient's Bill of Rights and the establishment of the National Institute of Health's Office of Research on Minority Health in 1990. The office of Research on Minority Health oversees biomedical and behavioral research on underrepresented minorities (Helmuth, 2000). Even though these controls are in place, African-Americans are still underrepresented

in clinical trials. What follows are suggestions for ways in which African-Americans can be encouraged to participate in clinical research activities.

### **PRESCRIPTIONS AND IMPLICATIONS FOR RESEARCH**

Lack of information, fear of experimentation, lack of familiarity with bureaucratic institutions, illiteracy, caregiver obligations, language barriers, and lack of benefits are several hindrances to research participation (Napoles-Springer, Grumbach, Alexander & Moreno-John, 2000). The question that begs an answer is how can medical, public health, and social science researchers attract African-American volunteers to participate in research studies. Burrus, Liburd, and Burroughs (1998) document several strategies that can be useful in targeting and increasing African-Americans participation in future public health research. They suggest 1) hiring a community organizer; 2) establishing a community advisory board; 3) soliciting community input; 4) scheduling public meetings for formal and informal question and answer sessions; 5) involving key African American personalities; and 6) including the black church.

Furthermore, they suggest approaches which can be used to eliminate barriers to participation and enhance trust among African-American research volunteers. Those approaches focus on: 1) community engagement; 2) explanations of the "why" and the "what"; 3) purposeful community relationships; and 4) non-traditional, culturally sensitive communications. What follows is a discussion of how these approaches can be implemented.

#### **Community Engagement**

One strategy that can be used to maximize medical research participation among African-Americans focuses on a model of community partnerships, which can be reflective of community needs, perspectives, and health priorities (Napoles-Springer, et al., 2000). There is agreement that community support is paramount in establishing credibility among researchers and minority groups (Hatchett, Holmes, Duran & Davis, 2000; Mastin, 2000; Witte, Berkowitz, Lillie & Cameron, 1998).

Burrus, et al. (1998) discuss the importance of informing the community about the proposed research to solicit their input. Hiring a well-known and respected African-American health educator is another significant factor in organizing. Equally important is the organizing of a community advisory board to serve as overseers for the community. Its purpose is to question the process and to ensure that the community will not be exploited. The advisory board provides the research team with easier entry into the African-American community and reduces what can be a time intensive process. Additionally, if at all possible, the research should be conducted in either the participants' community or an environment where they are most at ease. Furthermore, African-American recruiters or representatives who understand the task and can communicate the interest of both parties should be utilized.

The Black church is still the primary place where African-Americans congregate to address cultural, economic, and social issues. The impact and important role of the Black church in garnering and portraying the positive energy of African-American families is also recognized by Mastin (2000) in her study of media use and civic participation in the African-American population. She wrote:



The community church has long served as a facilitator of political action for African-Americans. The African-American church enjoys a historical reputation of working to improve members' socioeconomic and political conditions. Unlike many social organizations that draw attention to social differences, often excluding individuals based on economic differences, many Black churches do a good job of minimizing such differences. In short, the African-American church has been able to facilitate civic and political involvement among the economically diverse groups in the African-American community. (p. 117)

In essence, Mastin's (2000) findings clearly indicate that interpersonal relationships and church involvement are strong predictors of civic participation among African-Americans. This finding strongly suggests that including the Black church as a key player in significant community events is a well-conceived strategic move for researchers. Researchers have successfully approached African-American churches that have large memberships, to aid them in their mission to solicit African-American representation in public health studies (Burrus, et al., 1998; Hatchett, et al., 2000). However, researchers' recruitment efforts must be more than superficial to maximize the availability of the church as a resource. It is not enough to make an announcement and request help. Rather, individuals must be contacted and actively encouraged to participate (Hatchett, et al., 2000).

Additionally, onsite informational meetings should be held with representatives of the church to explain the goals and objectives of the study and to answer questions. Researchers would be wise to show sensitivity and take special care to address all questions to the satisfaction of potential participants with honest and forthright details. Schoen (1999) proposes "Giving investigators an opportunity to discuss their work with the public, through media interviews and community speaking engagements, can motivate them to become more personally involved in the product's trial, proving a compelling reason to prioritize it" (p. 52).

Another recommendation is to work closely with various community facilitators who have real and perceived positions of trust. These individuals can be recruited to encourage and lend an active voice for participation in research efforts. Given their high visibility within the African-American community, their collaboration with the research team may serve to enhance the validity of the study and heighten awareness regarding the importance of the study. In essence, they convey a seal of approval (Hatchett, et al., 2000).

Rather than researchers representing themselves as the community authority, the power of "knowing" is maximized when shifted to the people. An often overlooked fact is that African-Americans are weary of people who propose to know what is best for them (Hatchett, et al., 2000). Within the African-American community are resources, insights, and knowledge that are unknown to social science professionals (Saleeb, 1996). In defining the role of "expert" or "professional," Saleeb (1996) indicates that "a helper may best be identified as a collaborator or consultant: an individual clearly presumed, because of specialized education and experience, to know some things and to have some tools at ready but definitely not the only one in the situation to have relevant, even esoteric knowledge and understanding" (p.14). Rather than operate from concealed and predetermined agen-

das, researchers should consider a paradigm shift that allows African-Americans to define their needs and health priorities. The community engagement model utilizes a "village" approach to inquiry and problem solving.

### **Explaining the "Why" and the "What"**

Medical research campaigns must provide clear and understandable information to potential participants. Because of past experiences, African-Americans often feel justified in their negative perceptions and feelings of unfair treatment. Therefore, participants must clearly and truthfully be told the "why" as well as the "what" of their involvement in all verbal and written presentations. Croyle (1998) advises that researchers "make sure that what subjects are being told is consistent across the trial's stages—recruitment, consent and education, randomization and intervention—and across trial staff members" (p. 495). Research participants who received limited information decreased their participation. Conversely, when researchers provided people with detailed information concerning the nature of the research, the benefits, and research opportunities, recruitment results in ethnic populations were enhanced (Napoles-Springer, et al., 2000).

Target advertisements placed in newspapers and publications to recruit participants often emphasize the benefits of the trials without mentioning the risks. This is an identified concern and may raise questions about participants' level of understanding regarding what they are reading and subsequently signing. "Cash payments and other incentives are commonplace in medical research. But they are offered as compensation for a person's time, not as a fee for accepting risk. When you see an emphasis on cash payments and benefits, and little or no mention of risks, that's a real concern" (Weiss, 1998, p.A05). Napoles-Springer, et al. (2000) found that respondents sometimes subjected themselves to potentially harmful research and exploitation out of their dire need for money.

According to Napoles-Springer, et al. (2000) African-Americans greatly value scientific knowledge that will improve their quality of life. Additionally, if concerns are openly addressed, barriers to participation are reduced, and if tangible benefits of participation could be accrued by their communities, their interest in scientific knowledge will likely increase. Hatchett, et al. (2000) found that the failure of African-Americans to participate in research was not solely due to the legacy of the Tuskegee experiment but because they were not approached to be involved. Some African-Americans feel that researchers take information and ideas about African-Americans out to the majority community without caring that those under study receive any significant or substantial benefit. In essence, some African-Americans feel that they are exploited or that researchers do not give back to their community (Napoles-Springer, et al., 2000). The willingness of African-Americans to participate in research seems strongly linked to whether or not the research has positive benefits and if participants are informed of the outcomes.

### **Purposeful Community Relationships**

Leo J. O'Donovan (1998) describes trust as "being vulnerable and taking a risk—a leap of confidence—sometimes without any evidence that you will land on your feet" (p. 178). He emphasizes that the heart of a professional relationship is trust. For example, "We trust scientists and researchers will give us the right information

as we care for our aging bodies. We don't question how exactly Tylenol or the Inderol we take works; we trust the medication to work—we trust the science behind it" (p. 180). Yet, the biggest obstacle to clinical trial recruitment is public wariness (Schoen, 1999). Participants need researchers that are reliable and trustworthy. A paradigm shift in public health and medical research necessitates that research volunteers are informed of the true state of their health and given full explanations about the benefits or dangers of any research intervention (Jennings, 1998). Only then can researchers begin to engender trust and recruit African-American participants. Mistrust is real and it is serious. Ar'ean and Gallagher-Thompson (cited in Hatchett, et al., 2000, p. 667) found that during recruitment efforts with older minority adults, "researchers' willingness to address specific topics of interests created an attitude of trust."

### **Informed Consent**

Informed consent is, of course, related to the issue of trust. Bioethicist Arthur L. Caplan suggests that informed consent represents a moral challenge to researchers. Research participants should always have access to second opinions from experts who do not stand to gain from the outcome of the study (Jennings, 1998). The National Association of Social Workers' *Code of Ethics* addresses informed consent by prescribing that clients must be informed in clear and understandable language regarding purpose, risks, and limits of services, relevant costs, alternative to treatment, and the right to ask questions or to refuse or withdraw their consent for treatment (Linzer, 1999; NASW, 1996, 1.03).

Informed consent originated in the medical field as a mechanism for patients to receive detailed and pertinent information about medical procedures and their potential benefits and risks (Dunn, 2000; Linzer, 1999). Linzer (1999) indicates that social work practice includes a burden for informed consent that extends far beyond superficial efforts. Informed consent extends beyond obtaining signed release forms granting access to confidential information (Kutchins, 1991). This legal and ethical duty entails providing clients with full disclosure relative to all service or treatment areas, which can have an impact on the client's right to voluntarily participate or decline participation.

Therefore, it cannot be assumed that participants have given their full consent to participate in research studies until they receive full disclosure of all relevant information related to their participation. In cases where volunteers need support or assurance, Croyle (1998) advises involving family members in the informed consent process and recommends strategies for clarity in the consent process including the use of:

1. various font sizes, subheadings, and bullets in the consent form instead of long unbroken text;
2. printed materials as a backup, but with preference given to oral and aural communications to explain information; or
3. CD-ROM or audio tape presentations with the information to enhance volunteer understanding (p. 495).

### **Non-Traditional Culturally Sensitive Communications**

Traditional generic approaches to the promotion of medical research projects often prove to be ineffective (Mastin, 2000). Empirical evidence suggests that those with lower socioeconomic status and ethnically diverse populations appear to respond less to traditional recruitment methods (Mastin, 2000; Napoles-Springer, et al., 2000; Witte, et al., 1998). Non-traditional, culturally-sensitive communications that include the use of interpersonal networks (such as social gathering places, the Black church, neighborhood organizations, beauty salons, barber-shops) and African-American celebrities to bring important public health information to the African-American community should be adopted (Mastin, 2000; Napoles-Springer, et al., 2000; Witte, et al., 1998).

In an effort to protect billions of investment dollars slated for new drugs, pharmaceutical companies are scrambling to recruit clinical participants for drug trials. Many of the newer drugs will offer cures for or better management of conditions such as high blood pressure, diabetes, AIDS, cancer, and cardiovascular disease. To shift the negative perception about clinical trials, the pharmaceutical industry must recognize the need for relevant community campaigns. Schoen (1999) indicates, "With all the pressure to implement trials and submit results quickly, companies sometimes treat effective communications as an after-thought, rather than a key strategic tool" (p. 51). Schoen further suggests providing videos, brochures, and other information to clinical sites in order to raise the level of awareness among African-Americans about disease.

The readability of written materials may also affect recruitment. Volunteers are not likely to risk embarrassment if they are semi-literate. Rather than succumb to shame and humiliation, it is sometimes a natural response to decline involvement in an activity in order to save face. Advertisements and other forms of promotional communications such as brochures, pamphlets, posters, letters, flyers, and banners have been proven more effective when written at fifth or sixth grade literacy levels (Burrus, et al., 1998). According to Fackelmann (1998), "about 90 million adults in the United States have literacy skills ranking below 7<sup>th</sup> grade" (p. 15). Therefore, the readability level of written communication is an important consideration.

### **SUMMARY OF RECOMMENDATIONS**

Participation in research efforts by African-American populations may be enhanced through a strengths-based and empowerment framework (Blundo, 2001; Brun & Rapp, 2001; Early, 2001; Saleebey, 1996; Turner, 2001). The strengths-based perspective is an empowerment approach that focuses on the strengths of individuals, families, and communities, rather than problems or pathology. Saleebey (1996) points out that the strengths approach requires an accounting of what people know and what they can do (p. 297). In a strengths approach, practitioners must engage individuals, families, and communities as equals. "They must be willing to meet clients eye to eye and to engage in dialogue and a mutual sharing of knowledge, tools, concerns, aspirations, and respect" (p. 303). Saleebey's perspective provides an explanatory framework that highlights that when communities are provided with information, resources, and support, helpers as well as community residents are likely to benefit. The principles that Saleebey (1996) believes

particularly important to the strengths/empowerment perspective are: 1) language—the practice of using words to elevate or to lift and inspire; 2) empowerment—the process of assisting people to discover and to use the resources and tools within and around them; 3) resilience—the recognition that in spite of adversity, people accumulate skills, abilities, knowledge, and insight; 4) membership—the idea of valuing individuals as part of a viable group or community; 5) health and wellness—the belief that people's innate resilience and knowledge can be used to help them overcome trauma and embrace community vitality; and 6) beliefs and emotions—the concept that personal health and emotions in the context of daily living can transcend to community health.

### **RECOMMENDATIONS FOR CLIENT ENGAGEMENT**

A strengths-based empowerment perspective may be used as a foundation for researchers who hope to engage African-Americans in clinical trials or public health research. Recommended strategies include the following:

1. Approach African-Americans from an empowerment perspective, believing that they can provide and interpret relevant information about their needs and priorities and can offer their expertise to researchers.
2. Assume that African-Americans want to be included in relevant research and that because of the unequal distribution of power, opportunities, rights, and responsibilities, their voices often go unheard.
3. Convey a sense of reciprocity. Expect to receive ideas and cooperation and also expect to give something of value back to the community (e.g., briefings regarding the research outcomes, an ongoing community presence, donations to related causes, technical or professional assistance with identified concerns or requests for specific help, and so forth). In other words, avoid a one-way dynamic and being invisible until something is needed.
4. Honor the fiduciary relations. On a continuous basis, inform potential research volunteers of specific risks and benefits.
5. Protect research volunteers. It is imperative that researchers are reliable and trustworthy.
6. Increase the visibility of African-American researchers as well as African-American personalities within the community in all phases of research.
7. Create public forums within the African-American community in familiar and comfortable environments, where honest dialog about the nature of the research can occur.
8. Include representatives of the religious community in significant ways.
9. Maintain candid and regular dialogue and a willingness to listen to, instruct, and reassure participants.
10. Ensure that all written communications are compatible with the educational level of the participants.

11. Identify places within the African-American community (such as churches, laundromats, beauty salons, barbershops, and social organizations) that would be promising places to recruit, distribute information, and educate the community about research campaigns.

### **IMPLICATIONS FOR SOCIAL WORK EDUCATION**

The strengths-based empowerment perspective has implications and application for a broad range of professionals, including social work educators. "Historically, the social sciences, which includes the profession of social work, have negatively stereotyped African-Americans and most American social institutions have related to African-Americans from a white Anglo middle-class orientation" (Dhooper & Moore, 2001, p. 123). Additionally, traditional social work curriculum has focused on disempowerment, deficits (problem focus), individual disorders, and/or pathology (Blundo, 2001; Saleeby, 1997). Similarly, a large percentage of agency field practicums followed a diagnosis and problem-focused orientation. The medical or pathology model was therefore reinforced for students in schools and in agency settings. The shift towards embracing clients' strengths, individually and collectively, means acknowledging that clients' are the best authorities in defining their tribulations. This is a transformational evolvement in social work education and practice. As social workers assist individuals and communities, they are challenged to use conceptual lenses that allow them to visualize people's hopes and dreams, based on their assets and strengths. Brueggemann (2002) asserts that:

People who experience injustice, intolerance, or economic or political oppression need to define their own issues on their own terms, regardless of the size of their group, their influence, their perception, or the approval of the majority of the population. When the influential usurp their right, they not only steal people's humanity but assume that people in the mass are incapable of understanding their own social situation; they exclude people from the process of making their own lives better. (p.43)

Blundo (2001) underscores this point of view and asserts that "the strengths perspective offers the profession an opportunity to change frames and to collaborate with individuals, families, and communities in a more egalitarian working relationship based upon their strengths and resilience" (p. 301). In social work practice, the use of the strengths and empowerment perspective with families can aid practitioners in identifying strengths to build on. They also increase their ability to gain knowledge regarding desired outcomes and clarity regarding what families want to achieve and under what conditions. This model relegates the "expert" from the position of "all-knowing" to a more equal position of partnering. Clients are positioned to share power, which permits them to demonstrate their strengths and resilience in a collaborative environment. In essence, this framework then prepares social workers to teach and to be taught.

### **CONCLUSION**

The inadequate participation of African-Americans in research studies suggests implications that may negatively impact the understanding of health and social

factors among this population. The challenge for researchers is to be more aware of how socioeconomic factors and racism may discourage African-Americans from participating in valuable research. In particular, social scientists need to be aware that fear, past medical and government practices, mistrust, and a lack of knowledge about bureaucratic practices are primary reasons that African-Americans do not participate in research studies. Equally important is an understanding that mistrust of research is pervasive among African-Americans. Therefore, it seems reasonable to suggest that more concerted efforts to engage minority researchers, to address perceived and real barriers, and to improve awareness of racial and ethnic disparities would increase the level of African American participants in legitimate research studies. A strengths-based and empowerment approach allows individuals, families, communities, researchers, and other "helpers" to become co-participants with African-Americans to discover the power within themselves and to develop consensus in working as change agents.

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## Service Learning as a Transition into Foundation Field

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**Abstract:** *Service learning is a pedagogical method to bridge classroom and community experiences for students. Although social work education has historically emphasized this connection through internship experiences, service learning can fill a different function within the curriculum. This article proposes a service learning experience to assist graduate students with the transition into their foundation field placement. Beneficial outcomes of using service learning as an educational bridge are discussed for students, faculty, and the social work program.*

**Keywords:** *Service learning, social work education, curriculum, field practicum, community service*

During the last 10 years, colleges and universities have become more involved in providing students with opportunities for community service. Service learning is a type of community service that is designed to promote student education and development, along with promoting community goals (Gray, Ondaatje & Zakaras, 1999). In the 15 years since its initiation into educational institutions, faculty across disciplines (e.g., humanities, business, social and natural sciences) have started to include service learning projects in their courses as a way to bridge academic and experiential learning.

This article proposes service learning as a way to assist graduate students with the transition into foundation internships. The use of community experience is certainly not a new phenomenon in social work education, as the curriculum at both the baccalaureate and graduate levels involves extensive practicum experience. In fact, Jane Addams is credited with being one of the early proponents of "promoting learning by community service" which is the underlying premise of service learning (Morton & Troppe, 1996). Yet, service learning is largely absent in social work, as faculty seem to mistakenly perceive that internships and service learning serve the same purpose in the curriculum. Service learning can fill a different function and can be structured to complement a field program by preparing students for their initial social work practicum. Service learning serves to bridge practice and academic experiences by having students "learn while doing" in real community settings and functions as a transition into the foundation internship.

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## OVERVIEW OF SERVICE LEARNING

### History and Development

In the mid-1980s, faculty and administrators were increasingly concerned about the lack of civic mindedness within higher education. In 1985, presidents from Brown, Georgetown, Stanford universities, and the Educational Commission of the United States signed the College Compact to promote community service for students and provide national leadership in bringing together universities with their communities. The College Compact was based on the principle that students would willingly become involved and support their communities if they were given the opportunity (Kraft, 1996). By the mid-1990s, almost 1000 colleges and universities participated in some form of campus—community service partnerships (Cohen & Kinsey, 1994).

Statistics suggest that service learning has become an integral part of many school- and campus-based curricula. Current estimates indicate that about two million students participate in service-learning projects at four-year public and private institutions (Shumer & Cook, 1999). In addition, many students enter college having experienced service learning in their secondary education. Currently, the number of high school students involved in service learning is almost three million, with an additional 2.5 million middle school students involved in community projects. A boost for service learning was achieved in 1993 with the establishment of the National and Community Trust Act of 1993, which established 20,000 positions through the Americorps National Service and the national Learn and Serve America programs (Brandell & Hinck, 1997). Since the time that the College Compact was signed, the number of students involved in service learning has grown 3663% (Shumer & Cook, 1999)!

### Definitions

Although service learning was started to promote civic responsibility, it moves beyond the concept of volunteerism. As McCarthy and Tucker (1999) state, "Service learning is not volunteerism; it delivers on the learning objectives of the course (for which the student has contracted) via community service activity just as an exam or paper does" (p. 555). Likewise, service learning is not identical to an internship experience. Furco (1996) offers a useful typology of different kinds of experiential education based upon two dimensions: *intended beneficiary* of the service activity, and *degree of emphasis* on service or learning.

- **Volunteerism** engages students in activities where the primary emphasis is on service provided, and the intended beneficiary is clearly the service recipient. Examples are a friendly visiting program to a nursing home or being an activity leader in a recreational center for teenagers.
- **Community service** involves students in activities that primarily focus on service provided, with some defined benefit for the student. An example is having students provide a meal to the homeless population during the holidays. As a result of this activity, students receive some benefit by learning more about how this project makes a difference in the lives of homeless individuals.

- *Internships* require that students become engaged in activities primarily to obtain hands-on experiences to enhance learning or skill development. In social work, the internship typically involves a close relationship with an agency supervisor, structured objectives, and assignments.
- *Service learning* equally focuses on benefits for the service provider (the student) and the service recipient. Process and outcome are equally important in service learning projects.

While this typology is useful in discriminating among different instructional experiences, it does not yield a clear and precise definition of service learning. Multiple definitions exist. They stress various components of the service and learning dimensions. Some authors describe service learning in educational terms such as "structured learning" (Burns, 1998) or as involving reflection to further the understanding of course content and the discipline (Bringle & Hatcher, 1996; McCarthy & Tucker, 1999). Other definitions stress the connection to the community such as being a method to "participate in organized service activities to meet community needs" (Brandell & Hinck, 1997) or the opportunity to "engage students in real life experiences" (Morton & Troppe, 1996). The most widely accepted definition, however, appears to be based upon the National and Community Service Act of 1990. This conception includes these four dimensions of service learning:

- Students learn and develop through participation in organized experiences that meet actual community needs and are coordinated in collaboration with school and community;
- The program is integrated into the academic curriculum and provides structured time to think, discuss, or write about their experiences;
- Students are provided with opportunities to use their newly acquired skills and knowledge in real-life situations in their own communities; and
- Experiences enhance what is taught by extending learning beyond the classroom into the community, which fosters development of a sense of caring.

### **SERVICE LEARNING OUTCOMES**

Impacts of service learning have been identified for students, faculty, and communities. Students appear to develop both personally and professionally from involvement in service learning experiences. Service learning is also beneficial to faculty, who tend to become more involved in relevant community issues and learn along with their students. In addition, communities are enhanced by increased numbers of individuals involved in programs, and also benefit from resources associated with college and university settings.

Several studies on student outcomes in higher education have identified positive psychological, cognitive, and social results from service learning. Students in service learning courses have an increased sense of self-esteem (Conrad & Hedin, 1982; Hedin, 1989), and a sense of empowerment in promoting social change (Boss, 1994; Giles & Eyler, 1994; Miller, 1994). In addition, cognitive gains such as enhanced creative problem solving have also been reported (Batchelder & Root,

1994; Markus, Howard & King, 1993), enhanced ability to apply concepts to real life issues (McClusky-Fawcett & Green, 1992), and increased motivation to learn (Berson & Younkin, 1997). Gains were also reported in students' ability to empathize with individuals who are experiencing social problems (Forte, 1997; Nnakwe, 1999). These outcomes are beneficial for students in any discipline, but are specifically related to program outcomes in social work education.

Although faculty often benefit from service learning experiences, they may initially be reluctant to engage in service learning due to their perception that students will not be committed to projects or will fail to carry out assigned tasks (McCarthy & Tucker, 1999). However, the opposite appears to be the norm. In a study carried out by the RAND Corporation, students in higher education were surveyed about their experiences with service learning. Those enrolled in service learning courses reported more satisfaction by rating their classes as above average more frequently (72% compared to 47%) than their cohorts who were in courses that did not include service learning assignments (Gray, et al., 1999). Faculty report that their service learning students are eager to learn and demonstrate more defined skills in analysis and application of content (Hesser, 1995).

Communities also benefit from partnerships with academic programs. Since service learning is equally focused on education and the provision of community service (Furco, 1996), programs receive additional personnel and support. In 1997, for example, approximately 1,650 hours of service were, on average, generated for each service learning project (Gray, et al., 1999). In another evaluation of impact, 300 service learning projects were initiated from 17 sites that provided more than 150,000 hours of service (Center for Human Resources, 1999). The added resources allow communities to pilot innovative or novel approaches without over extending or sacrificing resources. In addition, service learning ventures provide an impetus for expanding collaborations between the academic and service communities. Possible outcomes of service learning partnerships include generation of grant proposals, stimulation of additional internship sites for students, and jointly authored publications.

### **SERVICE LEARNING AS A TRANSITION INTO FOUNDATION INTERNSHIPS**

In spite of the positive outcomes associated with service learning, there has been little attempt to integrate this instructional method into the social work curriculum. A notable exception is a service learning project for social work students with the homeless population (Forte, 1997). As a result of their experience on this project, students gained valuable insight into the lives of homeless persons and developed skills in civic responsibility and empathy building. Based upon similar outcomes reported from other disciplines, service learning can serve an important function in social work education.

### **Service Learning as an Educational Bridge**

Although social work education already includes community service activities through internships and volunteer requirements, service learning can serve as a transition into foundation field placements. Because of the focus and structure of service learning, this experience can help graduate students prepare for their first social work internship experience. Used in this way as an "educational bridge," service learning can be beneficial to faculty, students, and the program.

In certain respects, graduate students are much less prepared to enter their initial social work practicum than baccalaureate students. BSWs have frequently taken a variety of social work courses prior to an internship and have worked with a social work advisor to construct a program of study. When undergraduates enter their field placement, they have some initiation into the professional social work role. Conversely, graduate students often come to the social work program with a variety of backgrounds and baccalaureate degrees. Their understanding of the professional issues, roles, and dilemmas may be at an elementary level. Part of the focus in the initial semester is to help modify the identity that was molded in their undergraduate major (e.g., psychology, sociology, humanities) into that of a professional social worker. Service learning provides such students an opportunity to view some of the issues that face practitioners and communities, and to become involved in promoting positive changes. The initial experience as a "change agent" is a positive entry into the beginning identity as a social worker. After completing the service learning experience, graduate students may enter their foundation internships with a more realistic and holistic sense of social work practice.

Since students do not always have a comprehensive understanding of professional practice, service learning can acquaint them with different client populations and service contexts. For example, gerontology is an under-represented field of practice in social work. While about 60% of all NASW members recognize the need for gerontological knowledge (Damron-Rodriguez & Lubben, 1997; Peterson & Wendt, 1990), most practicing social workers have not received education or training in this field of practice (Klein, 1996). In fact, only about 10% of all social work students take a gerontology course (Damron-Rodriguez & Lubben, 1997). Students' reluctance to take content on aging in coursework and internships may be related to a lack of exposure to older adults, ageism, and feelings about the undesirability of working with this client population. Service learning experiences provide students an opportunity to become more familiar with older adults and break through the associated myths. In an analysis of service learning in a long-term care facility, for example, 90% of the students reported that the experience was useful in their education. In addition, significant positive changes were found in their attitudes toward older adults from pre- to post-experience (Hegeman, 1999). This is just a one example of how service learning can expose students to new situations to generate excitement and enthusiasm. As a result of positive experiences in service learning projects, students may be motivated to select internships in areas they had not previously considered.

Service learning also can be enriching for social work faculty and the entire curriculum. Since faculty collaborate with agency personnel to construct learning-practice experiences for students, they become cognizant of priority issues in their communities. These opportunities allow faculty to engage in real practice challenges that add depth to the entire curriculum. As the result of their involvement in service learning projects, faculty can bring knowledge and experience to the other courses that they teach. Some of these partnerships can translate into expanded collaborations with community partners on grants, publications, and other research.

While a service learning experience may be pivotal for some students, others may struggle with their beginning practice experiences. An additional benefit of



using service learning as a bridging experience in the curriculum is the opportunity to evaluate student readiness for fieldwork prior to placement. Social work education has been admonished for failing to assess whether students are prepared for internships (DeWeaver & Kropf, 1995; Gibbs, 1994; Isaac, Johnson, Lockhart & White, 1993; Koerin & Miller, 1995). Service learning provides a gatekeeping juncture early in the program and allows faculty to evaluate whether students possess the necessary skills and knowledge to move into the foundation practicum. More importantly, this experience allows students the opportunity to evaluate their own goodness-of-fit with the profession early in the curriculum. Students who have difficulty at this point are identified early enough to make a decision regarding their academic career prior to spending considerable time, effort, and resources in a graduate program.

### **Integrating Service Learning into Foundation Courses**

During the first semester of graduate study, many programs delay entrance into the foundation practicum. Some programs have students begin field placement midway through the first semester, and others have students start in the second semester. In either of these situations, a service learning experience can be incorporated into courses prior to the practicum. In this way, service learning functions as a transition into the more structured and individualized experience of the foundation internship.

Service learning activities vary greatly and can be incorporated into any foundation course. With the passage of the Educational Policy and Accreditation Standards (EPAS) in July 2001, foundation content covers eight major areas within the curriculum: values and ethics, diversity, populations-at-risk and social and economic justice, human behavior in the social environment, social welfare policy and services, social work practice, research, and field education (Council on Social Work Education, 2001). The following section provides examples of how service learning can be incorporated into various core courses, and demonstrates ways that projects can augment content. In addition, methods that instructors can use to help students learn from and with each other will be highlighted.

***Practice Content.*** In practice courses, students begin to master fundamental social work skills. They learn about ways to build relationships with clients, construct service plans, interview, and evaluate their practice. In some programs, students are also initially exposed to practice with various client systems, including individuals, families, groups, organizations, and communities. In addition, content on ethical issues, professional use of self, and working with diverse clients is typically included in this course.

Service learning activities can help students begin to employ their skill repertoire within various community contexts. As students begin to put these skills into action, the complexity of practice becomes more real, which provides opportunities to discuss how “reading about” practice differs from implementation. In addition, students have the opportunity to struggle with situations where the ideal outcome is not always achieved. In these instances, instructors can help the students identify alternate ways of progressing to accomplish their tasks.

One way of integrating service learning into a practice course is to have groups of students work in different agencies with various client populations. In non-

profit agencies, student support is welcomed as a way to maximize personnel and provide programs that go beyond what the agency could offer with its own resources. The course instructor could construct an assignment to run a program for participants in two different community settings. One group of students could be assigned to a homeless shelter, for example, leading a job readiness program. This assignment would involve serving as an educator to teach residents various employment skills, such as filling out applications and interviewing. Other skills include linkage to community resources including potential employers and GED courses. A second group of students would be placed at a different site in the community, such as an HIV/AIDS service agency. At this site, a program may involve providing community education about HIV/AIDS. This type of activity allows students to serve as educators on a macro practice level and focuses on prevention activities.

Assignments that focus on service learning experiences such as these can highlight several aspects of social work practice. Students can compare and contrast practice with client populations and different service contexts. In addition, students can begin to experience the complexity of social work practice as they become aware that some people are both homeless and HIV-positive. Using two different levels of practice (working directly with individuals and community education) provides examples of the ecological perspective. As they discuss and reflect on these issues, students become aware of the need to be flexible and innovative in their work with clients. In addition, they develop an appreciation for how the agency context impacts the various roles that social workers hold in different settings. Students also begin to struggle with personal values and biases such as racism, classism, ageism, or homophobia in themselves, classmates, or service providers. These personal values and biases can then be processed in classroom discussions. As students enter their initial practicum, they have an awareness of the dynamic and challenging context of social work practice.

***Human Behavior in the Social Environment.*** In the HBSE content, students learn theoretical perspectives that provide a comprehension for understanding and assessing human functioning. Similar to the practice sequence, the course provides a theory base from individual to community levels. In addition, this content has a dynamic perspective that looks at the phases of development for the various levels of client systems (e.g., lifespan, group dynamics, family development, organizational change).

Service learning can provide students with an opportunity to understand human functioning at different points in the life course. Students also can work with similar services in different types of communities to gain insight into the macro-level variables that impact human behavior, for example, working with geographic communities (e.g., urban, suburban, rural) or non-place communities (e.g., ethnic or racial communities, gay and lesbian communities). These experiences allow students to evaluate micro-level factors, such as developmental issues and life stages, as well as macro issues of discrimination and oppression on human behavior and functioning.

One example of a service learning activity for the HBSE sequence is for groups of students to work in settings that contrast issues across the lifespan. Some students

may be involved with children at a day care center, while another group works with older adults at an adult day care center. In both of these settings, students have the opportunity to assess individual functioning, group dynamics, and family issues. Through their interactions at either day care setting, students can evaluate various developmental tasks at different points in the life course. As the children are becoming more individuated, for example, the older adults are adapting to a period of decreasing independence. Family dynamics also serve as a rich source of comparison as both sets may struggle with juggling multiple demands of caregiving, such as being in the labor force and filling other roles (e.g., marriage, other family relationships, leisure pursuits).

Service learning assignments provide a way to have students apply human behavior theory to actual situations. Assignments can stress the relationship between social work assessment and intervention, as human behavior content provides the foundation for client assessment. In addition, students also can reflect on particular biases in different theories. If, for example, an Eriksonian perspective is used to conceptualize human developmental processes, the experience with different types of individuals can highlight groups that are marginalized or omitted in this perspective (Kropf & Greene, 1994). In day care settings, a contrast between the issues facing children and older adults can highlight how late life is undifferentiated in Erikson's psychosocial theory, which leads to a conclusion that all older people face similar issues. This critique can be extended to analyze issues of race, ethnicity, gender, sexual orientation, and disability status in human behavior theory. As students move into their internships, they have a more complete understanding of the relationship between assessment and practice. In addition, they will have also started the process of critical thinking about theories and application to various client populations.

***Social Welfare Policy.*** In the policy sequence, students gain an historical perspective of social policy. Policy is examined at local, state, and federal levels, as well as learning more about policymaking in each of these arenas. Students learn dimensions of social welfare policy and analyze implications for various individuals, such as women, racial and ethnic groups, older adults, gay men, and lesbian women. In addition, policies related to different service contexts, such as health care, aging, mental health, and income maintenance, are also considered.

Through the use of service learning activities, students can become aware of the link between policy and functioning of individuals, families, and communities. Students may also become aware of how various groups are marginalized or unrepresented in policy decisions and resource allocation. As a result, students learn ways to mobilize and empower these groups as a step to creating more just and equitable programs and legislation.

During an election period, a service learning assignment can involve students in voter participation campaigns. Through the project, students can become involved in community efforts to register new voters, provide education and information about relevant issues to community constituencies, and assist with methods to increase voter turn-out (e.g., requests for absentee ballots, transportation to polls). As a result of their experiences, students become involved in the various aspects that are part of the democratic process.

In the policy sequence, service learning projects can help students recognize how legislative processes and actions impact individuals, families, and communities. Assignments that relate to the service learning project can help students to focus on weaknesses in the current political structure as a way to stimulate thinking about necessary reforms. In addition, comparisons between different legislative models used in local, state, and national levels involve students in critical thinking about the strengths and limitations in the different political processes. Such assignments can help students become more aware of the political context involved in service provision (e.g., funding sources, accountability, constituencies).

**Research.** The foundation research course overviews the process of scientific inquiry. Students learn how to identify a problem for investigation, use existing research in problem definition, and understand various research methodologies. Students may also learn data analysis skills, and how to use various statistical procedures. In addition, they may be required to put all of these dimensions together in a research project.

In research, service learning provides an opportunity for students to collect, analyze, and interpret data. This type of experience allows them to master skills in the research process, as well as struggle with real challenges and ethics, such as informed consent, non-response, and missing data. In addition, many agencies lack the resources to collect and analyze data regarding their programs and services. This type of assignment can provide a valuable, needed service to many social welfare agencies.

One type of service learning project could involve working with an agency to evaluate a service that is currently provided. For example, foster care programs frequently run courses for families that are interested in providing care for children. A service learning activity could be constructed to help the agency evaluate the course and identify outcomes on foster family recruitment. Groups of students would assume different responsibilities in the research project, such as performing a literature review on foster family recruitment, constructing an evaluation instrument, completing Human Subject Reviews, collecting data, and performing the analysis. As a class, the students could make decisions regarding how to organize and construct a final report on their findings that would be shared with the agency.

The use of service learning provides a real experience for students with the research project. Students begin with a problem area, and are expected to use previous research as a beginning step in framing their study. This type of assignment links the practice community with research content and reinforces evaluation as a necessary component of practice. In addition, students face the challenges of reporting and disseminating data as they report findings from the project back to the agency. As students enter their first internship, they have a deeper understanding of the fit between practice and research content.

### **PROGRAMMATIC ISSUES**

The previous section provides a model for integrating a service learning project into foundation courses. Particular examples are included to demonstrate actual projects that can build upon content that is included in each of the courses. Assignments that relate to the service learning projects provide students with an

opportunity to process their successes and struggles, integrate course content with their experiential learning, and prepare them for their first social work internship.

While these experiences are beneficial, they are also intensive in both preparation and implementation. For faculty, this process is time consuming, as close collaboration between the academic program and community agency is necessary. The faculty role is to work with the community site to structure service learning experiences for students. Ideally, faculty should spend time in the community along with the students to provide support, structure, and integrate academic content at opportune moments. Service learning projects are not haphazard experiences for students, and faculty need to provide the connection between the different learning settings. Faculty need to think carefully and critically about ways to structure academic components with the experience that students are having in the community. In addition, faculty must be flexible and innovative as service learning projects do not always develop in the actual ways that they are conceived.

Programs must also consider the issue of possible competing demands on agency resources between service learning and field education experiences. As such, a service learning experience can help students master the knowledge and skills that will allow them to have a richer experience within their field setting. However, uncoordinated efforts between field and service learning components may tax agency resources and compromise the integrity of the program. Therefore, field faculty should be involved in identifying those agencies that are potential sites for service learning in order to avoid negative outcomes on field education.

Service learning can be intensive for students. With competing demands on their time, students may believe that a service learning project is difficult to schedule along with other course assignments and responsibilities. It would not be feasible, for example, to have students involved in different service projects in each of their foundation courses. Curriculum committees can take responsibility for examining which courses offer the best fit to include a service learning project in their particular program. In this way, learning is not diluted by having students spread across several projects within the same semester.

While the model that is presented examines service learning in discrete courses, an integrated model could also be developed. A service learning experience would be required for students in the first semester, and each foundation course would integrate the project into the course assignments. The students' experience in the service learning project would be reflected in assignments within their practice method, HBSE, social policy, and research courses. This model has exciting possibilities, but also requires a well-integrated foundation curriculum and faculty who work closely together around assignments. For these reasons, smaller programs might be better suited to implementing an integrated service learning project.

In conclusion, service learning is an educational strategy that helps students "learn while doing." Unlike volunteer experiences or internships, the goals of providing a community service and integrating academic content are equally important. Through service learning, social work programs can form partnership with their communities to help students learn more about relevant issues, promote civic responsibility, and leave a legacy by providing a real service to the community.

Service learning has the potential to serve an important function in the social work curriculum. As graduate students prepare to enter their first social work internship, service learning experiences can be incorporated into foundation courses to serve as an educational bridge between academics and practice spheres. Through initial "real life" involvement in service learning experiences, students learn more about the challenges of the profession, have exposure to a variety of contexts and client populations, and begin to employ their social work knowledge and skills.

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## Student-Identified Strengths and Challenges of Using Blackboard™ for Group Projects in a Social Work Course

Melissa B. Littlefield

**Abstract:** *Blackboard™ provides social work educators integrated online communication tools that they can employ to facilitate student learning through features such as e-mail, discussion forums, file exchange, virtual classroom, and links to online resources. This study describes students' experiences using Blackboard™ to support a group project assignment. The majority of students found it easy to use and useful for the project, and indicated that they would like to use it in other courses. In addition, students gained technical skills as a result of the group project. Students' group project grades and final course grades were comparable to those in other sections of the same course taught by this investigator.*

*The findings of this study suggest that online technology can be used to facilitate group assignments for MSW students. The benefits include increased efficiency of group functioning and increased accountability of group members. The challenges include technical problems and student resistance to using the technology.*

**Keywords:** *Social work education, technology, computers, Internet, diversity, racism*

The proliferation of online educational software packages such as Blackboard™ provides social work educators integrated communication tools to facilitate student learning through features such as e-mail, discussion forums, file exchange, virtual classroom, and links to online resources. Blackboard™ may be employed in social work courses to support group project assignments that require frequent communication and interaction among students. Scheduling difficulties and insufficient time pose a serious challenge to collaborative work on group projects outside of class. Many MSW students juggle coursework and field instruction with paid employment and family responsibilities. At regional schools, greater driving distances and long distance phone charges create additional challenges. Blackboard™ can help students overcome these obstacles by facilitating ongoing interaction outside of class and between group meetings.

This study described students' experiences using Blackboard™ for group projects in a social work course about racism and diversity. A qualitative study was undertaken to elicit student-identified strengths and challenges associated with using online technology for this purpose.

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## LITERATURE REVIEW

The promise of online technology for social work education lies in its capability to support adult learning processes. Andragogy is the art and science of helping adults to learn. According to Crook and Brady (1998), strategies that promote collaborative learning, self-directed learning, and the immediate application of newly acquired knowledge and skills are key to andragogical approaches. Online technology offers new formats for delivering course materials and facilitating ongoing interaction among students and between students and instructors that are congruent with andragogical approaches.

Social work educators have begun to employ online technology in courses about those addressing human diversity (Miller-Cribbs & Chadiha, 1998); research (Stocks & Freddolino, 1998; 2000); introduction to social work (Gasker & Cascio, 2000); psychopathology (Crook & Brady, 1998); and social work with task groups, organizations, and communities (Crook & Brady, 1998). Online technology has been employed to provide course materials, including lectures (Stocks & Freddolino, 1998; 2000; Wernet, Olliges, & Delicath, 2000), lecture outlines (Crook & Brady, 1998; Schoech, 2000), web pages with links to other web sites and documents that illustrate course concepts (Miller-Cribbs & Chadiha, 1998; Schoech, 2000), and for posting student work to share (Schoech, 2000). Online technology including listservs, e-mail, discussion forums, and online assignments have been used to enable students to collaboratively process course content and to extend class discussions (Crook & Brady, 1998; Faux & Black-Hughes, 2000; Gingerich, Abel, D'Aprix, Nordquist & Riebschleger, 1999; Miller-Cribbs & Chadiha, 1998; Stocks & Freddolino, 1998; 2000; Wernet et al., 2000).

Evidence suggests that online interaction increases class participation and enthusiasm for course content and enhances educational relationships (Gasker & Cascio, 2000; Gingerich, et al., 1999; Stocks & Freddolino, 1998; 2000; VanSoest, Cannon, & Grant, 2000). It is particularly beneficial for shy students (VanSoest, et al., 2000) and female students (Gasker & Cascio, 2000). The flexibility in terms of time and space for discussion allows for thoughtful participation, as students have more time to process interactions and prepare their responses (Schoech, 2000).

Schoech (2000) found comparable learning outcomes for students in sections taught entirely online compared to those in sections that did not employ online learning strategies. Several authors have reported enhanced student learning as a result of implementing online technology into their courses (Crook & Brady, 1998; Johnson & Huff, 2000; Miller-Cribbs & Chadiha, 1998). Improvements in student technical proficiency have also been reported (Miller-Cribbs & Chadiha, 1998; Stocks & Freddolino, 1998).

Despite the numerous benefits, the integration of online technology into social work courses presents significant challenges and raises certain instructional questions. For example, which students benefit from the use of such technology? Wernet, et al. (2000) found that graduate students benefited more from using online technology in a research class than did undergraduates. They also determined that non-traditional students were more likely than traditional ones to utilize online technology when it was available and to perceive it as beneficial.

The need for face-to-face interaction appears to be important for some students, but not for others. While Stocks and Freddolino (1998) found that students in MSW research courses taught entirely online experienced the lack of face-to-face interaction with their classmates as a loss of an important classroom element, Schoech (2000), who taught an online doctoral level course on technology-supported practice, did not.

Student-student interaction in online technology-enhanced courses has been relatively unstructured and voluntary. This may contribute to the somewhat less than optimal participation rates reported for students in online interaction and a high volume of exchanges that are not specifically related to course content. For example, some authors report a large proportion of online interactions related to questions about grades, assignments, acknowledgements of receiving messages, and other administrative concerns (Johnson & Huff, 2000; Stocks & Freddolino, 1998). Stocks and Freddolino (1998; 2000) found that providing more prompts for student interaction and self-directed learning increased the number of interactions that were relevant to course content and improved overall student perceptions of the class. A related issue is the need for guidelines regarding the appropriate uses of different types of online technology and the combinations of features necessary to support specific learning tasks. For example, Faux and Black-Hughes (2000) found that providing course materials online without opportunities for student-student interaction resulted in negative student perceptions of the online instructional strategy they employed.

Technical problems are a consistent theme in the literature. Students who lack computer skills or who are unable to consistently access the Internet are often blocked from fully participating and generally report negative perceptions of the course, overall. Students tend to experience frustration and anxiety as they develop new technical competencies. Other technical problems that interfere with the learning experience include limited understanding of the capabilities of the online features by instructors, which may result in flawed assignment designs and systemic problems with the software that prohibit executing even the best conceived assignments (e.g., slow connections, system overloads, and crashes).

The tiny body of literature on the use of online technology in social work education provides merely a glimpse of its possibilities and the concomitant pitfalls. To date, it has been used in very limited ways to deliver course content, to increase student interaction in processing course materials, and to enhance educational relationships. Only one study has reported using online technology for group projects. Schoech (2000) attempted to use a chat feature for a group debate in a class taught entirely online, but found it unwieldy.

This study involves the application of online technology for a group project in a class primarily taught face-to-face in a classroom setting. A qualitative research approach was adopted to allow a deeper examination of students' perceptions than is afforded by quantitative analysis, which characterize most previous studies on this topic.

## METHODS

### Group Project Design

Students in an MSW-level racism and diversity course worked in groups to critically analyze a current issue related to the course. Content included a brief historical summary that addressed how oppression and discrimination or socially-constructed difference shaped the issue; an incidence report; theories of causation; identification of current controversies; policy and practice intervention options; and implications for practice development. Students self-selected into groups of three-to-five based on topics they generated in a class brainstorming session. The groups' research findings were displayed in the form of "digital posters," in the form of Microsoft PowerPoint™ slideshows posted on Blackboard™ and presented at an in-class digital poster forum. Each student was required to complete a weekly journal that documented her or his experience completing the group project.

The digital poster accounted for 75% of the group project grade. All students in a given group received the same grade for the digital poster portion of the group project. Grading criteria included thoroughness in addressing the topic, appropriate utilization of concepts from class to analyze and discuss the issue, and organization and clarity. The journals accounted for the remaining 25% of the group project grade. The group project comprised 30% of the overall course grade.

At the inception of the assignment, the instructor created a "group page" in Blackboard™ for each group that contained a set of communication features that only group members could access. These included a discussion forum that enabled any group member to create a virtual space where all group members could post and respond to a particular issue; a "file exchange," where any group member could upload a computer file in any format for other group members to access (provided that they had the software to open it); and an e-mail feature that allowed for messages to be exchanged within the group. The groups were instructed to utilize their group pages to support their group project work. No specific directions about how they should employ the features were given. Brief instruction on how to use Blackboard™ was provided by the professor in the early class sessions. An online manual was available to students, as well. Students had some prior experience with using Blackboard™ for a previous assignment. No in-class instruction on the use of PowerPoint™ was given. However, links from Blackboard™ to online PowerPoint™ tutorials were provided.

### Participants

Participants were social work students in one section of a Racism and Diversity course on a large urban campus that enrolls students from a multi-state area on the Eastern Seaboard. Students ranged in age from 25 to 53, with a mean age of 31 years. The majority were female (84%), and predominantly white (58.3%), although 33.3% were African-American. The remaining 8.4% were Asian and Hispanic. Full-time students represented 64%, while 36% were part-time students. The overwhelming majority of respondents (88%) had Internet access at home, while 12% accessed the Internet at work or from some other location.

### **Measures and Data Collection Procedures**

Two mechanisms were used to collect relevant data: (1) a self-report questionnaire consisting of 13 closed- and open-ended items filled out by students at the end of the project; and (2) a 1,600 to 2,000 word journal where 400 to 500 words were written each week for the four week duration of the project. The questionnaire contained demographic items, items about the student's computing capabilities before and after the group project, items about access to computers, three Likert-scale items, and two open-ended questions about the disadvantages of using Blackboard™ for completing group projects and how the professor could have made the technology more useful for the group project. Journal content was required to focus on how the student used Blackboard™ to work with his or her group, including information about the strengths and challenges of using the software.

### **Limitations**

A limitation of this study was a potential social desirability bias in student journals. Students were strongly encouraged to be honest in sharing their feelings about their experiences with Blackboard™, and most reported both pros and cons of using the technology. However, some students may have been uncomfortable because their journals were not anonymous and counted toward their final grade. Also, some students may have been very negative because they were resentful about being required to use Blackboard™. The questionnaires were anonymous and posed less of a threat to validity; however, a few students could be identified based on demographic information (e.g. the only black male in the class). Again, the range of responses from positive to negative, suggested that social desirability did not pose a significant threat.

## **RESULTS**

### **Quantitative Analysis**

Students completed surveys in class at the conclusion of the group project assignment. A total of 25 surveys were returned (response rate of 96%). Table 1 shows the distribution of students' computing capabilities before and after the group project. Practically all of the students were able to send e-mail and use word processing software prior to the group project, and the majority could send an attached document via e-mail. However, fewer than one-third could use PowerPoint™ prior to the group project. Following the group project, there was a 32% increase in students who could send an attachment via e-mail and a 60% increase in those able to use PowerPoint™. Table 2 presents the distribution of students' evaluation responses. The majority of students agreed that Blackboard™ was useful in completing their group project, easy to use, and they would like to use it for group projects in other classes.

### **Qualitative Analysis**

A qualitative analysis of the journals was conducted to identify the major themes and elements concerning how students utilized Blackboard™ to support their group project work, identify the benefits of using the program for this purpose, and uncover problems and pitfalls they encountered. The results of the open-

Table 1: <i>Percentage Distribution of Students' Computing Capabilities Before and After Group Project</i>				
Computing Capabilities	Before		After	
	Frequency	%	Frequency	%
Send e-mail	25	100	25	100
Attach document to e-mail	16	64	24	96
Word processing	24	96	24	96
PowerPointTM	7	28	22	88
N=25				

Table 2: <i>Percentage Distribution of Students' Evaluation Responses</i>					
Survey Item	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Blackboard™ was useful in completing my group project	16%	52%	12%	8%	12%
Blackboard™ was easy to use	48%	28%	12%	12%	0%
I would like to use Blackboard™ for group projects in other classes	32%	32%	12%	4%	20%
N=25					

ended survey questions overlapped with the themes identified in the qualitative analysis of the student journals and are therefore not reported separately here.

Each student submitted four journal entries for a total of 104 documents that were analyzed. Journals were electronically submitted to the professor in a popular word processed format (e.g., MS Word, WordPerfect) via the “digital drop box” feature of Blackboard™. Analysis of the journals was facilitated by using Atlas™, a software program designed for qualitative analysis. First, an open coding process was used to examine, compare, and categorize the data based on their latent content. In the subsequent phase of the analysis, axial coding was used to make connections between categories and pull out themes that naturally emerged. Data were systematically reduced to three main themes: (1) how Blackboard™ was employed to support group projects; (2) the strengths of using Blackboard™; and (3) the challenges of using Blackboard™. Subthemes were identified within each of these main themes.

*Using Blackboard™ to Support Group Projects*

*Balancing Online and Face-to-Face Interaction.* All of the groups met face-to-face outside of class over the duration of the project; they used Blackboard™ for communicating with each other between meetings. Earlier meetings focused on formulating the topic and work plan. Towards the end of the project, groups met face-to-face to finalize their presentations. They also uniformly met in person to learn PowerPoint™. The following comment illustrates this process.

*Achieving the appropriate balance between using the Blackboard™ technology and meeting in person, our group worked extremely well together. At first, we were apprehensive about relying solely on Blackboard™ to complete the presentation; however, as time progressed, we discovered that Blackboard™ was helpful in facilitating meetings, posting any completed work, and, of course, communicating in the absence of any member. Our group found it necessary to meet in the final stages of completing our project so we could compile and edit our information and create appealing slides.*

The few groups that did not establish a work plan, deadlines, and procedures for posting and updating documents experienced problems communicating, regardless of the extent to which they employed Blackboard™. As with any form of communication, Blackboard™ was only useful if everyone in a group used it as prescribed by the group, including checking the group page frequently.

Many students found it difficult to have complex discussions or brainstorm online. One student who actively and effectively used Blackboard™ throughout the project felt that the creative process was somewhat stifled due to a lack of regular face-to-face contact with group members. A few expressed a feeling of isolation from their group members because the efficiency of Blackboard™ decreased the need to meet frequently. There seemed to be a general consensus that face-to-face contact is a valued aspect of group project work. Meeting in person was viewed as a way to get to know one's classmates and feel connected to the group. The following comments capture these sentiments:

*The Blackboard™ system, while good in theory, has made me feel very disconnected from my group. I think this is one of the negative aspects of the system. It doesn't mandate meeting in person and tends to discourage forming friendships that come out of working together with classmates. But it has allowed me to better manage my time, as it negates having to drive to (campus) or stay very late after class.*

**Use of Specific Blackboard™ Features.** E-mail was the feature most often used in the earlier stages of the project, probably due to the fact that most students were familiar with it. Students used e-mail to update each other on the status of their work, schedule meetings, send Internet resources to each other, send drafts of their work, and provide feedback to each other about those drafts. The file exchange was most often used by group members to share their ideas, resources, and drafts of their work. Many students used e-mail in conjunction with the file exchange to inform other group members when they had posted a document.

Eventually, some groups moved away from using e-mail in favor of using the discussion forum because it provided a central place for group members to view all messages on a given topic and it automatically organized messages posted there by topic. Students used the discussion forum feature to update their groups on the progress on their tasks and for group problem-solving. It was also used widely to provide feedback to each other on documents that were posted on the file exchange.



### *Strengths of Blackboard™ for Group Projects*

**Improved Group Efficiency.** Effective use of Blackboard™ increased the efficiency of the group process for most groups. Many students reported being able to accomplish more between meetings as a result of continuous communication. Students were able to share resources and preview group members' work prior to meeting, thereby eliminating the need to spend valuable in-person group time engaged in these tasks, reducing the number of group meetings, and shortening face-to-face meetings, as illustrated by the following remarks.

*The Blackboard™ system has been helpful in time management issues that all graduate students face but especially helpful in addressing concerns of a full-time working student. It has allowed me to work on the project anytime I have a free moment at the office or after I have finished my paid employment for the day. I have found this extremely helpful and wish my other courses were subscribed to this service. It would help me greatly with the term paper I am working on with two other students for Human Behavior 2.*

*... because of Blackboard™ we were able to stay focused during the meetings and they remained short and precise. In other group meetings I have had, we have always met for at least two hours and it would take the first half of the session to get all the information compiled and figure out who would do what. I definitely feel that by having Blackboard™ available and being able to communicate before the meetings through e-mail and file exchange, we saved a lot of time in face-to-face meetings.*

Many students found using Blackboard™ to be easier for contacting their group members than attempting to reach them by phone.

*...I never had to deal with telephone answering machines (a definite plus) and the complications of reaching a convenient time for all of us to converse.*

*... we do not have to make any long distance phone calls... We can respond even faster to each other's questions and comments over the Internet compared to a phone call"*

Finally, students found that the links to databases and other Internet resources provided on Blackboard™ by the professor and the university's library saved them time by helping them locate resources specific to their topic.

**Increased Accountability.** An unanticipated benefit of Blackboard™ was that it seemed to increase the level of accountability of students to their groups. Members who were unable to attend meetings could still participate if they were near a computer. Because there were ways to get information to the group even if they were not present, they were not "off-the-hook" in the eyes of their group members. Even students who did not miss meetings mentioned that they felt that Blackboard™ provided them with ways to demonstrate that they were making a contribution to the group.

*I have found that using Blackboard™ is ... particularly helpful when other group members simply can't meet due to various reasons. Blackboard™*

*enables all members of the group the ability to stay updated and current on the project at hand. Blackboard™ holds all members responsible for completing their part of the project, because all members can communicate and access each other's information from home, work or school.*

*I have sent back a message to everyone in the group so that they will know that I haven't abandoned the project and that I am still looking for information.*

### *Challenges of Using Blackboard™*

**Technical Issues.** Some students experienced technical problems that were most likely due to their limited computer skills. They often reported their inability to log on or that the system was down when it was not. Others experienced problems establishing network accounts at the university level, which delayed their online involvement and frustrated them and their group members. These students often needed hands-on technical assistance from the professor and the university technical support staff to resolve their issues. Also, several students exchanged files that were infected with computer viruses. In addition to possibly infecting other group members who received and opened the files on their computers, the corrupted files often were illegible when opened.

A major barrier for some students was limited access to a computer with an Internet connection at home or work. Using Blackboard™ increased the amount of time students needed to spend online. Those who could not frequently check their e-mail or their group's pages in Blackboard™ were at a disadvantage. In addition, students who relied on a dial-up connection to the university server experienced delays or were unable to log onto the system during peak traffic hours. These problems were extremely frustrating for students and sometimes led them to view Blackboard™ negatively and use it infrequently.

**Resistance to Computer Usage for Interpersonal Communication.** Some students were very resistant to using computers in a social work course for which they believe that face-to-face interaction is paramount, in this case, Racism and Diversity. For these students, even the improved efficiency they found in using the program was not persuasive.

*I am fine with the idea of group projects, I even like and look forward to them, but the idea that I have to communicate with this stupid monitor more than my fellow humans, bothers me. I am dependent on my modem and the Internet more than my brain, this doesn't seem right or fair: My grade should not be so dependent on my computer literacy. It seems that the whole idea is antithetical to the theories behind group discourse. The idea of a group is to work together and bounce ideas off of one another. If I can't see the faces of my group members, how will I know how they really feel about my ideas? To be perfectly honest, I feel like the entire conception and organization, as well as the digital nature of this project were highly unorganized.*

Lack of comfort or skill with using the computer in this capacity led some students to resist, causing them to delay using the program until very late in the project. However, once they began to use it more frequently, they became more com-

fortable with it and appreciated the increased efficiency. Ultimately, many of these students conceded that they never would have used the program if it had not been required, but they were glad they did because it helped them to overcome their technophobia and learn valuable new skills, as noted in the following comment:

*I am grateful for the exposure to Blackboard™ and PowerPoint™ that this assignment has given me. I see this opportunity as an important element of my graduate education. It is something I will take with me and be able to use in my professional career. As a matter of fact, I will be presenting this project to the adoption agency where I have worked ... for the past 10 years.*

## DISCUSSION

This study described students' experiences using Blackboard™ to support a group project assignment in a course about racism and diversity. The majority of students felt that the software was useful in completing the project and easy to use. They indicated that they would like to use it for group projects in other courses. In addition, students improved their technological proficiency as a result of the group project. Students' group project grades and final course grades were comparable to other sections of the same course taught by this investigator.

This study suggests that online technology can be used to support group assignments. The benefits include increased efficiency of group functioning and increased accountability of group members. The challenges include technical problems and resistance to using the technology. The one previous study that addressed employing online technology for group projects found it to be cumbersome for this purpose (Schoech, 2000). This may have been due to the fact that the course in that study was taught entirely online, suggesting that using online technology for group projects may be more appropriate as an adjunct to face-to-face courses. Alternatively, it may be that the some features or combinations of features of online technology are more appropriate for facilitating group projects. For example, asynchronous communication features, such as discussion forums and e-mail, may be more effective than real-time features, such as chat.

Consistent with other studies, this study found that online technology could support self-directed and collaborative learning for social work students. Students used the technology to work in groups to investigate a current issue related to racism and diversity, and to share their findings with their classmates. Given a structured task that required computer-mediated interaction, students employed technology primarily to facilitate their work, rather than for administrative purposes, as was the case in other studies in which the learning task involving online technology was less structured.

It is also noteworthy that the vast majority of the students used online tutorials and worked collaboratively outside of class to learn at least some of the technological skills necessary to complete the project (e.g., PowerPoint™, e-mailing attachments). This suggests that despite initial resistance, social work students can learn to use and appreciate technology. Basic training and direction on how they might employ particular features is beneficial in acclimating students. It may also be useful to help students anticipate how computer-mediated interaction

may differ from face-to-face interaction, and to offer guidelines for effective online communication. In addition, discomfort and limited proficiency may prevent students from voluntarily using available technology, thus, educators may need to make it a requirement in order to ensure participation. Finally, instructors need to anticipate technical problems and ensure that students have adequate computer and Internet access, as well as technical support.

Consistent with the findings of other studies, Blackboard™ did not eliminate the need for face-to-face contact, but supplemented it. Until more effective strategies for sustaining educational relationships online and conventions for conveying nonverbal communication are developed, it seems unlikely that computer-mediated communication can replace face-to-face interaction in social work education. However, "cyberculture" is rapidly expanding and such conventions are beginning to emerge in limited forms. For example, Schoech (2000) reported varied success in promoting online relationships in a course taught entirely online; student-designed personal web pages were useful, though online "class parties" were not. Also, America Online Instant Messenger™ allows users to accent their chats with "emoticons," that is, modified smiley face icons with facial expressions that convey various emotions.

In conclusion, online technology is redefining the educational arena—offering new formats for course delivery and expanded opportunities for students to engage in interactive, self-directed, and experiential learning that is relevant and related to real-world problems. Although research in this area is limited, social work educators can begin to take advantage of the increasingly available online resources on campuses to help students meet their specific course objectives and to introduce them to technology that they are likely to encounter in their professional careers.

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