BUSSW Policy Curriculum

Field Instructor Appreciation Breakfast

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Overview

- Policy I (WP700)
  - Conceptualization of social welfare
  - Key policies and programs
  - History of social welfare in U.S.
  - Role of social work
- Policy II (WP701)
  - Analysis of social problems and social policies
  - Policy practice
- Advanced Electives

Conceptualization of Social Welfare Policy

- What do people need? Or have a right to?
- Who is responsible for addressing?
  - Individual, family, community; local vs. national; government vs. private sector/market; religious communities; for-profit organizations
- Key ideological frameworks (liberal and conservative, etc.)

Key Policies and Programs

- Public Assistance (TANF, SSI, SNAP)
  - benefits
  - eligibility
  - financing
  - administration
- Social Insurance (OASDI, Medicare/Medicaid/ACA, Unemployment Insurance)
  - benefits
  - eligibility
  - financing
  - administration
- Tax Credits and “Corporate Welfare”
  - Earned Income Tax Credit
  - Child Tax Credit
  - Corporate subsidies and tax credits

Social Welfare History

- European legacy
- American colonies, Revolution, Constitution, slavery
- Post civil-war (Freedman's Bureau, industrialization, and changing philosophies)
- Progressive Era (urbanization, start of social work, policies)
- Great Depression, New Deal, Social Security
- 1980s Reagan conservatism and retrenchment
- Bush, Clinton, Bush II
- Obama and current issues

History: What are the lessons?

- There are reasons why we are the way we are based on historical legacy
- Some of our contemporary debates have long-standing historical precedents
  - E.g., ideas of deservedness for assistance
- Are any of the previous policy solutions relevant to contemporary situation?
- How does the context (ideological, political, economic, social, demographic, religious, geographic) influence recognition of social problems and policy design?

Social Work Profession

- Start of the profession in Progressive Era
- Development of the profession (early involvement in policy [Addams, and the New Deal advisors] professionalization, rise of psychoanalytic approaches)
- 60s – critique of social work (Ehrenreich, 1985)
- Policy practice (Figueira-McDonough, 1993)

Figueira-McDonough: Policy Practice

- Two goals distinguish social work from other helping professions:
  - (1) social justice and
  - (2) self-determination.

- Social work is more successful at #2; more attention is needed to #1 and this can only be done with policy practice → direct involvement in formation/modification of social policy.

Figueira-McDonough: Policy Practice

Methods of Policy Practice:

- Legislative advocacy*
- Reform through litigation
- Social action
- Social policy analysis*

* the focus of Policy II

Outline for Task Force Assignment

- Problem Definition: Conceptual
- Scope and Correlates of Problem: Data
- Causal Framework
- Current Social Policies: Analysis
  - Strengths/weaknesses? Equity, efficiency, effectiveness? Impact on populations?
- Policy Recommendations
  - What policy proposals would you recommend? Feasibility? Implementation challenges? Plan for dealing with challenges?

Poor Health and Poor Access Among Low-Income Adults

Victoria Cox, Allyson Meyer, Ellen Andrews, & Elizabeth Lang

Health Status Among Low-Income Adults

In the United States, income is tied to health, in that, those with high incomes experience the greatest health. This poster elucidates the persistent disparities in health outcomes and healthcare access and quality among low-income adults. Low-income adults are more likely to be uninsured and delay medical or dental care due to costs, and are less likely to have access to employer sponsored health insurance or a usual source of care. Research has shown access to primary care among low-income is associated with improved rates of receiving preventative care services, better management of chronic conditions, and reduced mortality.

In recent years, the government and health care reformists have worked diligently to ensure coverage for low-income families and children through passage of the Affordable Care Act. Since 2014, insurance rates have increased among all populations but disparities continue to exist among low-income individuals, in particular low-income childless adults affected by a Medicaid coverage gap.

Known Causes

Low-income adults face multiple health barriers, ranging from increased risk behaviors to residing in economically distressed areas with limited opportunities and access to services. Below is a list of the myriad of factors affecting low-income adults, and when combined with inadequate healthcare coverage, these factors engender an increased risk of disease, mortality, and poor health for an already vulnerable population.

Increased rates of Health Risk Behaviors

- Low-income adults are **40% more likely to smoke**, which increases the chances of developing various cancers, skin conditions, asthma, etc.
- More likely to **consume unhealthy foods or have nutritional deficiencies**, leading to adverse health conditions (diabetes, cancer, obesity)
- Low-income adults are **3 times as likely to be sedentary** & have lower rates of physical activity

Low Health Literacy (HL)

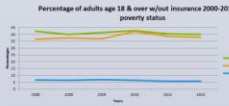
- Low-income adults are **disproportionately affected by low health literacy**, which is defined as a lack of ability or capacity to obtain, process, and communicate basic health information.
- Low HL associated with unhealthy behaviors, poor health status, less utilization of healthcare services, and negative health outcomes.

Environmental conditions associated with poor health

- **Less access to healthy foods and safe areas for physical activity** or leisure
- **More likely to be exposed to indoor or outdoor environmental pollutants**, such as lead-based paint from substandard housing and air pollution.
- **More likely to be exposed to crime and violence, producing increased stress** levels. Stress and chronic stress known to affect overall health, hormones, and immune system functioning.
- **Lower number of local primary care providers** and high-quality clinical facilities
- **Limited employment and transportation** options

Restricted Access to Care

- Employer sponsored insurance is rarely offered at low wage jobs
- **More likely to be uninsured or underinsured**
- Less likely to receive recommended health care services due to reduced access and affordability

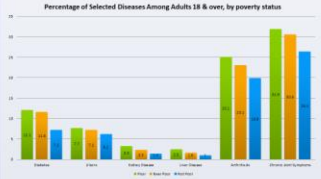


Less likely to be able to afford costs associated with insurance coverage

- Low income Americans **face greater financial barriers in regards to deductibles, copayments, cost of medicine, and other healthcare expenses.**

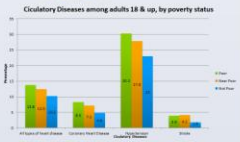
Poor Health Outcomes

Adults living at or below the poverty line are more likely to be in **fair or poor health**, have **shorter life expectancy**, and report **higher rates of chronic diseases and illnesses** compared to those living 400% or more above poverty level. The following data reflects information gathered by the CDC in *Health, United States, 2014.*



7.9 % of adults age 18-64 are disabled in the U.S.

16.6% of adults age 18-64 are disabled and living in poverty.



Poor Oral health

Higher rates of **poor oral health and periodontal disease** are reported among low-income adults.

Poor Mental Health

- 25% of the adults who suffered from a mental illness and 7% who suffered from a serious mental illness, within the past year, were poor.
- During 2009-2012, persons living in poverty were **2.5 times more likely to have depression.** In 2014, rates continued to be higher for poor versus non-poor adults.

Disparities in Access & Quality

The differences in health status between low-income and middle to high-income adults is further impacted by disparities in healthcare access and quality.

Access

According to the most recent data from 2014, low-income adults are disproportionately **more likely to experience problems accessing insurance coverage, establishing a usual source of care, receiving care as soon as wanted, and often encounter difficulties when seeking care.**

- Between 2001-2012, few of these measures improved substantially and there was a slight increase in access to insurance beginning of 2014.
- Having a usual source of care has been associated with better health outcomes and fewer disparities and costs.

Quality

In 2014, people in poor households experienced **worsening disparities related to chronic disease and a poorer quality of healthcare compared to non-poor.**

- **Worse management of chronic disease and prevention, potentially unsafe prescription medication, and worse health outcomes after surgery** were particularly high for low-income adults.

Policy Analysis:

The Affordable Care Act

The Affordable Care Act (ACA), signed into law March 23, 2010, is a complex piece of healthcare reform legislation aimed at improving individuals access to quality, affordable health insurance while slowing the growth of healthcare spending. Three features of the ACA – curb rising healthcare costs, increase access to quality, affordable coverage, and an emphasis on preventative care- address the noted health disparities among low-income adults and are analyzed below.

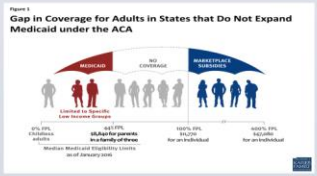
Amending Rising Healthcare Costs

- The act establishes a competitive health insurance marketplace for individuals and small businesses to compare health plans, thus, creating competition among health insurance companies that can regulate cost and quality of coverage. Additionally, middle and low-income families are given tax credits to cover a portion of the cost of coverage.
- Emphasis on preventative care in Section 2713 seeks to reduce costs associated with preventable medical conditions or worsening of chronic conditions
- Section 2718 requires a report of revenue which will contain costs through transparency

Expanding access to coverage

- Section 2716 forbides discrimination of salary
- Section 2713 – coverage for preventative health care
- Section 2002 Income eligibility for non elderly
- Provides assistance for those uninsured due to pre-existing condition

Current Gaps in Accessibility: Due to a Supreme Court ruling allowing Medicaid expansion to be optional for states, 19 states have yet to expand their Medicaid programs;in a majority of these states, childless adults remain ineligible for Medicaid. Since the ACA believed low-income individuals would receive coverage through Medicaid, there is little to no financial support for low-income childless adults in states that have not expanded coverage. This is illustrated in the image from the Kaiser Family Foundation below.



Establish a high health standard and ensure quality care

- Section 2713 requires coverage for preventative care. Starting 2014, all health plans were required to provide "many A and B rated preventative services at no out-of-pocket cost"
- Section 2717 implements case management, chronic disease management, and initiatives to assist in medication and care compliance
- Requires calorie counts to be listed at restaurant chains with 20 or more locations
- Implementation of educational campaigns regarding nutrition and consequences of health risk behaviors

Policy Proposal: The Amendable Care Act

Purpose: To streamline accessibility of health insurance for low-income populations, specifically targeting individuals (childless adults) currently stuck in the Medicaid coverage gap. Within the universal healthcare coverage, emphasis will be placed on preventative care and disease management, to include outreach activities targeting low-income communities.

Goals:

1) To provide universal health coverage to all U.S citizens
2) Ameliorate health outcomes among all socioeconomic classes and reduce disparities in health and healthcare
3) Reduce U.S healthcare costs through improved health outcomes and preventable hospitalizations and other costly medical services

Structure: This Act establishes three categories of healthcare coverage, to include:

Bronze Plan

- Designated for elderly (65 plus) or those with a documented disability or chronic illness. This would be similar to the current Medicare system.

Silver Plan

- Universal coverage, required of all citizens, with a focus on preventative care and standard set of services

Gold Plan

- Designated for individuals or employers who want to pay for an expanded network and additional coverage

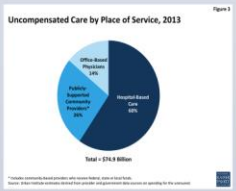
Implementation: This program will be overseen by the federal government and participation required of all states.

Budget: Currently, the U.S Government spends 1.3 trillion on health care. Providing universal healthcare coverage would increase government spending by 35% (600 billion), resulting in total expenditures of 1.9 trillion.

Funding:

In 2009, research by the Chicago Political Economic Group reported that a financial transactions tax on cash assets and derivatives in the U.S. would generate over 1 trillion dollars, annually. Funding for this policy would be generated through a similar structure- a financial transactions tax of less than 1% on stocks, bonds, and currency exchanges.

Administrative costs would be minimal due to the proposal's universal nature, and overtime costs would lessen as health outcomes improved. In particular, the costs and services associated with hospital based care would decrease, and as the graph below illustrates, this represents a large percentage of uncompensated care costs.



References

Available upon request

Mass Incarceration of Women of Color

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Rising Rates of Women of Color Incarcerated for Drug Crimes

The Problem: Rates of federal incarceration for drug crimes amongst women of color are rising

Despite the disparate impact that mass incarceration has on women of color, no policies currently exist to specifically target their unique vulnerability to the system

The problem has been framed as a result of shifting gender roles, financial liability, and a lack of treatment for substance abuse; however, the reality is far more complex:

Women of color are disproportionately incarcerated due to biases of the criminal justice system that compound the specific societal race, gender, and class-based prejudices that push women of color into drug use and drug-related criminal behavior

Common Themes/Causal Pathways as to Why Women of Color are in Prison

- Poverty and Economic Pressures
  - 60% of incarcerated women were not employed full-time when they were arrested
- Domestic Abuse
  - 55% of incarcerated women report physical and/or sexual abuse in their childhoods and immediate past
- Substance Abuse Problems
  - Approximately 80% of women in prisons have substance abuse problems

How Did We Get Here?

- In 1971, Nixon pronounces drugs "enemy number one"
- The Reagan era expanded the War on Drugs into a full crusade through multiple policies:
  - Mandatory Minimum sentences for drug crimes reduced the use of parole and extended sentence lengths, leading to a massive increase in the overall prison population *which particularly affected people of color from poor communities*
  - Disparate sentencing lengths for crack vs. powder cocaine unfairly targeted low income people of color
    - Crack cocaine use and trafficking remains subject to penalties 100 times more severe than those for powder cocaine
  - The Sentencing Act of 1984 – this attempt to eliminate discrepancies in sentencing by race and gender actually led to harsher sentencing for women
- Conspiracy charges disproportionally affect women, due to their minor roles in the drug trade and lack of substantial information that could be traded for a lower sentence
  - Longer prison sentences lead to higher recidivism rates
  - An increase in punishment for parole violations brought more people back to prison
  - Bans on public benefits for those with drug felony convictions limits economic resources and increases likelihood of resorting to illegal means to provide for self and family

Scope and Correlates of the Problem

The prison population grew by 700% from 1970 to 2005, a rate outpacing both crime and population rates. Since the 1980s mass incarceration has greatly increased the proportion of people of color in prison. Mass incarceration has also meant a surge in the incarceration rates of women.

Female incarceration is most often due to drug related crimes, the only crimes with mandatory minimum sentencing provisions.

Given the disparate effects the War on Drugs has on people of color, women of color are incarcerated at disproportionately higher rates than white women.

The rate of incarceration for African American women for all offenses has increased by 800% since 1986, compared to an increase of 400% for women overall.

Current Policies Addressing the Problem

Current Policies Aimed at Addressing Race and Gender Biases

- The 1991 Safety Valve Provision
- The Sentencing Reform Act of 1984 (creation of "Gender Neutral" sentencing)
- 2005 U.S. Supreme Court Decisions of Booker and Fanfan
- Gender specific drug courts and pretrial diversion programs (sometimes paired with gender-responsive treatment modalities)

*Many of these policies have actually **magnified racial, gender, and class-based disparities**, and women of color bear the brunt of these collective failures*

Current Legislative Efforts to Address Mass Incarceration

- Fair Sentencing Act of 2010 - Marijuana Legalization

Why Have We Not Seen More of an Impact?

These current policies fail to consider:

- Implicit racial bias within the judicial system
- The interactional role of gender, race, and class in women's pathways to crime
- Provision of adequate sentencing alternatives and widespread gender-responsive approaches to meet specific needs of growing numbers of women of color offenders

Policy Recommendations

In order to create a truly beneficial impact for women of color, we have developed three policy recommendations which target the problem from multiple angles:

1. Law Enforcement Assisted Diversion (LEAD) – Pre-trial diversion program: Police officers can divert women arrested for low level drug offenses into an intensive case management program that provides links to drug treatment, harm reduction services, and housing
   1. Implicit bias trainings for police officers and judges
   2. Annual reviews of the numbers of women of color in program vs. white women to measure and reduce implicit bias
2. Gender Responsive Federal Safety Valve for Drug Offenses to Reduce Implicit Bias (18 U.S.C. § 3553 (g)): Provides a specific pathway to help women avoid mandatory minimum sentencing through a safety valve law
   1. Female, first drug offense on record, current charge is non-violent, and has no previous record of violent charges
   1. Two out of the following four provisions must be applicable as well:
      1. The defendant is classified as low income utilizing as defined by 3 measures
      2. The defendant is diagnosed with a substance use disorder
      3. The defendant has been the victim of abuse in the past two years
      4. The defendant is the sole caretaker of a minor in their household
3. Repeal bans on welfare benefits for those with drug offenses on the federal level to allow women reentering communities access to much needed financial supports
   1. Sec 115a of The Personal Responsibility and Work Opportunity Reconciliation Act – lifts ban on TANF and SNAP
   2. Sec 483(f) of the 1998 Amendments to Higher Education Act – allows access to federal financial aid
   3. Sec 9 (b, d) of the Housing Opportunity Program Extension Act of 1996 – removes barriers to public housing eligibility

Ending Chronic Homelessness: The PUSH Act of 2016

Blakely Andrews, Audrey McDougal, Courtney Peck, Paola Theil, Maria Walcott

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Chronic Homelessness is a Social Problem

❖ 20 % of homeless individuals in US experience chronic homelessness: *live in place not meant for human habitation, have been homeless for at least one year or at least four times in last three years, and have a diagnosable disorder*

❖ Chronic Homelessness as a national problem can be viewed in three ways: individual, structural and biopsychosocial

The Scope and Trends in Homelessness

Percent of Homeless People by Household Type and Sheltered Status in 2015

Estimates of the Chronically Homeless Individuals by State in 2015

Figures:

83,170: Total number of the chronically homeless population across the US

13,105: People in families with children who are chronically homeless

70-80%: Individuals experiencing homelessness who are males

2/3: Chronically homeless individuals who stay in unsheltered areas

18: States experiencing an increase in the number of chronically homeless

Cost of Chronic Homelessness

The cost of providing emergency shelter to families is generally as much or more than the cost of placing them in transitional or permanent housing.

Figures:

$30,000 - $50,000: Cost of chronic homelessness to taxpayers per year

$8,067: Cost of an emergency shelter bed funded by HUD's Emergency Shelter Grants program

Pathways to Chronic Homelessness

1. **Cumulative Adversity**

❖ *Psychological.* Past experience of childhood instability, abuse, and violence

❖ *Social.* Lack or absence of social and family support systems.

❖ *Biological.* All chronically homeless suffer from disability.

❖ *Structural.* Less likely to have health insurance or public assistance.

	Mentally ill homeless	Mentally ill housed
Gender (% male)	80.2	35.9
Ethnicity		
% black	46.0	6.1
% white	36.2	52.8
% hispanic/other	18.0	42.1
Marital Status		
% married now	4.0	45.7
Recent alcohol dependence	46.2	19.9
Recent drug dependence	30.8	4.3

Study comparing over 1300 adults with severe mentally illness

2. **Lack of Affordable Housing and Insufficient Income**

❖ *Lack of affordable housing.* Number one barrier to securing housing.

❖ *Insufficient funding.* Exacerbates the scarcity of available units and Section 8 vouchers.

❖ *Insufficient outreach.* At times only half of eligible homeless adults with disabilities receive benefits.

3. **Disability and Lack of Access to Care**

❖ *Severe mental illness.*

❖ *Substance abuse disorders.* Can lead to loss of jobs and homelessness. Self-medication with drugs.

❖ *Access to treatment.* Programs that treat mental illness often do not accept people with substance abuse disorders, and vice versa.

4. **Being Homeless**

❖ *Chronic stress.* Being on the streets exacerbates factors contributing to homelessness.

❖ *Vicious cycle.* Revolving between hospitals, shelters, and jails, precipitated by reactivation of substance abuse.

❖ *Ontological security,* the feeling of well-being and constancy that comes from having a "home," fosters repair and healing.

Current Policies

The HEARTH Act of 2009

❖ The HEARTH Act amendment to the McKinney- Vento Act of 1987 authorizes supportive housing for the chronically homeless by consolidating multiple programs into one Continuum of Care (CoC).

❖ The HEARTH Act redefined HUD's definition of "chronically homeless" to be more inclusive of people with disabilities.

❖ CoC funds permanent housing, transitional housing, supportive services, and homeless management information system operations.

The Affordable Care Act of 2009

❖ The *Health Care for the Homeless Program* (HCH) makes grants to community-based organizations in order to assist them in planning and delivering high-quality, accessible health care to the homeless.

❖ In 2010 the ACA provided $11 billion to Health Care for the Homeless program centers.

❖ HCH funds primary health, mental health, addiction recovery, and social services. Intensive outreach and case management links clients, including those with mental illness & substance abuse issues, with housing and appropriate services.

The Rehabilitation Act of 1973

❖ *The Rehabilitation Act* (RSA) was the first major legislative effort to secure an equal playing field for individuals with physical and cognitive disabilities, funding a wide range of services through state grants, and prohibiting discrimination on the basis of disability.

❖ Title VII establishes guidelines for *Independent Living Services* and for the *Statewide Independent Living Council* which develops the principles for funding allocation.

❖ *Independent Living Centers* are nonresidential resources centers for the disabled that provide: advocacy, independent living skills training, assistive technology, & peer counseling.

Policy Gaps

❖ The Rehabilitation Act authorizes grant programs for vocational rehabilitation, supported employment, *independent living*, and client assistance. However, currently there are no official grant funds geared towards the development of permanent supportive housing for the chronically homeless with disabilities.

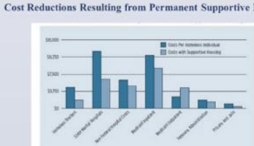
❖ *Opening Doors* employs a partnership model to reduce and end homelessness by maximizing the effectiveness of the federal government and key partners. HUD currently partners with the VA and DHHS, but *there is no official collaboration between HUD and the Rehabilitation Services Administration* housed under the DOE.

❖ The development of permanent supportive housing for the chronically homeless including supportive services provided on-site, is in jeopardy if new funding resources are not secured.

❖ The Rehabilitation Act of 1973 can be amended to better serve the chronically homeless population with mental health and substance abuse disabilities by funding grants through the Rehabilitation Services Administration for the development of PSH and partnering with HUD.

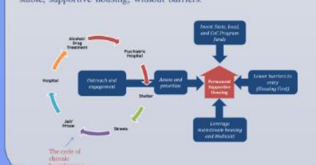
The Solution: Permanent Supportive Housing

Cost Reductions Resulting from Permanent Supportive Housing



Permanent Supportive Housing to End Chronic Homelessness

It works! It disrupts the cycle of chronic homelessness by providing stable, supportive housing, without barriers.



The PUSH Act of 2016

The PUSH Act of 2016:

❖ Addresses chronic homelessness by providing permanent supportive housing & outreach

❖ Is an amendment to the re-authorization of the McKinney-Vento Act

❖ Creates and maintains partnerships between government agencies: *Rehabilitation Services Administration & Independent Living Program; ACA & Healthcare for the Homeless Program; HEARTH & PSH*

❖ Establishes a self-evaluation function: Using Prevention Fund money from the ACA for research on the effectiveness of PSH and efforts of "the Push Act"

❖ Establishes best practices for outreach to the chronic homeless population, closing the gap between individuals who are eligible for but not receiving benefits (Medicaid, SSI, RSA, etc.)

❖ Reports to and coordinates w/ Homeless Management Information Systems (HMIS) under HUD

❖ Proposed Budget for Fund Year 2016/2017: $2 billion

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Advanced Policy Electives

- Mental health policy
- Child welfare policy
- Aging policy
- Substance abuse policy
- Family policy
- Children's rights and the law
- State legislative processes

Increasing the Focus on Policy Practice

- New grant from CSWE: *Policy Practice in Field Education Initiative*

Policy Practice in Field Education Initiative

- Project Goal: creating opportunities for all students to develop fundamental policy practice skills and knowledge about intersection of race, ethnicity, and poverty

- Project plan has three foci: (1) training and support of field instructors; (2) foundation placement; (3) advanced placement.

Training and Support of Field Instructors

(1) Strengthening current content in the Seminar for New Field Instructors related to policy practice assignments in the field.

(2) Developing several online workshops focused on policy practice assignments in the field for foundation and advanced clinical and macro students.

(3) On-going support: development and dissemination of resources such as key issue websites and listservs, relevant data sources, “tips” for meetings with legislators, communication strategies for effective lobbying. Issues areas of race, poverty, and social justice will receive primary focus. There will also be opportunities for consultation on student field assignments from policy faculty and field education staff.

Foundation and Advanced Placement Assignments

- *Foundation placement and linkage to foundation policy courses*. Products for the student portfolio will include: poster of WP701 task force project, MP759 community analysis, and field assignment (e.g., policy brief).

- *Advanced placement and linkage to advanced policy courses*. Students' policy practice field assignment in the advanced year will focus on either policy analysis or advocacy (primarily legislative advocacy). The portfolio product will include the resulting position paper for policy/program solutions based on this analysis.

Thank You

Comments?

Questions?