INNOVATION AND CHANGE IN THE HUMAN SERVICES

ABOUT THE AUTHORS

Nicholas D. Richie, M.S.W., Ph.D., practiced clinical social work in child welfare, medical, and psychiatric settings before teaching health administration students at four universities, in Illinois and Florida, for near thirty years. In his local communities, he has served as a volunteer in such human services settings as a psychiatric veterans hospital, a municipal health planning agency, a university AIDS peer education program, and a hospice for those with life-limiting illnesses. He was recently awarded the status of Professor Emeritus of Health Administration at Florida Atlantic University.

Diane E. Alperin, M.S., Ph.D., practiced social work in child welfare and health care settings before she began teaching social work students at Florida Atlantic University over twenty years ago, where she is currently Associate Provost and Professor of Social Work. In her local community, she has served as a volunteer and consultant in a hospice, a domestic assault shelter, and public and private child welfare agencies. She is currently the President of the Board of Directors of the Maternal Child Family Health Alliance of Palm Beach County.

Also by the authors: *Human Services and the Marginal Client*

Second Edition

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By

NICHOLAS D. RICHIE, M.S.W., PH.D.

Professor Emeritus of Health Administration
Florida Atlantic University

and

DIANE E. ALPERIN, M.S., PH.D.

Associate Provost and Professor of Social Work
Florida Atlantic University

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PREFACE

Since the publication of the first edition of *Innovation and Change in the Human Services* in 1992, significant activity in the human services has occurred on both the national and international scenes–encouraging us to prepare this expanded/revised second edition. In the first chapter of this new edition we expand on our twentieth-century overview of the evolution of human services in America during that tumultuous century. In the second chapter we discuss eight human services that made considerable strides in the late twentieth century, and which collectively illustrate an evolutionary model that we propose to illustrate how human services progress from an initial "individual-problem stage" to one of considerable government involvement and visibility. In the third chapter, we add a discussion of three important case studies based on major events that occurred after the earlier edition was published: the Clinton Health Care Proposal, the Oregon Death with Dignity Act, and the Welfare Reforms of 1996. Because human services workers are coming to their profession from a variety of educational routes today, we devote the fourth chapter to a discussion of innovation in human services education, illustrating several related educational models in operation today. In the last chapter, we have focused on several areas likely to receive considerable attention in the early twenty-first century: corporatization of human services agencies, privatization of human services, Social Security reform, and healthcare reform.

We believe this material will be of value not only to educators and students in the human services, but also to policy analysts and human services administrators/practitioners who face every day the challenge of refining/adapting/reinventing the programs they administer, study and support–to provide the highest quality service to the greatest number.

N.D.R.
D.E.A.

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Chapter 1

THE EVOLUTION OF HUMAN SERVICES IN THE TWENTIETH CENTURY–AN OVERVIEW

INTRODUCTION

Human services have been defined as those disciplines that undertake to help people solve their problems of living and growing (Epstein, 1981). Examples include the activities of health professionals, social workers, and criminal justice workers–in such fields as child welfare, crime and delinquency, disability and physical handicap, healthcare, family counseling, housing, income maintenance, labor relations, mental health, migration and resettlement, nursing home care, protective services, and recreational services, among others (Minahan, 1987).

Various human services organizations (hereafter, HSOs) have evolved to offer such services and have as their primary function "to define or alter a person's behavior, attributes and social status in order to maintain or enhance his well-being" (Hasenfeld and English, 1974, p. 6). Over the course of the twentieth century, the overall provision of human services evolved in an incremental, nonsystematic manner, and this evolution varied somewhat, depending on purpose, sponsorship, external and internal factors–among others.

HSOs may be divided into three main categories: governmental, voluntary, and private. We will use these three terms in the same way as Kahn, recognizing that the terms are variously defined by writers in the human services field. By *governmental*, we mean services that are a unit of government at any level (federal, state, county, municipal). By *voluntary*, we refer to agencies that are not-for-profit, community-based. By *private*, we refer to for-profit agencies–also known as investor owned, tax paying (Kahn, 1984).

Each of these types are discussed later, but overall, during the twentieth century, one saw a continued increase in demand for human services on the part of the public. The voluntary sector, in particular, was limited in its abil-

ity to meet these increased demands due to the pervasiveness of some of these needs, the cost to ameliorate them, historical and social conditions, and demographic shifts (Jimenez, 1990).

A major criticism of much of the human services sector today continues to be the lack of comprehensive, coordinated coverage of the problems affecting individuals, families, and communities. Indeed, even the identification of which problems are worthy of focus has often been debatable (Morris, 1986).

Using the sociological theory of functionalism, one may view the social world in systemic terms, with an emphasis on equilibrium/homeostasis, in which interrelated parts interact to accomplish mutually desired goals (Chambliss, 1973; Turner, 1982; Stoesz, 1988). As the following descriptions of the three main types of HSOs indicate, a holistic, coordinated approach in the human services will require considerable effort to achieve and involve the participation and cooperation of many competing groups and their respective agendas.

GOVERNMENTAL HSOs

At the turn of the twentieth century, the United States–which had inherited the "Poor Law" tradition of Elizabethan England (Kohlert, 1989)–had endured more than one hundred years of promoting the ideal of laissez-faire, free-enterprise capitalism. When combined with the rugged individualism espoused on the Western frontier, there was little incentive at the federal level to voluntarily assume national responsibility for many of the services currently believed to be the responsibility of government (Lee and Benjamin, 1988). It is true that at the dawn of the Republic, the federal government established the Marine Hospital Fund for the Relief of Sick and Disabled Seaman, in 1798–to protect merchant marines in a society highly dependent on sea trade for its economic well-being (Mullan, 1989). It is also true that in the nineteenth century, universal public education was made available by the individual states (Gutek, 1970). However, Dorothea Dix's struggle to establish mental hospital systems within the respective states, although ultimately successful, illustrates the reluctance of government at various levels to become involved in the direct provision of human services (Lee and Benjamin, 1988).

As Wilensky and Lebeaux argued, with increasing industrialization in the twentieth century came greater (and new) social problems that required a concerted, broad-based governmental approach (Wilensky and Lebeaux, 1958). Thus, at the start of the twentieth century, fear of epidemics of contagious diseases, particularly in crowded urban environments, prompted the provision of public health services–at the municipal, county, state, or feder-

al level, depending on the nature and severity of the problem. Popular techniques at that time were mass immunizations and quarantine (Rosen, 1958).

At the same time, widespread reports of danger to the public's health (such as in the case of spoiled meat, milk, and other foodstuffs and questionable medications and medical devices) prompted the federal government to establish the Biologics Control Act in 1902, which gave the Hygenic Laboratory (later to evolve into the National Institutes of Health) regulatory authority in the production and sale of antitoxins and vaccines (Mullan, 1989). The Food and Drug Administration followed, in 1906 (Luce, 1988, p. 290). Related governmental agencies were established at the state and/or local levels, in many instances.

Another problem, related to the proliferation of injury and death in the workplace, as industrialization increased, led to the passage of Workers' Compensation Laws, in the various states, beginning in 1911 (Mowbray and Blanchard, 1955). Industrialization also contributed to the social problems of overcrowding, unemployment, and poverty, which were the impetus for states to become active in the provision of welfare services. "Mothers' aid" and "mothers' pension" programs evolved to assist children in fatherless families. Some states followed with programs that focused on specific populations, such as the blind and disabled (DiNitto, 2000).

World War I, with its massive mobilization of men to be examined for service, and possibly accepted for military duty, led to a large-scale natural experiment, in which authorities were able to collect a great deal of data, within a relatively short period of time, on the male population. Results of the analysis indicated widespread illiteracy and undereducation, malnutrition, untreated chronic and acute problems, and poor dental care (Engleman and Joy, 1975). When resources were freed-up again, after the war, there was both professional and public pressure for programs at various levels of government that could deal with such problems. In addition, the long-term rehabilitation of World War I veterans, who had been gassed or otherwise disabled, required new solutions–sometimes including the development of "new professions"–particularly those involving vocational and psychological counseling, occupational and physical therapy (Stanfield, 1990).

Still, despite these developments at various levels in the governmental sector during the first three decades of the twentieth century, it wasn't until the New Deal of the administration of President Franklin Roosevelt that a national approach to social welfare, as an important part of the broader human services spectrum, was initiated. The massive collapse of the economy at the time of the Great Depression called for an equally-massive approach to provide economic security to all (Miringoff, 1980). The landmark federal legislation, on which so many other federal human services programs have been built, is of course the Social Security Act of 1935 (Social Security Act of