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by

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ABSTRACT

Caught in a cross fire of contradictory claims and charges, the social service component of the Aid to Families with Dependent Children (AFDC) program has been characterized both as a lever for increasing dignity and self-sufficiency and as an excuse for unproductive meddling and regulation by caseworkers.

The authors find, on the basis of survey data collected in Wisconsin, a very low level of social service activity, mostly directed toward maintaining or supporting the status quo rather than toward improving or altering life chances of AFDC clients. Clients seem to discriminate in their judgements among (1) specific aid services, which are helpful but not bothersome (2) services which are chiefly general discussions of little help, little bother, and little effect and (3) specific regulation stemming from social service, not helpful but often bothersome. Overall, for the social service areas of child care, house care, health and social life, women were more helped than compelled to follow advice, more compelled to follow advice than bothered.

Most women expressed positive feelings toward their caseworkers, perhaps in part because contacts were infrequent and because caseworker-client relationships were geared to diffuse discussions rather than to produce specific aids. In areas of more interaction and regulation, feelings of hostility and bother were reported by the clients, suggesting that client acceptance of AFDC social services may be attributable to the lack of impact and smallness of scale of the services.

In view of the data, the effect of reforming the administration of services and of separating income-maintenance from service is evaluated, particularly as to whether changes in the system would reduce dependence or foster it.

The Administration of Social Services in AFDC: The Views of Welfare Recipients

by Joel F. Handler and Ellen Jane Hollingsworth

In 1956 and 1962, the Social Security Act was amended to add a social service component to the Aid to Families with Dependent Children (AFDC) program. Under the amendments, the states were authorized to furnish "rehabilitation and other services" to AFDC families "to help maintain and strengthen family life" and to help families "to attain or retain capability for the maximum self-support and personal independence."[1] Services were to be provided by skilled workers and other specialists. The Ad Hoc Committee on Public Welfare, formed in 1961 by Abraham Ribicoff, President Kennedy's Secretary of Health, Education and Welfare stated:

> "Financial assistance to meet people's basic needs for food, shelter, and clothing is essential, but alone is not enough. Expenditures for assistance not accompanied by rehabilitative services may actually increase dependency and eventual costs to the community. The very essence of a vital program should be full use of all rehabilitative services including, but not confined to, provision of financial assistance. The ultimate aim is to help families become self-supporting and independent by strengthening all their own resources."[2]

Pressure to do something about public assistance, and particularly about AFDC arose in the late 1950's when it became

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[1] 42 U.S.C. § 601, as amended, 1962.

[2] Ad Hoc Committee on Public Welfare, Report to the Secretary of Health, Education, and Welfare (Washington: September, 1961), p. 13.

apparent that public assistance was not going to "wither away."[3] One of the important arguments made to Congress in support of the 1935 Social Security Act was that a large public assistance program was a temporary phenomenon. As the coverage of contributory social insurance expanded and as prosperity returned, public assistance rolls would decrease. This trend did in fact occur with the aged; the recipient rate for Old Age Assistance declined as more of the aged became eligible for old age insurance. On the other hand, AFDC and Disability rolls continued to increase, and overall, as prosperity increased, so did the public assistance rolls. A large public assistance program began to look like a permanent feature of American life.

It was in this context that the new Kennedy administration felt it had to come up with a "fresh approach," in the words of Secretary Ribicoff, a reappraisal "possibly unprecedented in its scope and depth." The reappraisal resulted in the 1962 amendments, hailed as a "landmark," a "new philosophy in welfare." Ribicoff, in testifying before Congress, said, "We have here a realistic program which will pay dividends on every dollar invested. It can move some persons off the assistance rolls entirely, enable others to attain a higher degree of self-confidence and independence, [and] encourage children to grow strong in mind and body...." According to Gilbert Steiner, "the welfare professionals responsible for developing the 1962

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[3]See Gilbert Steiner, Social Insecurity: The Politics of Welfare (Chicago: Rand McNally & Co., 1966), ch. 2.

legislative proposals were convinced that a new day had dawned."[4]

There is, of course, an old-age debate over what the poor need to improve their life chances: more money or more social services. It is claimed, for example, that if families on welfare were given a higher standard of living--in cash--they would have the capacity and the will to accomplish the objectives of the social service programs on their own. They would have higher aspirations for themselves and their children, they would have fewer health problems, higher standards of home care, and they would lead more satisfying personal and social lives. On the other hand, it is also stoutly maintained that the problems of the poor are much more than economic and that even if family incomes were increased, many families on welfare would still need social service help. The merits of these alternatives have never been tested, and are beyond the scope of this paper. But in 1956 and 1962, Congress adopted the latter alternative for the AFDC program. The amendments to the Social Security Act required a social service plan for every AFDC family[5] and, as an inducement to the states, increased to 75 per cent the

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[4]Ibid. In fact, the 1962 amendments did not add much substantively to the 1956 amendments. More was done in the 1962 amendments about training and incentives to the states. Steiner argues that on balance there was not that much "new" in the 1962 changes, and that the proponents were really engaging in public relations.

[5]See J. Handler & M. Rosenheim, "Privacy in Welfare: Public Assistance and Juvenile Justice," Law & Comtemp. Problems, XXXI (1966), 377, n. 64.

federal share of state rehabilitative and preventive services.

This paper will examine some aspects of the administration of social services in the Wisconsin AFDC program. First, we will set forth the state definitions of rehabilitative and preventive services. Second, we will examine how these services are administered in the field: what the caseworkers do, what the clients do, and what the clients think, attempting to shed light on the nature of the relationship that develops between caseworkers and welfare clients. Third, we will try to relate the implications of our findings to some of the basic issues concerning the structure and organization of social services.

The data for this study consist of state laws and administrative regulations and survey responses from 766 AFDC recipients. The survey was taken in the summer and fall of 1967 in Milwaukee County, the state's largest, and five other Wisconsin counties. Two of these counties (Dane and Brown) contained middle-sized cities (Madison and Green Bay) and three were rural (Walworth, Sauk, and Dodge). In Milwaukee, Dane and Brown, the respondents were randomly selected; in the rural counties, all AFDC recipients were solicited.[6] The distribution of responses by county was as follows:

Table 1

AFDC Recipients Surveyed by County

Milwaukee	Dane	Brown	Walworth	Sauk	Dodge	Total
302	179	86	80	57	62	766

[6]The average response rate for each of the six counties was about 80 per cent.

A. The Definition of Social Services

The Wisconsin State Department of Health and Social Services Manual defines social services as follows:

> "Social services are those direct service activities and interactions with the client which require knowledge and skill in the area of social casework, social group, and community organization technique. These skills are applied as the individual case situation requires. The mobilization of client capacities to make productive use of himself and others is accomplished primarily through the enabling and supporting character of the relationship he shares with the social worker."[7]

The purposes of the social service program are defined in terms of the 1956 and 1962 amendments to the Social Security Act--to help families and individuals to maintain or attain self-sufficiency, independency and dignity.

The caseworker, in a one-to-one relationship, is the principal administrator of the social service program. Through the interview method, he establishes a relationship and "consciously develops for himself and the client an understanding of the client and his problems that are standing in the way of full participation in family and community life." Client requests for service, even though related to specific needs, may be used to establish the relationship. "If the request for service embodies only the client's response to the immediacy of the precipitating problem, further exploration is indicated. . . .The end result may be a redefinition of the initial request, a

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[7]Unless otherwise indicated, all quotations from the state regulations are from the State Department of Health and Social Services Manual, Section III, Chapter 1.

progression from seeking symptomatic relief to a desire to correctively cope with past unresolved problems and handle anticipated problems."

The primary tool for direct casework services is the social study which consists of a reciprocal and joint inquiry between the caseworker and the client by which the caseworker gathers information about the client and her needs. Present client behavior is to be explored in depth to determine precipitating factors and to sift and weigh these factors in relation to the client's real life situation and environmental influences. Environment is defined as "the family, religious, social, community, cultural, and economic influences in the client's life." The social study is supposed to be a continuous process, starting at intake and lasting until the recipient leaves the program. During this process, "the social worker weighs the client's attitudes, words, and responses to his situation against the facts as the social worker has observed them. As a result of this process, the social worker is able to determine whether there are problems other than the need for money."

The extent of social services should be related to client needs, and not all clients need social services. "For some, certification for food stamps or surplus commodities, certification for medical care and authorization of a money payment to meet a budgetary deficit is all that is needed to accomplish the goals and objectives of our program." However, when certain "defined problem areas" are identified the family is designated by the county department of welfare as a "defined service case."

For AFDC, "defined problem areas" include "unmarried parents and their children. . ., families disrupted by desertion or impending desertion, families with adults or older child with potential for self-support, children in need of protection, children with serious special problems, families with serious problems in family functioning, families with problems in money management, families disrupted by absence of parent for reasons other than desertion, and children in foster care. . . ."

A "social service plan" is then developed by the caseworker for these "defined service cases." The plan means "the selection of the steps to resolve the problem, or to help the client to cope with it." As a guide to caseworkers, the Manual lists social service activities that may be appropriate for specific problem areas. For example, for unmarried mothers and their children, social service activities include counseling and facilitating the use of medical care, child care, training and placement, "counseling regarding environmental conditions seriously contributing to illegitimacy," obtaining legal counsel, and referrals to specialized agencies and community services. For families headed by deserted mothers, activities include counseling children about the loss of the parent, attempting to maintain ties in securing support, counseling the remaining parent about dual responsibilities, and recommending the use of specialized agencies and community resources for serious problems.

Many social service activities are of a maintenance nature; they are designed to help families cope at existing levels. Examples include health, child care, home and financial management.

Other activities are designed to help families to become self-sufficient, and able to get off welfare. These include making arrangements for assessing employment skills and opportunities, facilitating training or "appropriate" employment, helping make the best use of educational opportunities, assisting older teenagers in evaluating their interests and potentials, working out day care arrangements, and so forth.

Designating a family as a "defined service case" has important administrative consequences. Whereas the frequency of contact between the client and the caseworker (which is usually by a home visit) is ordinarily left to the discretion of the caseworker, for "defined service cases," there has to be a client-caseworker contact at least every three months "except in cases in which the achievement of service goals warrants the tapering off of contacts." Under the 1962 Social Security Act amendments, the federal government pays 75 percent of the administrative costs of social services for "defined service cases," including the caseworker's salary. Thus, there is a substantial incentive for the county agencies to classify families as "defined service cases."

Although the Manual stresses the one-to-one caseworker-client relationship as the basic social service instrument, there are other ways of accomplishing social service objectives. Caseworkers are instructed to use, where appropriate, group services ("helping clients cope better with problems through a group experience") and community and other social service resources.

Under the Wisconsin definitions, every aspect of AFDC administration can be considered social service. The determination of

eligibility and the administration of the budget, including special grants for special needs, if done properly, may have a social service or rehabilitative value. Indeed, the Wisconsin state department takes this position. The administration of the responsible relatives laws, whereby certain relatives may be required to support dependents, is supposed to be part of a social service plan to build family relationships. The administration of money payments is supposed to encourage home management and client responsibility. Other AFDC activities, such as employment and re-training programs, also have, at least in theory, this dual aspect.

For the purposes of this paper, we have included under social services the following topics: child care, health, home care, social life, and participation in special community programs such as Head Start, Neighborhood Youth Corps, Project Off, "Parents without Partners," etc. We have also included the client-caseworker relationship. The caseworker relationship extends, of course, beyond the administration of social services; indeed, it is often claimed that the most important part of the caseworker relationship arises out of the administration of the budget. We have included it here because of the central importance of the caseworker in the administration of social services.[8]

Our attempt here is to examine how social services are administered at the field level. But we are looking at administration

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[8]Employment has policy implications that extend beyond social services administration and will be treated in a separate study.

from the client's point of view. Statements as to what happened, as well as what impact it had and what attitudes were formed, are based on client responses and are, of course, subject to the limitations of this form of data.

The effect of race should never be absent from the consideration of AFDC policy issues. In Milwaukee County, there were sufficient Negroes to make comparisons. In general, we found that there were no significant differences in responses between Negroes and whites, and that our principal findings apply to all the AFDC recipients regardless of race. However, there were some differences, and because of the importance of race as a policy matter, we will discuss Negro responses separately at the end of the sections which deal with the social service areas and the caseworker relationship.

B. Social Service Areas.

Children. High proportions of clients reported having discussions with their caseworkers about their children. In two counties (Dane and Brown), almost 90 per cent reported such discussions; and the proportion for all the respondents was 80.7 per cent. The topics that were discussed are presented in Table 2. Of those who had these discussions, the median number of topics discussed was 2 per respondent.

Table 2

Topics Relating to Children Discussed by Caseworkers

Topics	No. & % Reporting Topics Discussed*	
General upbringing; nothing in particular	469	75.9
Health	463	74.9
How children are clothed and fed	212	34.3
Specific school problems	364	58.9
General plans for future education/employment	205	33.2
Employment--about present job	111	18.0
Employment--whether children should take a part time job	92	14.9
Other	58	9.4
	(618)	

*Percentage of only those respondents who reported discussing children with caseworker.

The distribution in Table 2 indicates that caseworkers tend to avoid topics which (a) might lead to complaints and requests and (b) would result in the caseworker finding it difficult to make delivery or be of help. Given the low levels of financial support, and the obvious relevance of the topic, one would expect that a high proportion of clients would report discussing how children were clothed and fed. Yet, fewer than a third of the respondents reported discussions about these matters. Even though lack of sufficient money for clothing and proper food are a persistent worry among the respondents, caseworkers seem to avoid discussing these matters, which would inevitably lead to requests for more money. According to the clients, the caseworkers tend to stay away from the issues of employment

for children. Of those respondents with children 12 years or older, only 35 per cent reported discussions of employment possibilities.

Conversely, proportions reporting discussions about general upbringing (nothing in particular), health, and school problems are high. Discussing general upbringing and school problems may be no more than mere conversation or advice and guidance, with no direct costs or other real burdens to the agency. School problems are, for the most part, handled by the school authorities. Health, on the other hand, is a tangible item calling for delivery that costs money. We will discuss the mechanics of the health care program for AFDC in the next section, but point out here that there are two reasons for high caseworker activity in this area. First there is impressionistic evidence that there is a real commitment to health care by the agencies and most of the caseworkers. Second, the Medicaid program makes it easy for the caseworkers to deliver in this area even though it is costly to the counties and the state.

Slightly more than half of the respondents reported that discussions about children occur on every caseworker visit. Attitudes toward these discussions are presented in Table 3.

Table 3

Client Attitudes towards Caseworker Discussions about Children*

Do you find the discussions about children helpful?

Very	23.5%
Usually	24.9
Somewhat	30.2
Not at all	20.9
	(615)

Do you feel you have to follow advice that your caseworker offers concerning your children?

All of the time	9.4%
Most of the time	31.2
Not very often	23.8
Not at all	31.4
	(592)

To what extent does it bother you to have your caseworker discuss your children?

Very much	4.5%
Moderately	4.0
Slightly	8.7
Not at all	82.2
	(615)

*Percentages of those reporting discussions.

The responses in Table 3 indicate that a substantial proportion of clients (a) find the caseworker discussions at least somewhat helpful; (b) feel some compulsion about following the caseworker's advice, but (c) are not bothered or upset by discussions. Does this mean that as long as clients are helped by caseworker activity, they are not bothered by it? Actually not. Clients who say they are helped by the discussions are also more likely to report they are bothered by them. That is, one of the consequences of meaningful caseworker activity (i.e., clients reporting being helped), is to increase client upset. Why do clients who do not find the discussions helpful say they are not bothered?

Perhaps these clients do not have any expectations; they are removed from the program, and are indifferent to the caseworker discussions.

Health. AFDC recipients are automatically eligible for participation in the Medicaid program, which was established and financed under a separate title of the Social Security Act. The cost of Medicaid is shared by the federal, state, and county governments. The federal share per state is based on per capita income and is subject to revision annually. In Wisconsin it was set at 56.58 per cent in 1967 and has not changed. The state contributes between 80 and 45 per cent of the remaining cost of medical expenses depending on the ability of the particular county to pay. During the time of this study, the state contribution to the six counties in this study was: Milwaukee, 55 per cent; Dane, 50 per cent; Brown, 45 per cent; Walworth, 45 per cent; Sauk, 50 per cent; Dodge, 50 per cent. Stated in other terms, for every $100 spent on clients under the Medicaid program, the six counties contributed between $19.54 and $23.88.

According to state regulations when a person becomes eligible for AFDC, she is to be given a certificate (card) which entitles her to use the Medicaid program. On her own initiative, without prior welfare agency approval, she can go to participating suppliers of medical services--doctors, dentists, hospitals, clinics. They supply the services and bill the counties at rates which have been fixed by agreement between the State Department of Health and Social Services and the state medical, dental, and hospital associations.

There are many reasons for expecting a high use of Medicaid. Health needs do not raise moral issues. Expenditures for even basic items such as food, clothing and rent may raise questions of frivolity, "high living," poor management, etc., questions not raised by expenditures for health. A professional of sacrosanct community prestige determines whether the need is justified. The costs of the need have been predetermined by the professional organizations. No money is given to the client; it is paid directly to the doctor, dentist, clinic, or hospital. To object to this program is to challenge the medical professionals on both the existence of needs and the cost of meeting them. In sum, the Medicaid program (a) gives the agency an opportunity to deliver a tangible good, as distinguished from a "talking good;" (b) does not raise the moral issues which surround most welfare issues; (c) has independent professional judgment to control the expenditures; and (d) does not involve high political costs for county welfare departments as opposed to other kinds of welfare department expenditures.

About 72 per cent of the respondents reported having discussions with their caseworkers about health problems. There was some variation in the rural counties. For example, 87.7 per cent of the Sauk County respondents reported having health discussions compared to 53.2 per cent of the Dodge County respondents. Legally, caseworker approval is not required before using Medicaid. Why, then, was there such a high rate of caseworker discussion and why was there some variation in the counties? It has been reported that the distribution of Medicaid cards was far from automatic and

that some caseworkers did not give out the cards until the clients asked for them. This practice would account for discussions and perhaps even the variations between the counties. In addition, social services may be needed to facilitate the use of Medicaid--counseling clients on how to use the cards, where to go, overcoming fears, arranging for transportation and babysitting, etc. County differences may also be related to the availability of medical facilities; more caseworker stimulus may be needed when medical facilities are distant or limited. Of those who had discussions, 90.9 per cent reported discussions about medical needs, 77.8 per cent about dental needs, and for 32.7 per cent, the discussions involved mental health problems.

Client attitudes toward caseworker discussions about health are presented in Table 4.

Table 4

Client Attitudes toward Caseworker Discussions about Health*

Do you find the discussions helpful?

Very	43.3%
Usually	22.9
Somewhat	24.4
Not at all	8.4
	(547)

Do you feel that you have to follow advice that your caseworker offers concerning health?

All of the time	16.0%
Most of the time	41.5
Not very often	19.3
Not at all	21.5
	(541)

To what extent does it bother you to have your caseworker discuss this?

Very much	1.8%
Moderately	6.5
Slightly	5.8
Not at all	85.1
	(548)

*Of those reporting discussions.

Generally speaking, there was no variation in the responses or attitudes between Milwaukee County and the two middle-sized counties, but there was some variation among the three rural counties. Even though Sauk had a higher proportion of respondents reporting health care discussions, a lower proportion found the discussions helpful. Again, this may be due to variations in the availability of services or the extent of actual use. The basic findings on the health discussions, however, are that most clients report having the discussions, the discussions are felt to be useful, and the clients apparently are not bothered by them. Furthermore, in contrast with discussions about child care, there is no relationship between the extent to which women are helped and the extent to which they are bothered. Apparently health care is not as sensitive an area of discussion as child care.

Home Care. Caseworker discussions about the clients' care of the house occur infrequently. The response rate for all respondents was only 10.2 percent, although in Milwaukee County, 18.5 percent reported having those discussions. The topics discussed were cleanliness, cooking, nutrition and diet, and general problems of home management. Although the numbers who had the discussions were small, about 45 percent said they were usually helpful or very helpful. About 27 percent said they felt they had to follow their caseworker's advice most or all of the time, and almost 70 percent were only slightly bothered or not bothered at all by these discussions.

Social Life. Eighty-two percent of the respondents did not have a husband living with them. This group was asked whether the

caseworker ever discussed their social life, specifically relationships with men, dating habits, or marriage plans. Of this group, 51.3 per cent said that they did have such discussions. If the respondent was divorced or deserted, she was asked about discussions concerning reconciliation. The topics discussed are presented in Table 5.

Table 5

Social Life (Relations with Men) Topics Discussed

1.	General encouragement -- get out more, talk about men, sex	18.2%*
2.	General information -- whether dating? marriage plans? have a boyfriend?	44.1
3.	Specific information -- about boyfriend, baby sitting, whether want to marry child's father	28.1
4.	Specific advice given -- contraception, counseling about specific marriage plans	12.1
5.	Caseworker hostile to social life -- don't go out or have fun, don't have men around the children	3.5
6.	Encourage marriage and reconciliation	10.5
		(313)

*Percentages of those who reported discussions totals more than 100% because more than one response tabulated.

Contrary to allegations in some of the literature, very little of the hostile, oppressive, moralistic or prying type of regulation appears in the responses. Most of the topics are of the type discussed by women over a cup of coffee. Attitudes towards social life discussions are presented in Table 6.

Table 6

Client Attitudes towards Caseworker Discussions about Social Life*

Do you find the discussions helpful?

Very	10.4%
Usually	10.8
Some	25.3
Not at all	53.5
	(316)

Do you feel that you have to follow your caseworker's advice?

All of the time	6.4%
Most of the time	19.9
Not very often	19.2
Not at all	54.5
	(312)

To what extent does it bother you to have your caseworker discuss this?

Very much	15.2%
Moderately	7.0
Slightly	14.9
Not at all	63.0
	(316)

*Of those reporting discussions.

There was some relationship between the type of topic discussed and client attitudes. Clients tended to get more upset when discussions moved away from general talk to specific information, and to say that discussions were helpful when they were encouraged to get out more.

Table 7

Client Attitudes toward Caseworker Discussions about Children, Health, Home Care, and Social Life*

	Children	Health	Home Care	Social Life
Helpful? Very; usually	48.4%	66.2%	44.9%	21.2%
Have to follow advice? All; most of time	40.6%	57.%	27.0%	16.3%
Bothered or annoyed? Very; moderately	8.5%	8.3%	26.9%	22.2%

*Of those reporting discussions.

The contrast between responses to discussions about health and to those in the other three areas indicates a discriminating attitude on the part of the clients. When caseworkers have something tangible to give that the clients want, then the clients find social service helpful; they feel that they have to follow the caseworker's advice but they say that this does not bother or annoy them. When caseworker services consist of just general talk and advice (including the non-health discussions about children), there is less feeling of being helped, less willingness to follow advice, and more feelings of bother and annoyance. And when discussions touched sensitive areas such as home care or specific aspects of social life, negative attitudes increased sharply. For these two areas, there was much less willingness to follow advice, and about one out of four recipients who experienced these discussions was either very, or at least moderately, bothered or annoyed.

Special Programs. Do the caseworkers try to interest the AFDC mothers in special community programs for either themselves or their children? Nearly half of the respondents (49.1%) said that their caseworkers had discussions with them about special programs.[9]

Only about a third of the respondents had participated in a special program, and three quarters of these had discussed the programs with their caseworkers. Of those who did participate, very few entered into more than one program. Since 75 per cent of all participants did report discussions, it is reasonable to assume that caseworkers were instrumental in getting clients to participate. The programs respondents participated in are presented in Table 8.[10]

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[9]The question asked was: "has your caseworker ever talked to you about, or tried to interest you in special programs offered for you or your children by the welfare department or some other community agency--job training, Head Start, special schooling, etc.?"

[10]There were 193 respondents reporting participation in War on Poverty programs, Of those, 75 per cent reported caseworker discussions.

Table 8

Special Programs that AFDC Recipients Reporting Caseworker Discussions Participated in: Kind of Activity Reported by Participants

Adult Programs	Percentages*
Vocational educational or job training	65.9%
Other education programs	6.6
Social (or self) improvement programs (not vocational or formal schooling)--e.g., Family Living program	28.6
Social groups--"Parents Without Partners"	3.3
Other community group or action groups--e.g., Mothers Club at Head Start	11.0
	(91)
Children's Programs	
Head Start	67.7%**
Other OEO programs--Neighborhood Youth Corps; Job Corps	14.5
Other education	16.1
Community groups--e.g., YMCA; Big Brothers	8.1
Summer camp	8.1
Other	1.6
	(124)

*Percentages equal more than 100 because some families participated in more than one program

**Percentages are based on number of families who have children participating, rather than the number of children per program.

It is interesting to note that a high proportion of those respondents participating are in work-oriented or self-improvement programs. For the children, most of the participation was in OEO poverty programs; very few participated in community programs that were not strictly defined for the poor. This raises a question about orientation of caseworker discussions of programs --to what extent do they fail to encourage clients to participate in programs or activities involving other social classes?

The three rural counties as expected, had lower participation rates than the other three counties. On the whole, the numbers participating in these counties were quite small. There was, however, an interesting difference in the proportions participating in the other three counties. In Dane, the progressive middle-sized county, 46 per cent of the respondents had participated in a special program; in Milwaukee and Brown Counties, the percentages were 39 and 34 percent respectively. What accounts for this difference? We noted above that caseworker activity, at least as measured by respondents' reporting caseworker discussions, was about the same for these three counties. However, if we look at the proportion of clients who participated as compared to the proportion who had discussions, we find that 65.7 percent of the Dane County respondents who had caseworker discussions, also participated in special programs. In Brown and Milwaukee Counties this was true for only about 48 percent of the respondents. Apparently, caseworker discussions about special programs are more effective in Dane County than in the other two. Differences in participation may also be due to the quantity and quality of services available, or to the accessability of alternative sources of information. Although Brown and Dane Counties are both middle-sized, Dane has far more programs, and has the University of Wisconsin with its School of Social Work. Differences might also be due to commitments on the part of the county social workers. Dane County social workers are reputed to be much more oriented toward special programs than are the Brown County social workers. Finally, differences in participation might be due to

the characteristics of the clients themselves.

A little less than a fifth (18.8 percent) of the respondents said they asked the caseworker about a special program either for themselves or their children before the caseworker mentioned it. In Dane and Milwaukee Counties, the proportions of clients who did this was about 22 percent; in Brown County, it was only 14 percent. What the clients asked about is presented in Table 9.

Table 9

Special Programs that AFDC Mothers Asked Caseworkers About*

Vocational for Adult--e.g., typing; job training, business course; practical nursing; refresher course; nurses aid; vocational school course; beauty school; Project Off	37.8%
Other Schooling for Adult--e.g., finish high school; education courses at home; child guidance; health; nutrition	7.7
School for Children--e.g., Head Start; nursery; summer school	30.8
Special Programs for Children--e.g., Y.M.C.A; camp; scouts	20.3
Special Programs for Adults--e.g., Family Living	2.1
Other	1.4
	(143)

*Of those initiating inquiries

Table 10

Caseworker Response to Client Requests about Special Programs*

Caseworker discouraged client or refused request	16.2%
Caseworker took no action	5.6
Caseworker gave support--information; told client to go ahead with idea	30.2
Caseworker helped to arrange program	38.0
Caseworker apparently helped (client participating with agency approval and money)	9.2
	(142)

*Of those initiating inquiries.

Clients' requests are apparently received favorably by the caseworkers. In about 80 percent of the cases, the workers took some positive action for the clients.

In summarizing client participation in special programs, we note that the programs clients request and participate in are clearly not frivolous. With adults, the programs are primarily either for education or employment; with children, it is primarily education. However, only about a third of the respondents have ever participated in any program, and very few have participated in more than one. When caseworkers raise this issue, participation increases markedly. Of those who had caseworker discussions, 62.2 percent have participated in a program, which is almost twice the rate for the entire group. Since clients tend to participate when programs are suggested, it would seem that the low level of participation is partly the result of the caseworkers' failure to bring programs to the attention of the clients.

Finally, for only a very small group (6.5 percent), was there any element of possible coercion. This group said that the caseworker did suggest that either they or their children participate in programs that they didn't want to participate in. The programs that the caseworkers suggested were as follows:

Table 11

Programs Caseworkers Suggested that Clients Resisted

War on Poverty programs for children	15.2%*
Adult vocational school	37.0
Social groups for adults (Parents Without Partners)	19.6
Community groups for children	6.5
Medical or mental health for groups for children	15.2
Other	8.7
	(46)

*Of those reporting unwanted programs suggested by caseworkers. Percentages equal more than 100 since more than one suggested program was reported per respondent.

No one participated in a program she didn't want, despite the caseworker's suggestion. If the clients were not interested in participating or thought that the program was not suited to their or their children's needs, they did not participate, despite the caseworker's suggestion.

Special Problems. About a third of the respondents (31.9 percent) said they or their children had problems or continuing difficulties other than money problems. They were asked whether they had spoken to their caseworkers about these problems and if so, had their caseworker been able to help them in any way,

Table 12

Non-Economic Problems of AFDC Families: Caseworker Help

Nature of Problem	% Respondents Reporting Problem		% With Problem that Talked to Caseworker	% Reporting Caseworker Helped Solve Problem
Respondent's health	21.0%*	(49)	78%	74%
Children's health	29.1	(71)	83	64
Children slow in school	7.0	(17)	88	80
Children behavior problem	37.7	(92)	75	40
Lack of transportation; communication	4.1	(10)	60	17
Problem related to husband	10.7	(26)	81	48

*Percentages equal more than 100 since some respondents listed more than one problem.

Health and children's behavior account for almost all of the non-economic problems reported. The proportion of respondents who discussed these problems with their caseworkers is high. The percentage being helped by the caseworker follows previous patterns of helpfulness responses; in addition, these responses are lower for children's behavior problems than they are for health problems.

Comparing the results among the six counties, the proportions of respondents who discussed non-economic problems with their caseworker were practically the same for Milwaukee, Dane, and Brown Counties. Again, we note the lack of difference between the large urban center and the middle-sized communities. Concerning caseworker helpfulness as reported by the respondents, there were few differences between Milwaukee and Dane Counties, but

lower proportions in Brown County said the caseworker helped.

In Milwaukee County, when we compared the responses of Negro recipients with white recipients, we found the following:

(a) children: for most of the topics, the reported frequency of caseworker discussions was about the same, with one exception: how children were clothed and fed. Here, Negroes were twice as likely as whites to report caseworker discussions;

(b) health: there were no differences in frequency of discussions;

(c) home care: the percentage of Negroes mentioning discussions was twice that for whites;

(d) social life: there were no differences. In two areas, then, there seemed to be different treatment of Negroes and whites. It must be kept in mind, however, that the number of respondents who reported discussions in these two areas is rather small. For example, about 80 Negroes reported discussions about how children are clothed and fed and only 40 reported discussions about home care.

Negroes had more favorable attitudes towards discussions about children than whites. This is consistent with the overall pattern of client responses. Clothing and food are tangible, pressing problems. Clients, in general, respond more favorably to social services for these types of issues than they do to more general advice and guidance or discussions about sensitive social issues. On the other hand, Negroes were more upset than whites concerning discussions about health matters, although they did find the discussions helpful. The reason for this may lie in the experiences that Negroes encounter when using medical facilities.

There were too few recipients reporting discussions about home care to detect differences in attitudes. Finally, more whites than Negroes felt that they had to follow their caseworker's advice regarding social life.

We found no differences in the response rates concerning special programs. Equal proportions of Negroes and whites reported caseworker discussions about special programs, and there were no differences in rates of participation or in the kinds of programs.

Although Negro and white recipients did not differ in mentioning non-economic problems, Negroes were much less likely than whites to turn to their caseworkers for help with these problems.

C. The Caseworker Relationship.

We have seen thus far what types of problems AFDC clients discuss with caseworkers and what their attitudes are towards these discussions. We now turn to more general questions concerning the caseworker relationship: what is the extent, nature, and quality of the relationship between clients and caseworkers?

Almost 80 per cent of the respondents had more than one caseworker since coming on the program. In all of the counties, the longer the respondents stayed on the program, the more caseworkers they had experience with. The average number of caseworkers per respondents was 2.49.[11] For Milwaukee, Dane and Brown counties the average length of time spent with the present caseworker, at

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[11]Average number of caseworker per respondent on the program one year or less was 1.97, from one to two years was 2.53, from two to three years was 2.84, and over three years was 2.83.

the time of the interview, was slightly less than 10 months. There was great variety among the three rural counties: Walworth, 7 months, Sauk, 22 months, Dodge, 18 months. For the respondents as a whole, the average length of time with the present caseworker was 11 months.

The frequency of caseworker visits and the length of their visits are shown in Table 13.

Table 13

How often do you see your caseworker and how long does your caseworker usually stay when he or she comes to your home?

	Milwaukee	Dane	Brown	Walworth	Sauk	Dodge	Total
More than once/month	7.0%	3.9%	2.3%	6.3%	5.3%	1.6%	5.1%
Once/month or two	40.7	19.0	26.7	27.5	29.8	30.6	31.1
Once/three months	30.5	71.5	57.0	30.0	33.3	29.0	43.1
Few times per year	13.9	4.5	11.6	23.8	28.1	35.5	15.3
Less	6.3	.6	2.3	8.8	3.5	3.2	4.3
N.A.	1.7	.6	0	3.8	0	0	1.2
	(302)	(179)	(86)	(80)	(57)	(62)	(766)
Mean minutes per visit	33	48	34	40	39	44	39

It was pointed out that under the 1962 amendments to the Social Security Act, county departments of welfare have a strong incentive to classify AFDC families as "defined service cases" and thus qualify for the 75 percent federal reimbursement. A "defined service case" requires caseworker contact (usually by a home visit) generally no less than once every three months. Officials at the Wisconsin state level report that the federal incentive has not only taken effect, but that the county departments treat the minimum contact requirement as a maximum. It would appear from Table 13 that there is something to these fears.

In Dane County, for example, almost all of the families are "defined service cases" and most of them are visited with the minimum qualifying frequency of only once every three months.

Interestingly, the respondents in Milwaukee report more frequent visits than those in the other counties. The average time spent visiting is slightly less than 40 minutes. Although the Dane County caseworkers appear to visit somewhat less often than the Milwaukee and Brown County caseworkers, they stay a little longer.

The overwhelming majority of respondents (86.2 percent) felt that the caseworkers visited them often enough. This was true regardless of whether the caseworkers visited once a month or more often, once every other month, once every three months or only a few times per year.

Is the caseworker someone the respondents like, trust, talk to, and discuss problems with? Practically 80 percent expressed positive feelings toward their caseworker: 53.8 percent said that their caseworker is someone they very much like, can trust, talk to, and discuss problems with; 23.9 percent said fairly; and about 20 percent said not really or not at all. Milwaukee had the highest proportion (26 percent) expressing negative feelings. The proportions in Brown and Dane were roughly the same--about 15 percent. Attitudes towards the caseworker did not vary with the number of visits; that is, regardless of the frequency of visits, the same proportions of clients had positive feelings. And this pattern was true in all the counties.

As a measure of client-caseworker interaction other than the home visit, respondents were asked a series of questions about their own initiative in trying to contact the caseworker. Eighty-five percent had tried to contact their caseworker at a time other than the regular visit. Of those who attempted to make contact, the average number of efforts was 4. Only 12.9 percent said they were unsuccessful. The resondents' reasons for calling their caseworkers are presented in Table 14.

Table 14

Problems For Which Clients Called Caseworkers

	% Of those Making calls	% Of all Calls	
Health	33.4%*	18.9%	(217)
Children	16.3	9.2	(105)
Husband (situations involved)	10.4	5.9	(67)
Social service need	26.7	16.9	(194)
Finances--purchases, repairs bills	45.1	26.6	(293)
Checks, grants	23.9	13.6	(156)
Report moving	10.7	6.1	(70)
Other	6.7	3.7	(43)
	(652)		1145

*Of those making calls. Percentages equal more than 100 because several respondents listed more than one thing that they contacted their caseworker about.

Practically 70 percent of the respondents attempting calls had made requests about financial matters. Almost a quarter had requests about their checks or basic grants; 45 percent wanted various bills paid, needed higher rent grants, or requested money for special purchases or repairs. Health problems included

questions about changing doctors, Medicaid cards, and hospitals. Problems concerning children (other than health) varied; school, employment, children moving in and out of the home were among those mentioned. Husband problems usually involved visiting privilages, non-support, and protection from threats. Under social service needs, clients mentioned requests for transportation, baby-sitters, nursery school, children's camps, Project Off, special shoes, employment and personal problems, and the seeking of general advice.

Even though requests for financial aid predominate, 53.4 percent of the respondents making calls did seek out the caseworker for a family or social service need, other than health. Although money may be involved in these requests too (e.g., payments for baby-sitter), many did not involve money and were probably not of a crisis nature (e.g., nursery school, employment problems).

Although a very high proportion of AFDC recipients did call their caseworkers on several occasions, one must not get the impression that there is intensive contact between clients and caseworkers. The number of contacts initiated by the respondents was only 1.64 per year. Dane County respondents called the caseworkers the most, but the average was only 2 calls per year. Moreover, the number of calls to caseworkers did not increase with time on the program. Women in the program two years did not make more calls than women who had been in the program for only one year. We are not sure what this means. One possibility is that women who call their caseworker have a more independent, assertive personality and

leave the program early. Another possibility is that women new to the program are more nervous, insecure, have more problems and therefore make more calls, and by the second year, may become more accustomed to the system and to their status. A third possibility is calls may be non-productive or there may be sanctions for calling. In any event the rate of calls to caseworkers does decrease over time on the program.

What is the relationship between attitudes toward the caseworker and calls to the caseworker? Regardless of the amount of trust in the caseworker, about the same percentage of respondents made no calls (12 to 17 percent) and about the same percentage (20 percent) made a large number of calls (about 7 calls). On the other hand, there was a relationship between trust of caseworker and success in contacting the caseworker; that is, the less trust the respondent said that she had for the caseworker, the less likely she was to say that she was usually able to reach him. Again, it is difficult to interpret this relationship. Lack of trust could result in lack of persistence in attempting to reach the caseworker. Lack of trust may have been induced by the caseworker's not being accessible, when the recipient was in need of him. Or, the client may have the opinion that a caseworker is generally not accessible and therefore doesn't really trust him.

High proportions of respondents said that they make "a special effort to stay on good terms" with their caseworker. There were some variations among the counties. Lower proportions of Milwaukee County respondents made such efforts than in the other counties.

Table 15

How often do you make special effort to stay on good terms with your caseworker?

	Milwaukee	Dane	Brown	Walworth	Sauk	Dodge	Total
Always	65.6%	82.7%	82.6%	76.3%	78.9%	90.3%	75.6%
Usually	11.9	7.8	7.0	8.8	21.1	3.2	10.1
Once in a while	6.3	1.1	1.2	1.2	0	1.6	3.1
Never	14.6	8.4	5.8	12.5	0	3.2	9.9
N.A.	1.7	0	3.5	1.2	0	1.6	1.3
	(302)	(179)	(86)	(80)	(57)	(62)	(766)

There was a relationship between the amount of trust the respondent had in her caseworker and the frequency with which the respondent reported making a special effort to stay on good terms with the caseworker; that is, the less the trust, the less the effort to stay on good terms. This could mean that if one doesn't trust the caseworker, one doesn't try to establish a relationship. An alternative interpretation is that because one doesn't try to establish it, there is no relationship and therefore there is a lack of trust. The causality problem remains.

Do the respondents think that their caseworkers have good reasons for what they do? Again, an overwhelming majority say yes, but the proportions expressing positive attitudes are somewhat lower in Milwaukee than in the other counties.

Table 16

"To what extent do you feel your caseworker has a good reason for what he or she does?"

	Milwaukee	Dane	Brown	Walworth	Sauk	Dodge	Total
Always	43.0%	64.8%	77.9%	50.0%	47.4%	54.8%	54.0%
Usually	31.1	28.5	11.6	36.3	47.4	35.5	30.4
Not very often	13.9	3.4	5.8	6.3	1.8	4.8	8.1
Never	8.9	1.1	1.2	5.0	3.5	1.6	4.8
N.A.	3.0	2.2	3.5	2.5	0	3.2	2.6
	(302)	(179)	(86)	(80)	(57)	(62)	(766)

There were high correlations (from .43 to .56) in all counties between the amount of trust a respondent had for a caseworker and the extent to which she thought the caseworker had good reason for his actions. And, when clients felt their caseworker had good reasons for what he did, they were also more inclined to make special efforts to stay on good terms with him. The same relationship applied to the specific social service areas of caseworker discussions (children, health, home care, social life): the more trust that a client had for a caseworker, the more likely a client would feel that she had to follow his advice in one of the specific social service areas.

Despite the very strong, positive attitudes that most respondents had toward caseworkers, the expectations of what their caseworkers could do for them were not very high.

Table 17

Clients' Expectations of Caseworkers

"Do you think that there are things that your caseworker--possibly if he had more time or freedom to act--could do to help you that he isn't doing now?"

Yes	22.5%
Not Sure	15.5
No	62.0
	(766)

(If yes) "What is it you think he could do?"

Help respondent get more money (unspecified)	11.0%
Grant special requests more often	25.0
Help with financial problems (e.g., help with the budget)	7.6
Help respondent with other things (e.g., employment)	13.4
Spend more time with the family	23.8
Help children do things	7.0
	(172)

Estimations of caseworker expectations were related to the respondents' continuing non-economic problems and their problems of managing budgets. The more difficulty a women reported, the higher her expectation of her caseworker. But regardless of the number or types of problems reported, women were more likely to say financial assistance was the kind of aid they thought a caseworker could provide. On the other hand, women without problems did not think caseworkers could do more for them.

But problems or no problems, most clients did not think the caseworker could aid them. Requests of extra money for special needs and calls to the caseworker declined over time; therefore, we anticipated that expectations of caseworker assistance would similarly decline--that is, the clients would become more realistic

in light of their experience. This was not true, however; expectations did not vary with time on the program. But it must be kept in mind, that, overall, expectations were low anyway.

There was a certain proportion of recipients that were bothered or annoyed by caseworker discussions in specific areas. These specific negative experiences seemed to shape their general attitudes toward caseworkers, in that women who were bothered reported less trust of caseworkers, less inclination to think caseworkers had good reasons for their actions, and lower expectations. On the other hand, their behavior toward the caseworkers--calling them between visits, turning to them with problems, making requests for changes in basic grants, complaining about decisions--was not consistently predictable on the basis of the amount of bother mentioned. Evidently, program use is about the same for those who are bothered and for those who are not. But evaluations differ.

In Milwaukee County, the responses of the Negro recipients concerning the caseworker relationship were quite similar to the white responses. Negro and white women reported the same frequency of caseworker visits. Negro respondents made the same number of calls to the caseworker and were just as successful in contacting the caseworker as white respondents. But there was some difference in general attitudes toward the caseworker: white respondents were more likely to report that they trusted the caseworker, thought he usually had a good reason for decisions he made, and that they, in turn, made special efforts to stay

on good terms with him. However, these differences in attitudes were small and far less striking than the overall similarity of responses, regardless of race.

D. Conclusions and Implications

1. The level of social service activity. We opened this paper with a description of the goals of the 1956 and 1962 amendments to the Social Security Act and the definition of social services by the Wisconsin State Department of Health and Social Services. We may now ask to what extent are the legislative goals of the Social Security amendments or the aims described in the Wisconsin Manual being fulfilled? How widespread and successful are the preventive and rehabilitation services which are designed "to help maintain and strengthen family life" and "to attain or retain capability for the maximum self-support and personal independence?" This question cannot be answered definitely on the basis of these data. The data are survey responses of clients, and their views and perceptions may or may not coincide with the views of local administration or the actual record. There are no set definitions of such things as strengthened family life, capability for maximum self-support, and personal independence, and there are no standards by which one can tell whether these qualities exist or not. There are no methods by which one can measure the impact of various social services on the AFDC clients. Is discussing children once every three months often enough? Perhaps it is in particular cases--but by whose standards? The question of whether or not the administration of

social services is accomplishing legislative goals cannot be answered until we know how to measure the goals and the precise impact of the various service activities on the clients.[12]

Within the confines of the data, we have described the level of activity in the field. We think that this evidence strongly indicates a very low level of social service activity and that, in common parlance, a "new day has" certainly not "dawned" in the AFDC program. For the vast majority of AFDC families, social service means a caseworker visit a little more than once every three months for a little more than 30 minutes per visit, with an occasional client's call to her caseworker. Qualitatively, the dominant characteristic of the service is one of minimum intervention. Three types of social service activities can be distinguished: (a) provision for tangible, specific things that clients want; (b) general counseling, advice, and guidance; and (c) specific advice or guidance disapproving or approving of specific client behavior. Social service can further be described in terms of its capacity to maintain and cope with or to change the status quo.

The significant social service activity providing tangible results was that of implementing the use of health facilities; caseworkers were active in this area and clients reacted very positively. We pointed out that because of the Medicaid program,

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[12]We are re-interviewing the respondents in this study when they leave the AFDC and hopefully, may be able to shed some light on these questions.

social services in the health area were cost-free to the caseworkers. But aside from health services, caseworkers tended to avoid areas which might lead to specific requests that would cost the agencies or would be hard to accomplish. This finding parallels the findings in our study of the administration of AFDC budgets, through which we discovered that very few clients made more than occasional requests for money grants to meet unusual needs. Either they were not advised about the availibility of the grants or were discouraged from making requests.[13] In sum, with the exception of health, the caseworkers had very little of a tangible, specific nature to offer clients.

Most of the caseworker contact was devoted to general counseling, advice, and guidance. But here too, areas of activity must be distinguished. There was a definite tendency to stay away from sensitive issues--such as home care and specific aspects of social life--and to concentrate more on children and health. Even within the subject of children, caseworkers stayed away from areas on which delivery would be difficult, e.g., clothing, food, employment, and concentrated on discussions of general upbringing, school problems, and behavior problems. When social life was discussed, general matters rather than specifics were usually raised. The half-hour visit, then, was devoted to talking about general topics that are of interest to single women with families--children, school, and social life in general.

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[13] Joel F. Handler & Ellen Jane Hollingsworth, "The Administration of AFDC Budgets: The Views of Welfare Recipients," Institute for Research on Poverty, University of Wisconsin, January, 1969 (mimeo).

There was very little specific advice, particularly of a negative, disapproving kind. Few clients reported caseworker disapproval in any of the social service areas. This corresponds to findings on the administration of AFDC budgets. There, few clients reported caseworker disapproval of how they spent money. There was some effort on the part of caseworkers to encourage clients to use resources in the community, but again, it seems to us, that activity here was still very low. We base this conclusion on the fact that the rate of client participation in community programs was highly related to caseworker activity and that overall, participation rates were low.

The absence of meaningful caseworker contact, either positive or negative, is reflected in client attitudes toward caseworker discussions in the four specific social service areas. On the whole, clients felt neither constrained nor upset by caseworker activity. In Table 18, we have summarized client feelings of constraint (coercion) and bother or annoyance with the caseworker discussions.

Table 18

Percentage of AFDC Respondents who felt constrained or upset by caseworker discussions in specific social service areas

Clients who felt that they had to follow the caseworker's advice "all" or "most of the time"	
For four areas	.8%
For three areas	5.1
For two areas	18.2
For one area	31.6
Never felt constrained	43.9
	(766)
Clients who felt "very" or "moderately bothered or annoyed" by caseworker discussions	
For four areas	.5%
For three areas	.8
For two areas	3.4
For one area	15.3
Never felt bothered or annoyed	80.0
	(766)

Most of the feelings of constraint arose from social services dealing with the use of health facilities, including children's health matters. We will discuss the implications of this below. Most of the feelings of bother and annoyance arose from discussions about home care and specific aspects of social life. These were sensitive issues and, it will be recalled, rates of upset for these areas were high (one out four clients). Overall rates of bother and annoyance were low not because clients acquiesced, but because for most clients, the caseworkers stayed away from these areas.

What emerges from the data is that, in the main, social service activity is little more than a relatively infrequent,

pleasant chat. It is somewhat supportive. It is rarely threatening but also not too meaningful in the sense of either helping poor people get things they need or in changing their lives. And it seems to bear little resemblance to the legislative goals of the Social Security Act amendments or to the descriptions in the Wisconsin State Department Manual.

2. Client attitudes and the structure of dependency. On the whole, clients expressed very positive attitudes toward their caseworkers. But this finding is grounded in the existing level of caseworker activity, both quantitatively and qualitatively. Although the clients liked the home visit, they had low expectations about what their caseworkers could do and they did not express any strong desire to increase caseworker contact. For them, caseworkers were visiting about often enough.

In fact, there is evidence that the level of positive attitudes probably existed because the caseworkers were not doing their job. The Wisconsin Manual told the caseworkers to establish a "relationship," to "explore precipitating factors and to sift and weigh these factors in relation to the client's reality situation and environmental influences" which include "the family, religious, social, community, cultural, and economic influences in the client's life." Yet, for the most part, this was precisely the activity that caseworkers stayed away from. And when the caseworkers did discuss these matters, the clients' positive attitudes declined and negative feelings rose sharply.

These AFDC recipients much preferred discussions of tangible items over mere advice and guidance, and became upset when the

caseworkers started to talk about home care and specific aspects of social life.

Similarly, in our study of the administration of the budget, we found that clients reacted negatively to caseworker supervision of expenditures. Yet, if the administration of the budget is to be used for social service objectives, as the Manual states, caseworker supervision is necessary. But it is not welcomed by the clients. In short, positive attitudes toward the caseworker that are reported in this paper existed for a program in which there was a sharp disjuncture between what was going on in practice and what was called for in federal and state policy or in social work theory. The findings of this study cannot be used to support the view that clients would welcome an expanded program of caseworker involvement in their personal lives. Despite the fact that practically all AFDC families are "defined service cases," very little of this type of caseworker activity went on, and when it did occur, clients reacted negatively.

Clients attitudes toward the caseworker varied with the type of things that caseworkers did. We refer again to the three types of activities: (a) delivery of tangible items, (b) general advice, and (c) specific advice (usually negative). When the caseworkers were able to deliver something that the clients wanted, the clients felt the discussions were most helpful; they said they had to follow advice, and were not bothered. With (b), general advice, there was less feeling of helpfulness and constraint (or coercion). And with (c) specific advice, clients felt free to disregard the caseworker. Constraint or coercion,

then, arises primarily when caseworkers can deliver things that clients want. Moreover, clients who felt they had to follow their caseworker's advice on a specific matter, also tended to say they trusted their caseworker. In this area, the delivery of specific items, we find a high degree of dependency.

Dependency--and coercion--are matters of degree. It arises when people have discretionary authority over things that other people want, and it is not confined to welfare programs. Many middle and upper class people would probably respond very much like these AFDC recipients when asked what they thought of their lawyer, doctor, psychiatrist, or automobile mechanic. They might be even more inclined to say they make special efforts to stay on good terms, since qualified, competent professionals would not need their business. To a considerable extent, these AFDC recipients may be expressing dependency attitudes that are quite similar to those expressed by the non-poor.

There are, of course, different policy considerations when one is dealing with dependency in private relationships and dependency that arises from relationships with government, particularly welfare programs. One distinction that is often made has to do with legal compulsion. It is claimed, for example, that the middle class person is free to reject his psychiatrist and go elsewhere whereas the AFDC client is not free to reject her caseworker. This distinction is only partially true, and really obscures very important policy issues. The fact of the matter is that highly dependent, if not coercive, relationships arise in many welfare programs that are strictly voluntary by law.

In programs of this kind, where there are no legal requirements that clients must see caseworkers, clients are subject to manipulation because they badly need what the social worker has to give. Prominent examples are programs where social workers visit lonely old people and hospital patients. There is no legal complusion; there is no requirement that the clients must see the social worker. But the service is highly valued, and social workers often report an ingratiating, embarrassing type of dependency.[14] And this study of the Wisconsin AFDC program supports the converse: if the service is not valued, it will be rejected, regardless of legal requirements. Dependency arose here when the caseworkers were doing something that the clients valued. On more general topics, there was less feeling of constraint, and when the caseworkers suggested something specific that the clients did not want to do, no client said that she had to follow the caseworker's advice. In none of these situations would it seem that the legal requirements of the AFDC program have much significance in providing coercive elements in the caseworker relationship.

Legal compulsion has received attention in those situations where welfare administration has been punitive, moralistic, and harsh. Of course clients object (or should object) to this kind of manipulation. But what we are emphasizing is that dependency

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[14]Anyone familiar with social work knows the power that can be exercised over dependent applicants and clients. For a discussion of coercive relationships arising in the activities of Children's Departments in London, see Joel F. Handler, "The Coercive Officer," New Society, 3 October, 1968, No. 314 (London, England) (Institute for Research on Poverty, University of Wisconsin, reprint 19).

and manipulation also arise out of the discretionary distribution of benefits.[15] And when clients receive these benefits, they do not object; they like their benefactors, and they like to please their benefactors. This attitude may be deplored; but we do not think that dependency of this nature is a peculiar characteristic of welfare clients. It exists in all social classes. In sum, we would argue that dependency is more a product of the structure of social relationships than legal requirements; it exists when there is discretionary authority over benefits that others need. And it has very important consequences for the future organization and structure of publicly administered social services.

3. The organization and structure of social services: reform and dependency. The nature or inevitability of dependency has led to efforts to reduce welfare officials' descretion over the distribution of benefits. One prominent proposal is to separate income-maintenance in AFDC from the administration of social services and routinize the distribution of money payments. It is difficult to find a clear, detailed statement as of exactly what this proposed reform is or what it is supposed to accomplish. For example, the Task Force Report, "Services for People,"[16] favors the Federal Government's assuming direct responsibility

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[15]This point, of course, has been well expressed by others, e.g., Kenneth C. Davis, Discretionary Justice (L.S.U. Press 1969); Charles A. Reich, "The New Property," 73 Yale Law Journal 733 (1964).

[16]Report of the Task Force on Organization of Social Services, "Services For People," U.S. Government of Health, Education and Welfare, October 15, 1968.

for administering money payments for public assistance, through a highly routinized system, with the states and local governments assuming responsibility for the administration of social services. The Report suggests that social services are to be voluntary for the clients. The assumption is that caseworker discretionary authority over the budget gives them the power to coerce clients into accepting social services that they may not need or want, and this new approach is intended to eliminate that situation. In addition, under the present AFDC program, welfare recipients are legally required to accept caseworker visits as a condition of receiving the money grant; the proposed reform would eliminate this legal requirement. Clients would then be free to accept or reject social services: there would be no legal compulsion, and, with the elimination of caseworker discretion over the budget, there would be no economic compulsion. Although the Report does not deal with the administration of social services, it is also argued that since social workers would be free from administering money payments (including investigations), they could spend more time and effort in administering social services.

In states where discretion is exercised over budgets, routinizing money payments would reduce dependency by curtailing the discretionary authority of welfare officials in this area. But if routinization is taken seriously, one of the costs would be the loss of individualized treatment through the use of special grants for special needs. In Wisconsin, at least, the special grant program is not very effective, and some reformers would be

willing to pay this price on behalf of the welfare clients. In New York City, welfare groups hotly protested this reform (routinization) and it seems to us, their position was well taken. As long as basic grant levels are low, there must be provision for emergencies and other unusual losses. Furthermore, many rehabilitative programs require money, for example, education and re-training costs. Two questions, then, must be answered: Which agency--the money-payment agency or the social service agency--is going to administer the special grant program, and under what criteria? Routinization of money payments, if it is to accomplish its objective of reducing discretion, must objectify the criteria under which special grants are to be distributed. This gives clients entitlements or rights to the grants and concomitantly, reduces official discretion. Yet it is one thing to specify objective criteria in the books, (as is already the case for many special grants). It is quite another matter to insure that welfare officials will communicate these rights to the clients, that the clients will understand what they are entitled to, and will demand what is due them rather than rely on the good will of the caseworker.[17] In certain parts of the country (e.g., New York City), much of this has been accomplished through the use of effective welfare client organizations. But this is no easy task.

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[17]The enforcement of rights is an extremely difficult task. See J.F. Handler, "Justice For The Welfare Recipient: Fair Hearings in AFDC - The Wisconsin Experience," Social Services Review, March, 1969.

Furthermore, there is the danger that expanded "improved" state and local government social service programs will increase client dependency and coercion. If social service administration does what the clients really want--which is increasing delivery of specific, tangible items, possibly including special money grants--then dependency as shown in this study will increase. This will be true regardless of whether or not social services are voluntary. Poor people who need things will be free to reject social services in a formal sense only. Experience with many legally voluntary programs amply demonstrates the development of highly dependend and coercive relationships. Problems of reducing discretion and dependency due to specific social services may be even more difficult to solve than those stemming from special money grants. In addition, if social services administration takes the federal and state policy seriously, there will be a significant increase in official intervention and control of the lives of clients, which we feel is not likely to be resisted. The extent to which welfare clients will be able to reject this interference will depend upon a number of things; one of the most important will be how much discretionary authority the social workers have over the distribution of tangible things that clients want. In Wisconsin, the AFDC clients were able to resist caseworker-interventions they did not like, but coercive elements were low because: (a) administration of the budget was already highly routinized; (b) there were few things that the caseworkers could give that the clients wanted; and (c) the caseworkers did not insist on behavioral changes for

these things (i.e., health services). In short, there was not much coercion in Wisconsin because not much discretionary power was exercised.

Another issue that is not discussed is how the present home visiting practice is to be administered if income-maintenancee is separated from social services. Granting that clients who participate in social service programs will be dependent and may be manipulated, it is argued that clients still should have the choice of participation. It is bad enough that they become dependent on welfare officials by necessity; they should not be required to do so by law. We agree with this position, but do have a question about how client choice should be implemented. Specifically, should there be no caseworker visits (or other contact) unless the client requests the service, or should there be caseworker visits unless the client says that she does not want them.

Most of the appeal lies with the first alternative. If clients really feel that they need what social services has to offer, they they will ask for it; otherwise, let them be. In our view, this is a very close question. Requiring client initiative may exacerbate the already difficult problem of failing to distribute social services among the very poor. A great deal of concern, if not effort, is centered on how to make known the availibility of services and how to encourage the poor to make better use of them. It is entirely possible that the caseworkers in the AFDC program (at least as described in this paper) contribute somewhat to the solution of some of these problems. For

example, we pointed out that AFDC recipients automatically qualify for Medicaid and do not need caseworker approval for health services. We found that most recipients do talk to their caseworkers about health problems and they report the caseworker discussions helpful. We don't know why they discuss health problems with their caseworker, that is, what psychological mechanisms are operating, and we have no data on the extent to which they would have used Medicaid without caseworker support. Furthermore, it is entirely possible that some respondents had to talk to their caseworker because Medicaid cards were not distributed to them. But it is commonly said (although some small studies indicate otherwise) that poor people do not make adequate use of available medical facilities. The caseworkers may be performing a valuable function in getting clients to use the health program. In the other social service areas, there are lower levels of activity, but even at these levels, there are indications that the clients are getting something of value. It will be recalled that practically all of the clients who said they had problems other than money problems, did seek out their caseworkers and had been helped by them. Although not that many clients participate in special community programs, we think that the caseworkers were probably instrumental in getting these clients to participate.

The question is: would welfare clients make less use of services if they had to call a caseworker in order to raise their problems and needs rather than have them discussed in the course of the routine house visit? Answers here are speculative, but it

seems reasonable to assume that habitual dependent people would be more likely to raise problems and requests with (a) a person that they see somewhat regularly, (b) whose duty is to help them, (c) who apparently has access to services and resources, and (d) whom the clients like and trust, than if there were no home visits and the clients had to take the initiative. Requiring a client to request help from an unknown official "downtown," requires her to magnify her problem and may increase her fears and insecurities about being refused and rebuffed.

One can't push this argument too far. It could very well be that if caseworkers were not available, welfare recipients would seek other, perhaps even more efficient, sources of help. But the impressionistic evidence points the other way--that the very poor lack knowledge about and access to community resources and social services. Requiring welfare clients to take the initiative may have the effect of cutting off a reasonably valuable service that most clients, in their words, seem to like.

This is not to argue that welfare recipients should not have the right to say they do not want social service, even the home visits. Some writers on welfare reform have posited that clients will feel they have to accept social services as an implied condition to their grant, whether services are formally voluntary or not. We are quite skeptical of the coercion argument: clients know how to refuse to do things that they do not want to do. On the basis of this paper, most clients would want the service (at least at its present level). A client hesitant to sign a form saying that she did not want any home visits would

not suffer very much (and in fact, might very well find that she enjoyed the caseworker contact). Nevertheless, there will be some who want to be left alone, or may find visits bothersome, and these people should have the option of refusing social services.

In sum, much of the hoped-for benefits of separating social services from income-maintenance may not in fact reduce government discretionary power over welfare recipients. Furthermore, depending on how special grants and the home visits are handled, they may even cost welfare clients some of the benefits they know and enjoy under the existing program, at least as described in this study. It seems to us that if significant progress is to be made on the deep-seated problems of client dependency and the control of official discretion, far more radical change is needed. One such change is the growth of effective welfare client groups. It is claimed, for example, that when such groups are effective, as they seem to be in New York City, significant changes in dependency relationships have occurred, including more effective use by clients of what the welfare program has to offer. Another radical change could be local community social service centers run by the clients themselves rather than, or in addition to, state and local government agencies. These, as well as other far-reaching proposals, raise many difficult issues that are beyond the scope of this paper.

In the meantime, we think that much can be said for encouraging clients to use social services and particularly the home visit as described here. Even though this service comes nowhere near the legislative goals of the Social Security Act amendments

and the description in the Wisconsin Manual, it is a service that most recipients like and use, particularly when it can deliver tangible results. Although it creates dependency, most clients are not upset. Additional improvements can be made, such as the further routinization of the basic grant and even formally separating income-maintenance from the administration of social services. Perhaps the caseworker relationship that we have described here could be performed by less highly trained people who would operate primarily as a referral mechanism. Intensive home visiting or social services (for sensitive areas) at community centers could be available for those who request them. Many variations are possible. Practically every modern nation with a developed welfare system is concerned about the social and economic problems of this particular group--the very poor, fatherless families--and particularly the problems of encouraging these families to use the social services that are available in the community. Much more information about the operation of the present system is needed than is presented in this paper. But until we are sure that other mechanisms can do the job at least as well, the present system should not be abandoned without more careful empirical evaluations of the needs, perceptions, attitudes and behavior of the welfare clients themselves.