Case to Cause: Public Health Concepts
Associated with Infant Mortality and Morbidity
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There is a current trend in social work practice moving the practitioner's consideration of client problem from one of "casing the case" to one of attempting to understand the notion of "case to cause." This broader case to cause idea within a biopsychosocial context engages the social worker in a public health process that focuses on the "causes of social and psychological health and illness," drawing upon principles from social epidemiology for the analysis of social and personal problems. In this regard the public health social worker leads the way by moving beyond consideration only of case specificities to extend the continuum of inquiry to include the identification of high-risk groups within the population who evidence disturbances in their physical, emotional, social, and coping functioning.

The case to cause approach provides a way of thinking that may involve the development of a simple survey study or requires a highly sophisticated methodology as a means of isolating key etiological factors. In the real world of social work practice—however we define that term—not all social workers are equipped by either training or proclivity to engage in research. Research is frequently a collaborative process, one in which social workers may shape the questions for inquiry, based upon their empirical experiences. It would be incorrect to imply that casing the case is passé, that social workers are forfeiting micro activity for macro excitement. On the contrary, the case to cause process starts with data gathering and assessment relevant to the case, multiplied by similar identified case problems, within the worker's caseload, multiplied by all similar cases within a given population where services are delivered. In this process the worker attempts to specify/isolate those variables that impact positively or adversely on a population in order to further refine assessment and differential interventions at both the case and population levels.

The "doing" or pursuing of research is not the issue; rather, it is the thinking about the way research informs social work practice, the way data may indicate priorities for shaping programming, and how research conclusions indicate political, legislative, social welfare, and health directions. This micro to macro process is the framework for this paper which considers the multivariable factors that impact on an intensely felt and frequently debated issue in the United States today.

Moving from general to specific, the topic of infant mortality and morbidity is an area of health concern in this country that has spawned considerable research, produced massive data, and illuminated unsettling conclusions.
One thing is certain: the vast literature provides ample data about multiple factors to be considered if positive outcomes are to be achieved in the physical and emotional growth and developmental maturation of our infants and children, even in this era of fiscal constraints and continuing decline of federal involvement in the health and welfare of women and infants at the lower levels of the economic scale.

Pursuing a case to cause paradigm for infant mortality and morbidity requires a three-pronged approach including demography, policies, and programming for service delivery. Demography provides the facts about the population at risk for infant mortality and morbidity; policies at various governmental levels determine issues of access, eligibility, entitlement, and distribution of health and welfare services; and both are indicators of need for program development to insure service delivery congruent with client need.

For 1984, the National Center for Health Statistics reports infant mortality in the United States fell to its lowest level in our history, even as the number of births showed the largest increase since 1970. Within one year the infant mortality rate dropped from 10.9 deaths per 1,000 live births in 1983 to 10.6 per 1,000 births in 1984.2 While this is encouraging news, the rate represents an overall decline for the country and does not reflect the disturbing fact that we have “a higher rate of early childbearing in the United States than in other industrialized countries,” the consequences of teenage parenthood.3

Of pressing national concern, within this adolescent group researchers find economically disadvantaged teenagers, a disproportionate number from racial and ethnic minority groups. One out of five teenage mothers, regardless of race, has a repeat pregnancy within 12 months of delivering her first child, while the rate of repeat pregnancy is nearly twice as high among women at the lower end of the economic scale. One study, based on a sample of 675 teenage mothers from eight cities in the United States, offers base-line data which provide a profile of these adolescents: the greater number of girls were approximately 16 years old, high school drop-outs, did not use birth control, were living in an AFDC household, and were children of mothers who themselves had been teenage mothers, and who had not finished high school. For these teenagers, entering the world of work was very difficult, especially if they had not completed their education, and none achieved well-paid positions. Within two years of the beginning of the study, “82% of the repeat pregnancies to black teenagers were unplanned . . . . At an average age of just over 18, teenagers in the research sample had already had more than half of the total number of children they said they wanted.”4

If we look at all pregnant women, in 1982, one of every 20 pregnant women and one of every 10 pregnant black women received either no prenatal care or none until the final trimester; among pregnant women under the age of 20, one in nine received little prenatal care or none at all. Babies born to women who receive no prenatal care are three times more likely to be born with low birthweight, and low birthweight infants are 20 times more likely to die in the first year of life or to suffer handicaps.5

Moving beyond basic health data about pre and postnatal care, birthweight of infants, and physical and developmental impairments, the social
worker also explores for data illuminating psychosocial factors, including the mother’s day-to-day functioning, her perceptions about her coping in the environment, as well as the quality of transactions between mother and child.

Current research investigating the association of illness with stressful life events indicates the relationship between stressful life events and illness has been found to be small. A more important factor may be the individual’s ability to maintain control over the environment. In one study of low-income mothers of young children who were at high risk for depression, the researchers hypothesized that everyday stressors were more strongly associated with depressive symptoms than with life events. The data indicate that “every day stressors were associated with depressive symptoms, but only among unmarried women and that unmarried mothers with high stressors were approximately 19 times more likely to report high depressive symptoms than were unmarried women with a low level of stressors.” For unmarried mothers, unemployment, housing problems, and inadequate income were among the stressors strongly associated with depressive symptoms. Similar to findings in other research studies, one important finding is the risk for depression to unmarried mothers with poor social networks. The findings indicate that “employment may be most beneficial to these women since they may have less access to social support, as well as fewer opportunities for enhancement of self-esteem.”

Social stressors also adversely affect high-risk infants with low birthweights, failure to thrive, and handicapping conditions. Family structure, environmental factors, and public policy determinations all impact on infant mortality and morbidity. For example, the problem of child abuse deserves special emphasis, given a “tenfold increase in the number of reported cases in the course of a decade.” While the true incidence of child abuse is unknown and a review of the research findings indicates little empirically-grounded theory, there remain enough data to provide social workers with some knowledge to inform their practice about a social problem with which they are particularly familiar. Several studies indicate that a difficult pregnancy, abnormal labor, separation of mother and child in the early months following birth, and infant illness are all factors over-represented in the child abuse sample. For whatever of these reasons, the failure of mother/child bonding is highly correlated with child abuse. “Factors such as prematurity, mental retardation, and physical handicaps are clearly over-represented in abuse populations.” Other factors identified from detailed histories of family-child relationships indicate that an irritable, demanding, or unresponsive child could result in a disciplinary interaction resulting in abuse. Studies indicate that among many stress factors, “loneliness—social isolation—is the single characteristic found more than any other in abusive parents.”

Granting sampling problems related to specific settings, such as infants seen and identified as abused in outpatient clinics or in hospitals, numerous research studies indicate social class is a factor in that child abuse is heavily concentrated among the lower class. In one study abuse and neglect were related to poverty: in a sample of 830 cases, 61% were from the lowest class and within that group fewer than half received financial assistance.

While only a selected number of demographic factors have been touched
upon, an important conclusion drawn by Susan Smith's review of child abuse research highly correlates with the findings discussed above: we have few multivariate studies that measure and assess biopsychosocial interacting factors to guide the social worker planning interventive strategies to decrease the prevalence of infant mortality and morbidity and childhood handicapping conditions. In this regard there is much to be done.

Turning to public policy, legislation regulates and circumscribes who gets services, how much service is offered, and at what cost. A promising health initiative begun in the mid 1960's has turned into a bleaker reality for the 1980's. Both the quality and quantity of health care delivered to underprivileged women and children are mirrored from time to time by the fluctuating funds allotted to such programs as, for example, Maternal and Child Health (MCH) and Crippled Children Services (CCS). Titles V and XVI (Medicaid) complement each other, although there are no regulations that specify their relationship. While both titles provide access to health services to greater numbers than ever before, in recent years millions of women and children have had their health care diminished or denied as the result of budget determinations at the state level.

As we move into the 21st century, the United States, among all industrialized countries, still has no national health policy. Ruth and Victor Sidel correctly observe that there continues to be much resistance to innovative programming. They find three sources for this resistance:

...those that were resisted so successfully—if not overtly, then covertly—that they never really took hold in any significant way; those that were indeed implemented but were co-opted or absorbed by the system in ways that left the structure of the system fundamentally unchanged; and those that after a brief period of success were essentially destroyed through underfunding and a fundamental lack of commitment on the part of health professionals and of government at all levels.

Resistances to new programs perpetuate and reinforce a two-class health system: one for those who pay for services out-of-pocket and/or through co-insurance arrangements; another, for those who meet eligibility for public assistance income. As income ceilings for Aid to Families with Dependent Children (AFDC) change, some families formerly entitled to Medicaid find themselves excluded from health benefits. For those women who attempt to remove themselves from income-maintenance programs into the world of work, many within that group, either because of fluctuation in the employment market-place, or for the lack of day care, return to the welfare rolls. Lacking a universal comprehensive health insurance plan in this country, we place at medical and health risk those women and their children who strive, but not always successfully, to climb out of their welfare status.

With the passage of the Omnibus Budget Reconciliation Act (OBRA), the Maternal and Child Health Block Grant Program was created, whereby the bulk of federal funds was allocated to the states. When left to their own devices, states do not uniformly meet the health needs of disadvantaged women and children and crippled and handicapped youngsters. Nor are all states compliant with federal law for the type of services to be delivered, in-
cluding comprehensive child health services, access to preventive services, and maintenance of quality care. But it is also true that some state initiatives have resulted in innovative programs that demonstrate cost-effectiveness and improvement in the health status of targeted population groups.

For example, a Missouri study indicates that “Babies of mothers who received the most WIC (Special Supplemental Food Program for Women, Infants and Children) food supplementation experienced the greatest increase in mean birthweight.” In another project initiated in Mississippi, where monies were used to develop a comprehensive, coordinated community program for high-risk mothers and infants, there was an impressive increase in the use of prenatal care. South Carolina, a state until recently not known for strong fiscal support of programs for the poor, passed the Medically Indigent Assistance Act which resulted in many innovative changes, including the provision of prenatal care for women who are not welfare recipients, but unable at their income level to pay the costs of care. Such state initiatives indicate that we can do the job, that there are governors and legislators who understand preventive programming is cost-effective for all in the long run, also that prenatal care curtails postnatal hospitalization of premature infants or babies with developmental impairments.

But overall, the picture is not that rosy. Under block grant funding many states have curtailed prenatal and delivery services. Yet the funding of these programs could have had the greatest preventive impact on the future health of women and infants, insuring the healthy growth and development of poor children. Lack of funding has adversely affected genetic screening programs initiated under The National Genetic Diseases Act for genetic screening, research, and professional training, which is now part of the MCH block grant.

Since the Reagan Administration, new restrictive categorical eligibility standards have left millions of children and women uninsured: “11.7 million children under age 19—one in every six children—has no health insurance. One in every seven women of childbearing age, or 6.6 million women is uninsured...one of every three black children has never seen a dentist.” In the present climate of Gramm-Rudman-Hollings, there are exponents of this new variety of lawmakers who are devoted to “individual aims, not group goals.” Today there are those who define social policy as a code term used by starry-eyed liberals still yearning for the programs of the 1960’s. This is not so. Such a characterization is balderdash. Without consideration of group goals, there is no way to begin to correct the multiple inequities, many of them sources of social stress for the poor, unless we shape and develop programs to provide this part of the population with services, incentives, and opportunities to enable them to realize their potential and their individual aims. Throughout our history the principle of group goals has been variously defined and shaped by political expediency. Social workers have always accepted the principle of group goals as a basic social work value that must not be forfeited or compromised, even under the pressures of current policy.

Commenting on governmental and public indifference, Urie Bronfenbrenner says, “A child requires public policies and practices that provide
opportunity, status, example, encouragement, stability, and above all, time for parenthood, primarily by parents, but also by adults in the society. And unless you have those supports, the internal systems can't work. They fail."

While demography and health policies relevant to the social worker's understanding of high-risk mothers and infants are two areas of inquiry that shape knowledge base, other societal structures and public policies within the social welfare arena must also be considered. Single parent families, while the most hard pressed, are among many family groups across ethnic and social classes seeking adequate housing and then struggling to meet maintenance costs. For those mothers aiming to complete their education or seeking employment the need for child care providers and facilities is paramount. Other services—nursery schools, day camps, recreational facilities, social agencies, religious structures—all provide community support, moderating forces against isolation, anomie, and despair.

For the practitioner the basic question remains: How does "knowing" inform "doing"? In all instances interventions are balanced by what is programmatically achievable for desired goals against policies that call for fiscal retrenchments by the present administration.

While many programs based upon research designs indicate positive outcomes to reduce infant mortality and morbidity, or provide new developmental avenues for handicapped children, or supply income transfers to needy mothers, or initiate educational programs and training for employment, with few exceptions these programs are fractioned, not coordinated to provide a continuum of services to modify multivariable social stress factors. Anything short of comprehensive programming will perpetuate current "scotch-taping" measures. It is crucial that an all out effort be made at both federal and state levels to expand the current parameters for organizing existing services within a broader definition of prevention.

An infant admitted to a hospital on three different occasions during the first six months of life for failure to thrive, with proper nutrition and nurture presents weight and shows positive developmental milestones. Place that infant back into the environment with a mother unable to meet her own life-stage tasks, educationally, financially, emotionally, and that infant is at risk for being unable to continue its own healthy physical and emotional growth. It is obvious that the infant's problems interact and are inextricably tied to the mother's plight.

Strategies to combat dysfunctional factors require interventions on several fronts. At the federal level, for example, MCH has earmarked funds, albeit but 15% of total Title V appropriations, for purposes of research, training, and direct service activities. These funds should be awarded for projects which engage public health professionals in primarily comprehensive service delivery models. At the programmatic level public health social workers should assume both initiator and collaborator roles, working with other social supports to effect a continuum of preventive, primary, and continuing services, as needed. Granting resource differences from one geographical section of the country to another, the problem is not so much the lack of social support systems, but rather the way these organizations relate one to the other. Social utilities are not feudal structures, although they sometimes take on that char-
acter. In doing so, they impede linkage arrangements, thereby obstructing the optimal access and flow of services to a client population.

Too many demonstration and empirical research projects develop expensive designs that duplicate programs already in place in the community. A health setting is not the place for an educational program, a vocational service, a child care center or for family therapy, when these resources are available nearby. Yet these models are promoted in the name of comprehensive care. Such models are a mistake for many reasons: they are not cost-effective; the programs are frequently short-lived; they are limited in the number of clients served; they frequently do not encompass the range of expertise available in other settings; and they cannot possibly address all the needs of the clients. Rather, support should be given for programs and studies that initiate strategies for engaging municipal officials, agency directors and their boards, and community neighborhood councils for the development, community by community, of networking services to provide avenues whereby clients move from service to service as needed.

This is a big undertaking, one that cannot meet the mark with two or three-year project support, but it is time to bite the bullet. Hundreds of small demonstration projects, most of which never get institutionalized, are not needed. What is needed is support for long-range programs and longitudinal studies. While such a stance means fewer of us will be the recipients of federal and state largesse, it is time to put our money where our data dictate better long-range outcomes. A few carefully orchestrated projects are needed, with funds providing both demonstration and research not one without the other, projects that can be replicated.

Too grandiose a notion—maybe. A new idea—no. A design we’ve tried before and given up when the going got tough—frequently. Hard to sell to schools of public health, schools of social work, social agencies, universities, all of whom want a piece of the action and the funds that go with it—of course. But much of the baseline demography is already in, at least enough to point us in the direction we must go. We can’t sit by and rationalize that with a change of administration in Washington, the coffers will open for social programs. Given the national debt, the next administration will inherit the same problems, if somewhat smarter about the efficacy of supply-side budget theory! Nevertheless, we are left with the task of reshaping our present service delivery system, if we are to begin to modify the problems of our unempowered clients. The means for change do not rest with them but with us.

Now for some caveats. There is disconcerting evidence that regardless of the programs available, whether for prenatal care, WIC provision, educational opportunities, vocational counseling and so on, many teenage parents and single parent mothers do not avail themselves of these services, or if they choose to select some, they reject others. And somewhere along the way we lose touch with them altogether. There are motivational forces that determine client choice for accepting some programs and rejecting others. We do not yet understand what these motivational forces are, if they are shaped by intergenerational, life style, class factors, or social institutional arrangements—or probably a combination of factors.

Several years ago a successful New York businessman gave the commence-
ment address to graduating sixth graders at a school he had attended in his own youth. The school is in Harlem; the children are of minority backgrounds and underprivileged. At the end of his speech he astounded his audience of teachers, pupils, and parents who heard him tell the sixth graders that if any of them upon completion of high school applied and were accepted into a college he would pay for their tuition. Next fall, 75% of the students from that sixth grade class will be continuing their education, with many of them, over the years, having sought out their donor for advice and guidance. This has occurred in a New York school system that reports a 40% daily absentee rate. What motivated these sixth graders: was it the assurance of college tuition, or was something communicated to those families who in turn reinforced a goal with their children, or did the children hear a message about their potential and self-worth? If more were known about motivating forces, programs could be shaped more adeptly wherein a whole society might be helped to dispel stereotypical thinking about underprivileged people.

When programs engage pupils, education is a powerful force. Studies of teenage mothers indicate that those who are not school dropouts are also less likely to have a repeat pregnancy, but data also show that “despite the fact that 75% (of a sample in one study) had participated in special teenage parent programs that discouraged further early births, half the teenagers went on to become pregnant again in the short two-year study period.” It has become “fashionable” for social workers and others to promote sex education courses in the school, as if that alone is the panacea for curtailing adolescent parenthood. Obviously, this is not true. Social workers ought to acknowledge that they do not have the answer and clear the air of suspicion—subliminal or overt—between school and health provider about this issue. Sex education is but one endeavor.

Beginning in the primary grades and continuing throughout the educational years, innovative ways to help youngsters ought to be pursued, to plan for and engage them in activities to help them learn more about empowerment and the means of control over their own lives. The school system cannot do all of this alone but could achieve these objectives in consortium arrangements with other social support systems. Some of the models are familiar: didactic presentations, discussion groups, role modeling by presentations from community leaders, formation of self-help groups, coalitions for developing work-incentive programs, health fairs, and so on. The entry point for the introduction of such programming must occur before adolescence, with outreach to the pupils’ families an essential ingredient.

Engaging families is frequently a difficult task. Many of them have been engaged before, not always with positive results, for reasons not necessarily their fault. Short-lived programs carrying the message “now go it alone” fly in the face of positive outcomes based upon coalition activity, including professionals and community leaders. This is all the more reason to try again in an effort to keep family units as closely knit as possible.

Focus on the family is crucial. Policy makers need to be engaged so as to reassess income-manitenance criteria. Keeping families intact with income transfers has the potential for enabling an adolescent mother to return to school, while her infant is cared for by a family member, usually the adole-
cent’s mother, or other caretaker. Additional financial support over the short
haul is more cost effective than stringent AFDC eligibility criteria that blunts
mobility and has the potential of reinforcing a lifelong welfare pattern. While
it is tempting here to support a universal family-allowance plan, every indica-
tion suggests that such legislation is not within the purview of the Congress.
We may have to negotiate smaller aims.

Social network theory, family centered services, high-risk screening pro-
cedures, accurate assessment of psychosocial problems, targeted differential
interventions, and planful referrals are the major ingredients for a model.
Interagency cooperation and collaborative planning teams are essential, with
primary responsibility assigned to a case manager with whom the client family
has an ongoing relationship as determined by need.

The case manager, a skilled social work practitioner, coordinates services
and facilitates the client’s movement through the health, welfare, and social
systems. He/she is an enabler, a clinician, an advocate, and a gatekeeper;
in short, a social worker who aids, supports, and enhances the client’s objec-
tives, while offering positive reinforcement through a reciprocal relationship.
The focus for the work is problem-solving at both micro and macro levels.
Here, again, there is much to be learned about the placement of the case
manager, under what agency auspices, the lines of accountability, as well as
the delineation of roles and functions. Much has been written about the case
manager role, but the blueprint is yet to be drawn.

In a society where the aims and goal of the rich are divergent from the
needs and aspirations of the poor, those of us who enunciate theory and shape
services do so at risk for failure. Yet the challenge is great: for the first time
in the history of our civilization when the growth in numbers of our aged
population exceeds that of the birthrate, means must be found whereby tomor-
row’s adults, healthy and motivated, can move into the American stream
nourished and housed, properly educated, gainfully employed, caring for
themselves and their loved ones, while providing security for those at the end
of the life cycle. Our message to Senator Gramm is: through group goals we
shall help people achieve their individual aims. Affecting change in infant
mortality and morbidity requires much more than the efforts of health pro-
viders. We can’t go it alone—case to cause tells us why.

References

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