Public health social work is an interdisciplinary, epidemiologically oriented approach to improving human health and well-being. About one quarter of all social workers in the United States currently work in medical or public health settings, a number that is expected to increase significantly in coming years. This handbook, written and edited by respected leaders of the Social Work Section of the American Public Health Association (APHA), addresses the rapidly expanding roles of public health social workers as these two disciplines continue to join forces.

The handbook describes how the alliance of social work and public health has already made significant progress and ways in which it will further improve health care in the United States. It addresses job opportunities for public health social workers in such fields as disease prevention, health promotion, child and adolescent welfare, maternal and child health, immigrants and health care, gerontology, genetic health service delivery, disabilities, chronic health conditions, and mental health. The text also covers social work in regard to disaster response, trauma intervention, substance abuse, outreach services, and advocacy. Public health social work with the armed forces is included, as are policy and administration scenarios, workforce issues, and access to health insurance. The book also addresses public health social work with special populations and in neighborhood, rural, and global settings. These multiple opportunities will enable public health social care workers to continue advocating for those whose needs are often overlooked by legislative bodies, particularly during our uncertain economic times.

KEY FEATURES:
- Authored by highly respected APHA Social Work members
- Describes the ways in which the alliance of social work and public health is improving health care
- Highlights key settings and job opportunities for public health social workers
- Addresses public health social work with special populations and in neighborhood, rural, and global settings
- Covers opportunities in disaster response, substance abuse, advocacy, policy and administration scenarios, health care across the life span, and much more
Handbook of Public Health
Social Work
Robert H. Keefe, PhD, ACSW, is an associate professor of social work at the University at Buffalo, State University of New York, where he teaches courses in social work practice and human behavior and conducts research on macro-level factors that lead to negative health outcomes. Dr. Keefe’s research has been funded by the National Institutes of Health, the Metanexus Institute, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and the Administrations on Aging and Developmental Disabilities. His published research articles have focused on the topics of health disparities in birth outcomes, HIV/AIDS, childhood lead poisoning, teen pregnancy, and managed care. He has held elected offices in the American Public Health Association, and his awards and honors include being awarded the Insley/Evans Public Health Social Worker of the Year by the American Public Health Association and being named to Who’s Who in Medicine and Healthcare and Who’s Who Among Executives and Professionals in Healthcare. He has also received teaching awards at both the University at Buffalo and Syracuse University. Among his other scholarly activities he is a member of the editorial board of several journals including the Journal of Adolescent Health, Journal of Healthcare for the Poor and Underserved, American Journal of Managed Care, and Medical Science Monitor. Dr. Keefe’s community service includes serving as a member of the board of directors for various not-for-profit health care agencies.

Elaine T. Jurkowski, PhD, MSW, is a professor and graduate program director at Southern Illinois University at Carbondale’s School of Social Work, where she teaches courses in health and aging policy, research, and program evaluation; she also holds a joint appointment with the Department of Health Education. Dr. Jurkowski’s early career experience working as a social worker in a community public health interdisciplinary setting in Manitoba, Canada, exposed her to mental health, disability, vocational rehabilitation, and aging programs. These early experiences, coupled with her training in community health sciences and epidemiology, have shaped Dr. Jurkowski’s research and practice interests. Dr. Jurkowski conducts research on factors that influence access to care in rural communities, and intervention strategies that lead to positive health and public health outcomes. She has also served as a Great Cities Research Scholar through the University of Illinois at Chicago and as a Social Work Leadership Fellow for the New York Academy of Medicine. Dr. Jurkowski’s research has been funded by the National Institutes of Health, The Hartford Foundation, the U.S. Department of Health and Human Services, the Administration on Aging, and the Illinois Department on Aging. Her published research articles have focused on the topics of health disparities, access to mental health and health care services, aging, and disability issues. She has held elected offices in the American Public Health Association, National Association of Social Workers, the Gerontological Society of America, and the Illinois Rural Health Association. Her public health social work experiences have included consultation within public health settings in Niger, Hong Kong, India, China, Russia, and Egypt, and employment as a public health social worker in Canada. Dr. Jurkowski’s community service includes serving as a member of the board of directors for various not-for-profit health care agencies within the southern Illinois area.
Handbook of Public Health
Social Work

Public Health Social Work Section of the
American Public Health Association

Robert H. Keefe, PhD
Elaine T. Jurkowski, PhD

Managing Editors

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NEW YORK
This book is dedicated to public health social work practitioners and students who continue to effect change and improve the lives of individuals, families, groups, and communities throughout the world.
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Contributors

Chris Anne Rodgers Arthur, Ph, MPH, MCHES, Associate Professor, Director of Faculty Development and Medical Education, Department of Family Medicine, The University of Mississippi Medical Center, Jackson, Mississippi

Julie Cederbaum, PhD, MSW, MPH, Assistant Professor, School of Social Work, University of Southern California, Los Angeles

Elaine Congress, DSW, LCSW, Professor and Associate Dean, Fordham University Graduate School of Social Service, New York, New York

Bari Cornet, MSW, MPH, Field Consultant and Lecturer Emeritus, School of Social Welfare, University of California at Berkeley, Berkeley

Patricia A. Ely, MSW candidate, School of Social Work, Southern Illinois University at Carbondale

Theora A. Evans, PhD, MPH, MSW, Past Chair, Social Work Section, Memphis, Tennessee

William J. Hall, MSW, Doctoral Student, School of Social Work, University of North Carolina at Chapel Hill

Julia F. Hastings, PhD, MSW, Assistant Professor, School of Public Health, School of Social Welfare, University at Albany, State University of New York

Mary Helen Hogue, MSW, LCSW, Department of Health Education & Recreation, Southern Illinois University at Carbondale

Elaine T. Jurkowski, PhD, MSW, Professor and Graduate Program Director, School of Social Work, Southern Illinois University at Carbondale

Karun Karki, MSW, MA, Doctoral Student, Louisiana State University, Baton Rouge

Robert H. Keefe, PhD, ACSW, Associate Professor, School of Social Work, University at Buffalo, State University of New York
Contributors

Michele A. Kelley, ScD, MA, ACSW, Associate Professor, School of Public Health, Division of Community Health Sciences, University of Illinois at Chicago

Gary Lounsberry, PhD, LCSW, Professor, Social and Behavioral Sciences, Alfred State College, State University of New York

Whitney E. Mendel, MSW, Doctoral Student, School of Social Work, University at Buffalo, State University of New York

Mizanur Miah, PhD, MPH, MSW, Professor and Director, School of Social Work, Southern Illinois University at Carbondale

Abigail M. Ross, MSW, MPH, Doctoral Student, Boston University School of Social Work

Kathleen Rounds, PhD, MPH, MSW, Professor, School of Social Work, University of North Carolina at Chapel Hill

Betty J. Ruth, MSW, MPH, Clinical Associate Professor, Director, MSW/MPH Program, Boston University School of Social Work

Patricia Welch Saleeby, PhD, MSW, Assistant Professor, School of Social Work, University of Missouri—St. Louis

Edward Saunders, PhD, MSW, MPH, Associate Professor and Director, School of Social Work, The University of Iowa, Iowa City

Derek R. Smith, MSW, MPH, Program Director, Tobacco Prevention Program, San Mateo County Health System, San Mateo, California

Joseph Telfair, DrPH, MSW, MPH, Professor, Public Health Research and Practice, Director, UNCG Center for Social, Community, and Health Research and Evaluation, University of North Carolina at Greensboro

Tammie L. Scamell, MSW, LMSW, CADC, Clinical Therapist, Bootheel Counseling Services, Sikeston, Missouri

Jeanne Saunders, PhD, LISW, Associate Professor and MSW Program Director, School of Social Work, The University of Iowa, Iowa City
I am fortunate to have degrees in both social work and public health. As a result, I have always been comfortable with the overlap of paradigms, the transference of skill sets, the lack of clarity of definitions, and the transdisciplinary aspects of practice. I have never been concerned about role blurring but instead see the clear advantages of role blending.

I am a stronger advocate, a better rounded professional, and a more qualified health care practitioner because of my social work and public health linkage. Whether looking at the person-in-environment or the person-in-population; whether working in prevention or intervention; whether focusing on the micro, mezzo, or macro levels; whether using the methods of epidemiology or ecology, the combined knowledge and skills from public health and social work provide a unique framework and lens that are crucial to health care and social welfare today and in the future. In fact, public health social work will have a major role in the delivery of the health care of the future (Van Pelt, 2009).

Perhaps public health and social work can best be described as two sides of the same coin. Although there are certain differences—for example, more of an emphasis on prevention for public health and on intervention for social work—the connections far outweigh the divisions between the two disciplines. Both professions seek to promote individual and public health; both want to reduce social, psychological, and environmental risk factors; and both want to promote self-sufficiency and self-determination.

Linked Roots

The similarities between social work and public health are partially a result of linked historical roots beginning in the late 1800s and early 1900s, as social reformers worked to bring about positive social change. Many of the names
of the historic activists found in the chronology of events of each profession are the same: Lillian Wald, Jane Addams, Jeanette Rankin, Julia Lathrop, Grace Abbott, Harry Hopkins, Frances Perkins, Ida Cannon, Virginia Insley, Elizabeth Watkins, and Ruth Knee (National Association of Social Workers Foundation, 2012; Stuart, 2008), to name just a few.

The original organizations and government programs that underpin both professions—including settlement houses, health clinics, social insurance, and maternal and child health programs—were essential to, and heralded by, pioneers of social work and public health.

The founding of the Children’s Bureau in 1912, by Julia Lathrop, a social worker, is well known to most public health social workers (Sable, Schild, & Hipp, 2012). However, the efforts of social workers Frances Perkins and Harry Hopkins may be less well known examples of the impact of social work on early public health efforts.

The Children’s Bureau came into existence after a decade of advocacy and activism. It grew out of the settlement house movement and was assisted by the labor movement as well as by social work educators in schools of social work that were established at the end of the 19th century. The goal was to protect the well-being of children.

During its first 50 years, four of the five leaders (Julia Lathrop [1912–1921], Grace Abbott [1921–1934], Katherine Lenroot [1934–1952], and Katherine Oettinger [1957–1968]) were social workers. The main areas of focus in the early days included child labor, maternal and child health, and infant mortality, all of which are still clearly linked to public health (Copeland & Henry, 2008). During the Depression in the 1930s, the Children’s Bureau also helped to frame the social welfare program, Aid to Families With Dependent Children (U.S. Department of Health, Education, and Welfare, 1962).

In a similar fashion, much of the social safety net we rely upon today, including Social Security, was fashioned by Perkins and Hopkins. Perkins was the first woman (and social worker) to be appointed to a Presidential cabinet position. She served as Secretary of Labor from 1933 until 1945, throughout Franklin Delano Roosevelt’s entire presidency. Perkins had worked with Jane Addams at Hull House before moving to New York City, where she became a crusader for improved factory safety—a serious public health issue of the time. Before accepting her cabinet position, Perkins had gotten Roosevelt to agree to support her major unemployment relief program and workers’ rights protections, such as minimum wage, maximum hours of work, and ending child labor (Cohen, 2009). She also served as chairwoman of the President’s Committee on Economic Security, which ultimately crafted the Social Security Act of 1935 (Downey, 2009).

Hopkins was from Iowa, and he moved to New York City after college where he, too, worked in a settlement house on New York’s Lower East Side. Hopkins understood the linkage of environment and social issues to
health and well-being. Roosevelt chose Hopkins to head the first state emergency relief agency in New York during the early days of the Depression. Hopkins persuaded Roosevelt to create a $500 million federal relief program, which he then administered (Cohen, 2009).

Regardless of historical figures or era of activism, or the social problems each profession has had to face, the focus of both public health and social work has been unwavering. The common goals—the elimination of health disparities and the promotion of social, economic, and environmental justice (Sable et al., 2012) remain firmly entrenched and continue to guide the practice and actions of both fields.

Public health has greatly affected Americans’ health care. Public health’s focus on fairness and common rights for all citizens is consistent with American values of equal rights for all. Despite the positive impact of public health, social and health disparities remain in all aspects of the U.S. health care service delivery system. Health disparities, defined as “persistent differences in health conditions and illness rates that cut across many illness categories and demographic groups” (Keefe, 2010, p. 238), have led to poor health outcomes, unequal access to care, and premature death for many population groups. Consequently, health disparities has been a hotly contested issue for many years and will continue to be one through the foreseeable future.

As early as 1959, René Dubos in his book, The Mirage of Health, noted: It is generally assumed that . . . the cause of all diseases can and will be found in due time—by bringing the big guns of science to bear on the problems. In reality, however, search for the cause may be a hopeless pursuit because most disease states are an indirect outcome of a constellation of circumstances rather than the direct result of single determinant factors. (pp. 86–87)

In 1988, Sloane, in a supplementary statement to an Institute of Medicine (1988) study, The Future of Public Health, noted, “There is overwhelming evidence from this report, and from a myriad of studies, that the financial problems confronting the poor must be solved before we can have a significant impact on the other health issues confronting the American people” (p. 160).

Smedley, Stith, and Nelson (2008) also emphasized that disparities exist in different contexts and are rooted in the discriminatory and inequitable distribution of health care resources.

Disparities remain an area of concern for our government. Every ten years, the U.S. Department of Health and Human Services drafts a comprehensive set of health objectives that form the priorities for our nation’s health. The most current objectives were released in December 2010 in Healthy People 2020, which embraces public health social work values. The Healthy People 2020 document underscores the need to continue focus on disparities in health care among various racial/ethnic,
socioeconomic, gender, age, disability, sexual orientation, and geographic
groups (U.S. Department of Health and Human Services, 2010).

Common Values

Of particular significance with regard to social–health disparities is the simi-
ilarity of the value structure of both fields. The Code of Ethics of the National
Association of Social Workers lists six ethical principles that delineate social
work’s core values of service, social justice, dignity and worth of the person,
importance of human relationships, integrity, and competency (National
Association of Social Workers, 2008). The Code further requires social
workers to challenge social injustice and to work for social justice for all
people, but especially those who are marginalized and who are targets of dis-
criminatory practices.

Public health also takes a “social justice” approach. The Public Health
Code of Ethics lists 12 Principles of the Ethical Practice of Public Health. Prin-
ciple 4, in particular, links directly to social work practice: “Public health
should advocate for, or work for the empowerment of, disenfranchised com-

munity members, ensuring that the basic resources and conditions necessary
for health are accessible to all people in the community” (Thomas, Sage,

Given these values, social work and public health have an interlocking
social justice mandate to improve the well-being and to ameliorate social
health problems (Ruth et al., 2008). The two professions routinely intersect
at points of social action and advocacy. The points of intersection, when
taken together, map the breadth and depth of public health social work.

Social Justice Philosophy

Social justice from the social work perspective is defined as “an ideal con-
dition in which members of a society have the same rights, protections,
opportunities, obligations, and social benefits. . . . A key social work value,
social justice, entails advocacy to confront discrimination, oppression, and
institutional inequities” (Barker, 2003, p. 405).

In 1998, while celebrating 150 years of public health, Krieger and Birn
noted that during the formative years of public health in the mid-1840s,
social justice was seen as the foundation of both the movement and the pro-

fession. They noted the importance of looking back:

Because knowing the paths our field has traversed and identifying which
dreams of the early public health visionaries have been fulfilled, and which
have not can help us understand our current situation, put contemporary con-

licts in perspective. . . .and inform options for future endeavors (p. 1603).
Beauchamp (1976) contended that “public health should be a way of doing justice, a way of asserting the value and priority of all human life” (p. 8). He further defined justice as meaning that “each person in society ought to receive his due and that the burdens and benefits of society should be fairly and equitably distributed” (p. 8).

These common values form the foundation for common agendas. Both public health and social work have an obligation to work for social justice to eliminate health disparities. Advocacy at all levels is needed and, working together, public health and social work can amplify their efforts. It would be useful for the two professional associations to establish a combined Action Agenda. The beginning framework for such an agenda is set out below.

**SUGGESTED ACTION AGENDA**

- Forge a common policy agenda and collaborate for its greatest impact.
- Expand professional understanding and commitment to a collective human rights perspective.
- Locate and understand domestic social justice issues within the global context (Finn & Jacobson, 2008).
- Integrate social and economic justice concepts into research and academic curricula (Vincent, 2012).
- Engage in transdisciplinary research, especially comparative effectiveness research (Social Work Policy Institute, 2010).
- Coauthor publications and expand publication in journals outside of the fields of social work and public health (Institute for the Advancement of Social Work Research, 2003; Social Work Policy Institute, 2010).
- Work together to advance Healthy People 2020 goals to eliminate health disparities.
- Translate the value of social justice into public health social work practice (Finn & Jacobson, 2008).
- Strengthen the ability of public health and social work to influence the political and corporate landscape at the federal, state, and local levels (National Association of Social Workers, 2005).
- Build coalitions and partnerships to effect better policies and to advance needed legislative change at state and federal levels.
- Provide written and spoken testimony from an integrated public health social work perspective.
- Review ethical standards and professional competencies and cross-list in both fields as appropriate.
• Continue the national dialogue on the importance and future of public health social work (Ruth & Sisco, 2008).

This handbook helps to map the direction forward for public health social work. It not only marks existing obstacles and challenges but also highlights strategies for moving beyond the current constraints. The chapter authors, all public health social work experts, provide a comprehensive look at the field. Their writings include past successes, life span analyses, practice settings, and what the future might hold for the field of public health social work and the health issues we may face as a nation.

As we move forward with health care reform and the implementation of the Patient Protection and Affordable Care Act, with its emphasis on outcomes, effectiveness, and efficiency, the need for public health social work has rarely been stronger. Recent political changes will affect the future delivery of health care, leading to more emphasis on prevention and wellness and on integrated and transdisciplinary care. The ability of public health social workers to bridge prevention and intervention; to practice at both the individual and community levels; and to link research, practice, and policy will become increasingly valued. In fact, public health social work may well be the future of health care.

Elizabeth J. Clark, PhD, MSW, MPH
Chief Executive Officer
National Association of Social Workers

REFERENCES


Preface

For well over 100 years, public health social workers have been at the forefront of promoting the health and well-being, and of eliminating negative health outcomes, for individuals, families, groups, and communities. Throughout the past century, the field of public health social work has grown to include primary, secondary, and tertiary prevention efforts in various contexts around the United States and abroad. Public health social workers practice in any number of settings, helping an individual address issues of diabetes management, a family access health care services for a sick child, or a community center obtain funds for an obesity-management clinic. Whereas public health social work students 25 years ago were largely from the United States, students from various nations now come to this country to pursue social work degrees and learn the necessary skills to practice effectively as public health social workers in their home countries.

Throughout the years, public health social workers have advocated on behalf of people everywhere whose voices are not heard by legislative bodies. We have worked to eliminate infant mortality, improve the quality of care in nursing homes, and promote legislation that will allow people with limited financial means to receive competent and culturally appropriate health care. We continue today by addressing these and additional pressing challenges, including the ever-increasing numbers of returning veterans who are unable to access treatment for post traumatic stress disorder, poor families who are unable to find service providers willing to accept Medicaid, frail elderly individuals who are homebound and unable to access community-based services, and people living with chronic health conditions whose insurance companies refuse to reimburse services for long-term care.

As the field of public health social work moves forward, we face many ongoing challenges. Various legislative efforts, developed ostensibly to facilitate better health care for all Americans, have languished as politicians looking to further their own careers vote to slash funding for health services, including reproductive health care for young mothers, clean-needle
exchange programs for intravenous drug users, and behavioral health care services for people living with severe and persistent mental illnesses. The uncertain economic forecasts leave many voters unwilling to use tax dollars to pay for much-needed services in spite of the services' proven effectiveness. Shifts toward political conservatism lead many citizens living with stigmatizing conditions such as HIV to avoid reaching out for services due to the shame and stigma associated with receiving care.

As we move well into the second decade of the 21st century, we are faced with ever-widening disparities in health outcomes in all branches of health care. Healthy People 2020 addresses many of these issues and charges us, as public health social workers, with developing solutions that will eliminate these disparities and enhance the well-being of all Americans. To accomplish this charge, public health social workers must be skilled in working at all levels of intervention including the micro, mezzo, and macro levels.

The idea for the book came about a few years ago, during a business meeting of the Public Health Social Work section at the annual American Public Health Association conference. Many of the section’s members have been in practice for over 30 years in various health care settings. Our concern over the condition of many health care services, the upward predicted job growth for social workers nationwide, and the ever-challenging and ever-changing health care needs of our fellow citizens served as the motivating forces for the section members to propose this book. The profits from the sales of the book will go directly to the Public Health Social Work section, which will use the profits to support mentoring students and new professionals into the public health social work profession, provide funding for students to attend the annual conference of the American Public Health Association, and promote the public health social work profession around the country and abroad.

I am proud to be associated with this project and with all of you, who, as aspiring public health social workers, strive to enhance the well-being of citizens wherever they may live and remove barriers to care so that we can all live fulfilling and healthy lives.

—Robert H. Keefe
Chairperson, Public Health Social Work Section
Pittsford, NY
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As any well-practiced public health social worker knows, large-scale efforts require the assistance of many people. Our efforts to bring this book to completion would have been in vain without the ongoing support and tempered guidance of the staff of Springer Publishing Company. Our thanks to Jennifer Perillo for helping us broaden our ideas for the handbook and for setting the project in motion; Sheri W. Sussman, Executive Editor, for providing ongoing support and guidance to help us bring this project to conclusion; and Kathryn Corasaniti, Associate Editor, for offering quick feedback on each chapter assuring the book would be completed in a timely and thorough manner.

We also wish to thank the members of the Public Health Social Work (formerly Social Work) section of the American Public Health Association who stepped forward to share their ideas and experience gained from many years of practice by and coauthoring several chapters, in particular Bari Cornett, who developed the format for each chapter.

We extend thanks to Sarah DeWolfe and Thuy Duong, students at the School of Social Work, Southern Illinois University at Carbondale, who spent many hours proofreading manuscripts and checking references and tables for accuracy.

Lastly, we would like to acknowledge the many public health social work students and practitioners who continue to inspire us with their never-ending quest for excellence in providing services to individuals, families, groups, and communities around the United States and abroad. Without their passion to learn and to share the wealth of their experiences in the field, this book would be severely limited in its contribution to the important field of public health social work.

—Robert H. Keefe and Elaine T. Jurkowski
Public health social workers are employed in many different areas throughout the world. Their roles are as diverse as the places in which they work. To be effective, public health social workers must learn multiple skills, be adept at multitasking, have excellent oral and written communication skills, and be competent working with individuals from various professional disciplines.

The first chapter of this book introduces the student to the fields of public health and social work, including the purpose, mission, and history of each discipline, and how professionals in each discipline began to work together in response to the ever-changing and increasingly complex health and social needs communities face. The authors discuss the emergence of social work as a pivotal entity within the American Public Health Association and the important role social workers have played within this large organization. Additional areas of focus include the core functions of public health (assessment, policy development, and assurance), key objectives of Healthy People 2020, (US DHHS) public health social work standards and competencies, and the education and professional experience necessary to be a competent public health social worker. The chapter concludes by providing the reader key dates in public health social work history.

Chapter 2 addresses the complex issue of public health ethics. The values of both the public health and social work professions are detailed along with each profession’s standards and competencies. Case scenarios and websites are provided to enhance student learning regarding how to address various issues to assure as public health social workers that we are rendering services that are culturally competent, ethically sound, and pertinent to clients’ needs.
While reading these chapters, write down some of the important health issues residents in your community face, how these issues have changed over time, and the services that have been put into place to address them. As you develop your thoughts, think about the role of the public health social worker, what should he/she do to be of service, how would he/she reach out in a way that is culturally sensitive and ethically astute. When you finish, discuss your answers with other classmates and your instructor and think about recommendations you could make to improve the public health service system in your communities.
CHAPTER 1

Introduction to Public Health Social Work

Robert H. Keefe and Theora A. Evans

OVERVIEW: HISTORICAL PERSPECTIVES ON PUBLIC HEALTH AND SOCIAL WORK

The origins of public health and social work are rooted in antiquity. However, most people are familiar only with the American adaption of these disciplines, which were procured from England during the 19th century when John Snow, a renowned physician of that time, helped to stop the great cholera outbreak of 1848 in London. Snow collected statistics from various neighborhoods to prove that cholera was caused by “poisoned” drinking water, which devastated certain neighborhoods. Although few people today know of Dr. Snow, many people are familiar with his methods to contain the spread of disease: mapping the location of a disease outbreak, tracing the names of individuals who may have contracted an illness, and developing sanitary methods to dispose of waste. Consequently, many Americans today think of “public health” for its role in disease control and surveillance, campaigns for yearly flu vaccines, and public service warnings to boil water during times of flood and other natural or bio-terrorist emergencies.

The social work profession also began to grow during the 19th century when Dorothea Dix, a well-known activist, lobbied state legislatures and the U.S. Congress to create the first American mental asylums. Later, pioneers such as Jane Addams and Lillian Wald helped to bring forth political activist strategies that would lead to women’s suffrage and services that promoted the health needs of new-born children and communities. Because of the well-known efforts put forth by Dix, Addams, Wald, and other activists many Americans today think of “social work” for its roles in government lobbying, case and cause advocacy, and neighborhood change.
Over the past many decades public health and social work professionals have grown to rely increasingly on each other’s skills (Ruth, Wyatt, Chiasson, Geron, & Bachman, 2006). Public health professionals have become more aware of the psychosocial determinants of health (Awofeso, 2004; Krieger & Birn, 1998; Northridge, 2004) and social workers have become more aware of the importance of epidemiology (Ruth et al., 2006). Today, professionals in each discipline practice in all countries and with all populations. They hold elected office, administer large-scale organizations, and conduct research in various settings around the globe. Public health social workers fill many different roles including educators, case managers, and program evaluators (Sable, Schild, & Hipp, 2012). The purpose of this book is to fuse the principles and practices that underlie the public health and social work professions in their relationship to our nation’s health and to help the reader learn of various roles public health social workers play in various settings.

To begin discussion of the interrelationship of public health and social work, a definition of each must be put forward. Charles Edward Amory Winslow, a professor of public health at Yale University in 1920, defined public health practice as,

> The science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, ... the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual ... a standard of living adequate for the maintenance of health.

—Winslow, 1920, p. 30

Over time, numerous definitions of social work have been offered. For our purposes we will use the following definition:

Social Work is the professional activity of helping individuals, groups or communities enhance or restore their capacity for social functioning and creating societal conditions favorable to this goal.

—Standards for social service manpower, 1973, pp. 3–4

Public health social work expands this definition to include:

... an epidemiological approach to identifying social problems affecting the health status and social functioning of all population groups with an emphasis on intervention at the primary prevention level.

—Practice Standards Committee, 2005, p. 4
These definitions make clear that although the public health and social work professions vary in their practice methods, their intended goals are similar: to improve the health, welfare, and social well-being of society-at-large. Both professions share an ecologic perspective for problem-solving, and a systemic approach toward intervention that calls upon various sources to bring about change to complex social problems (Volland, Berkman, Stein, & Vaughn, 1999). Likewise, each profession shares a core value of “social justice” and an essential role of “service provision” targeted at enhancing the lives of the disadvantaged (Krieger, 2003; Krieger, & Birn, 1998; Stover & Bassett, 2003). Both professions use social action and advocacy in numerous domains including community health (Wallerstein, Yen, & Syme, 2011); maternal, child, and adolescent health (Jaffee & Perloff, 2003); substance abuse (Skiba, Monroe, & Wodarski, 2004); immigrant health (Chang-Muy & Congress, 2008); HIV/AIDS (Smith & Bride, 2004); primary prevention (Vourlekis, Ell, & Padgett, 2001); bioterrorism (Mackelprang, Mackelprang, & Thirkill, 2005); and the uniformed services (Wheeler & Bragin, 2007).

THE EMERGENCE OF PUBLIC HEALTH IN AMERICA

Since antiquity, countries around the world have been concerned about upholding the health of their citizens. In 1798 the U.S. Congress required the provision of health care and compulsory insurance to merchant seaman via the Marine Hospital Service. In 1902, the program was expanded and reorganized as the United States Public Health Service (USPHS). The goal of the USPHS was to limit the spread of disease. Seamen were afforded benefits through the Marine Hospital Service because of their risk for contracting diseases while serving in the import/export industry, which put them in contact with people from far-off lands. Upon return from international travel on tall sailing ships, seamen were clinically evaluated for any diseases they may have contracted.

One of the principal tasks of the USPHS has been the diagnosis, mandatory reporting, and quarantining of individuals who are carriers of infectious diseases. Consequently, some people perceived public health as serving a sanitation function. That narrow focus was broadened by the work of Louis Pasteur and Robert Koch who in 1870 put forth “germ theory” as the cause of disease. Germ theory gained much momentum in the United States as more and more individuals moved to large, urban areas where frequent exposure to strangers living in nearby and often cramped housing gave rise to the spread of various communicable illnesses for which there was no known cure.
Germ theory helped people understand that the etiology of disease (i.e., germs) leads to the spread of illness, and the subsequent morbidity and mortality of citizens. In turn, public health moved toward the field of medicine to carry out its mission. This move was facilitated by scientific progress of the 19th century that included the dawn of bacteriology and the invention of the stethoscope in the mid-1800s, the introduction of antisepsis in England in 1876 (through the practice of hand washing with carbolic acid introduced by Dr. [Sir] Joseph Lister), and the discovery of ether in Boston in 1867 (Starr, 1982).

Public health services were later expanded to include direct-service interventions to stop the spread of illnesses. The ability to diagnose and provide primary intervention versus curative care put public health at odds with the American Medical Association (AMA), which was more interested in the treatment of illnesses once they developed than arresting the spread of disease outbreaks. Additionally, public health conflicted with the values of individuals who believed that providing services such as vaccinations, maternal and infant care, tuberculosis (TB), and venereal disease (VD) (or in today’s nomenclature, sexually transmitted infections [STI]) prevention, and establishing clinics (known as dispensaries) for the poor was in opposition to groups who supported Social Darwinism and eugenics. Social Darwinists believed that only the healthiest members of society survived, thus ridding society of individuals who were unable to contribute to it. This way of thinking changed with more forward-thinking men and women who believed social reform was needed so that all people could receive necessary care and take part in society.

SOCIAL REFORMERS AND THE ADVENT OF SOCIAL WORK

The Social Reform Movement, begun in the 1890s, was brought about by individuals who were typically from well-educated and privileged backgrounds, who opposed Social Darwinism and laissez-faire ideology. Philosophically, the reformers had moved from a “blaming the victim” mindset of the 19th century to the realization that systemic evolution was necessary for the impoverished to subsist in America.

The women of the progressive movement took on leadership roles and were often among the first generation of women to have acquired a college education. They were typically from well-educated and privileged backgrounds, with fathers who were well-regarded attorneys, legislators, or businessmen. Many of their fathers supported equality for women and the right for women to vote. The reformers shared avid supporters during their formative years from settlement house reformers, labor union leaders, Children’s Bureau (CB) staff, and the Women’s Bureau’s affiliate-
the Women’s Joint Congressional Committee (Chambers, 1963). In large part due to their efforts, the field of social work grew and “scientific” methods were applied to charity work.

The reformers understood that good health was a key to longevity and one way to assure that people had good health was to impose strict laws (such as child labor laws) to ensure that children remained in school and were not forced to do dangerous jobs that often led to serious illnesses and injuries. In turn, the child labor movement became the means by which social reformation was to occur. The reformers teamed with union activists to support compulsory education for children and to press industrialists for better wages, unemployment compensation, safety codes/devices, and shorter work hours. They tied child labor to poverty, ill health, and limited opportunities for upward mobility. Social justice became fashionable and the “sleeping dog” (i.e., the indigent), was awakened and mobilized. Their efforts helped lead to the ratification of the 19th Amendment to the Constitution in 1921, whereby women were given the right to vote. Having achieved legislative success at the local, state, and national levels, the reformers moved to formulate federal programs that would impact poverty, child welfare, disabled persons, and the elderly. As a result, social work and public health were launched and national social policy (i.e., the Social Security Act [SSA]) was mandated.

Public health social work took active roles during the Great Depression of the 1930s by advocating for the passing of the SSA including the formulation of Maternal and Child Health Services (Title V), and the implementation of the New Deal programs. Public health social workers also pushed for passing The Great Society programs of the mid-to-late 1960s, which focused on social justice and empowerment (no doubt encouraged the Mental Health section’s governing councilor, Ruth I. Knee [a social worker] and others to encourage the re-emergence of a Social Work section within APHA).

During the 1970s and 1980s, public health social work focused much of its efforts on community-based care. Fiscal cuts in health care led to shorter hospital stays, increased nursing home admissions and greater use of home health care and outpatient services. Thanks to vaccines, many communicable diseases were curable, or at least treatable. Long-term, chronic diseases, however, became ubiquitous. Consequently, although Americans were living longer, they were doing so with greater pain, more frequent visits to health care providers, and less adequate insurance coverage. Today, legislative changes including The Affordable Care Act place a spotlight on public health and community organizing. Forever present are the societal issues that continue to pit individual rights against the national agenda to maintain our society. Our ethics and values and our global responsibilities are competing forces requiring a wider lens to address our challenges.
THE FOUNDING OF THE AMERICAN PUBLIC HEALTH ASSOCIATION
AND THE SOCIAL WORK SECTION

The American Public Health Association (APHA) was founded in 1872 by Dr. Stephen Smith. Its members were primarily physicians who worked as state and local health officials (Starr, 1982). APHA’s early agenda focused on the development of a centralized and systematic demographic database as well as preventive and primary interventions for children.

During the first annual APHA meeting in 1875, Dr. Elisha Harris stressed the need for an effective system of birth registration and primary prevention methods that would insure the health of Americans. His goal was to ensure cities and states had proper techniques for sanitation and a mode for vaccinating infants against smallpox. At this time, the smallpox vaccine was not in widespread use in the United States and generally was provided as a charity service (About the Cover, 1985; Schmidt & Wallace, 1982). For his efforts, Elisha Harris was remembered as a pioneer in American public health.

Social Work’s roots within APHA date back to 1910, under the auspices of the Sociological section, one of five sections initially organized within the Association. The Leadership of the Sociological section was credited with introducing the concept of “social context” to the diagnosis of population-based assessment. They argued that the environments in which people live serve to enhance or undermine health. Julia Lathrop, the first chief of the Children’s Bureau, referred to her work (eradicating infant mortality, initiating a national birth registry, and launching a program of child health conferences) as a “public health” line of attack whereby social workers could help to eliminate child health problems and promote the health and wellbeing of children. Lathrop touted her agenda and accomplishments as representative of a “sociological” perspective of public health practice (Parker & Carpenter, 1981).

Homer Folks, the first chair of the Sociological section, is credited with supporting Lathrop’s intent to address the preventable phenomenon of infant mortality. In 1903, Folks studied the context of tuberculosis and realized that living in crowded housing conditions gave rise to the spread of the disease. Consequently, if individuals were removed from their home environments they were less likely to spread tuberculosis. Having pioneered the importance of integrating social and economic indices and an ecosystemic approach to assessing communicable disease to impact public health issues, the section moved on to introduce Mental Hygiene (1916) as an area in need of attention (Rosen, 1971).

Despite its work within APHA, the Sociological Section disbanded in 1922 and many social workers migrated to the newly organized Maternal and Child Health section (1921) and subsequently to the Mental Hygiene
section. Numerous reasons have emerged to explain the demise of the Sociological section, but the most prudent rationale was the social work profession’s decision to shift its attention away from social reform and prevention to casework and treatment.

PUBLIC HEALTH VERSUS MEDICAL SOCIAL WORK PRACTICE

As we have seen so far in this chapter, public health and social work share many of the same goals and objectives. However, public health social work and medical social work practice differ in two very essential ways: (1) public health social work practice stresses health promotion and primary prevention, and (2) targets groups rather than solely individuals in need of services (Watkins, 1985). Public health social workers recognize the need to provide culturally relevant services at all levels of intervention (micro, mezzo, and macro) (Sable et al., 2012) and acknowledge that there are few interventions that have been tested on each level and are generalizable across cultural groups (Chin Walters, Cook, & Huang, 2007).

Public health social workers also bring additional skills to their practice including social epidemiology, which examines the effect of social variables on health and behavioral variables that affect a community (Oakes & Kaufman, 2006) (such as the effects of socioeconomic status on health status (Lynch & Kaplan, 2000)) and Geographic Information Systems (GIS), a software packaged used to map spatial correlations of particular interest to public health workers including access to healthy food options for pregnant women living in neighborhoods that lack fully stocked food markets (Lane et al., 2008). Another skill is Community Assessment used to identify strengths and weaknesses in a community. Community members meet to implement projects that may help eradicate community health problems (Kelley, Benson, Estrella, & Lugardo, 2009). Community members in turn may collaborate with public health researchers to evaluate the impact.

CORE FUNCTIONS OF PUBLIC HEALTH AND ESSENTIAL SERVICES

Public health social work practice emphasizes the identification, reduction, or elimination of social stressors associated with poor health (including poverty, discrimination, limited access to care, and fragmented service delivery), and determines the social supports that promote well-being and provide protection against poor health outcomes. Identifying populations at-risk of poor health outcomes and providing primary prevention services to arrest the possibility of contracting an illness are rooted in epidemiology. Social epidemiology assumes that diseases, disparities in access to care,
outcomes of care, as well as poverty are not randomly distributed throughout society. Therefore, subgroups within a population differ in their frequency of exposure to social problems that lead to poor health. Understanding the social context of an at-risk population is essential for public health social workers to render the most appropriate intervention (Krieger, 2001). Therefore, knowledge of the uneven distribution of risk factors as well as awareness of the economic and cultural indicators that can be utilized to formulate programs for health promotion, illness control, and prevention (Mausner & Kramer, 1985, p. 1).

The funding for public health programs and services comes from federal, state, and local dollars. Data including the rates of diagnoses, morbidity, and mortality, and demographic information are aggregated at state and local levels from both public and private health care providers and reported to federal agencies including the Centers for Disease Control and Prevention (CDC) for analysis. These data are in turn shared with the World Health Organization (WHO), which monitors the spread of various diseases around the world.

THE CORE FUNCTIONS OF PUBLIC HEALTH PRACTICE

The three core functions of public health practice and their essential services that address public health problems are assessment (surveillance of disease/injury), policy development (to address problems discussed through assessment), and assurance (implementation of policy that in turn leads to service delivery for all citizens regardless of their ability to pay), which dictate how public health social workers render services. The professional public health community works to identify not only the bio-medical (e.g., virus) and psychological aspects of disease (e.g., trauma), but the social determinants (e.g., poverty) as well. By addressing the determinants, public health social workers are better able to render care at the primary, secondary, and tertiary levels. Public health social workers are employed within every level of service from surveillance, research, policy development and planning, to the delivery of care.

MEDICAL SOCIAL WORK

In contrast to the role that public health social workers play, the role of social work practitioners in medical practice is more restricted. In general, medical social workers are hospital-centered, acute-care focused, and their community interaction is usually limited to making referrals for patients post discharge for ongoing medical care (Silverman, 2008). Once highly regarded
and considered a staffing necessity, today’s medical social worker role has largely been usurped by the field of nursing. Many hospitals no longer employ social workers and those that do, often relegate them to discharge planning; minimizing their supportive counseling role, while increasing interdisciplinary collaboration with the goal of limiting lengths of hospital stay (Lechman & Duder, 2009). Often hospital settings do not provide medical social workers with clear promotional tracks to administration, and supervision is often provided by nonsocial work professionals.

This model is not universal. For example, medical social workers employed by Veteran Administration (VA) Hospitals are well compensated, integral members of interdisciplinary teams. They frequently have numerous opportunities for upward mobility, research activity, and public health service. The VA model for social work practice was the ultimate goal for medical social work envisioned by Ida M. Cannon. This pioneer of medical social work acknowledged the need for individualized patient care within medical settings, but also saw a place for social workers in public health programs (Bartlett, 1975).

It seems that although pioneering social work leaders promoted clinical practice, the need for prevention and population-based interventions supported by a social epidemiological perspective was also an ongoing goal. Mary Richmond engaged in social action to address social injustice and Jane Addams employed casework methods as a fact-finding vehicle that recognized a sudden tendency of social work practitioners to limit social work to casework. Richmond declared,

I have spent twenty-five years of my life in attempt to get social casework accepted as a valid process in social work. Now I shall spend the rest of my life trying to demonstrate to social caseworkers that there is more to social work than casework.

—Bruno, 1948, pp. 186-187

Unfortunately, Richmond was unable to complete her task, leaving future generations of social workers to ponder the validity of cause versus function.

**HEALTHY PEOPLE 2020**

The initial goals and indices of Healthy People were the brainchild of Julius B. Richmond who served as Surgeon General during the Carter Administration (1977-1981). Healthy People has been published every decade since 1990. (The website www.HealthyPeople.gov provides information for the current and prior editions of Healthy People.) Richmond has been lauded for his attempts to address the public health needs of all Americans.
(Julius) Richmond remains best known for his leadership in devising and implementing quantitative goals for public health, first published in 1979 as *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*. *Healthy People* moved PHS beyond its limited capabilities to lessen disparities in health services provision, to spur change by getting information out to journalists, health departments, and others about gains already made in reduced mortality from noninfectious causes.


The goals of *Healthy People 2020* are to (1) attain high quality, longer lives free of preventable disease, disability, injury, and premature death; (2) achieve health equity, eliminate disparities, and improve the health of all groups; (3) create social and physical environments that promote good health for all; and (4) promote healthy development and healthy behaviors across every stage of the life cycle (*Health People 2020*, nd a). A glaring reality is the inclusion of indices that are clearly within the practice domains of the social work profession. Note, this chapter does not include content on all of the newly added indices, but we do incorporate many of them, as well as many of those identified earlier that are of ongoing importance. The *Healthy People 2020* goals differ from previous goals in the addition of the following indices: Adolescent Health; Blood Disorders and Blood Safety; Dementias (including Alzheimer's Disease); Early and Middle Childhood; Genomics; Global Health; Health-Related Quality of Life and Well-Being; Healthcare-Associated Infections; Lesbian, Gay, Bisexual and Transgender Health; Older Adults; Sleep Health; and Social Determinants of Health.

**PUBLIC HEALTH SOCIAL WORKER STANDARDS AND COMPETENCIES**

By definition, professionals have standards and competencies that are used to assess and measure their practice performance. Prior to 2004, public health social work practitioners had not developed their own standards and competencies. A growing national movement of transparency, evidence-based practice, and outcomes measurement, compelled public health social workers to assess the required knowledge and skill sets needed for effective practice.

The task of formulating standards and competencies was led by Kathleen Rounds and Dot Bon, who were the co-directors of the *Beyond Year 2010: Public Health Social Work Practice Project* in 1998. The *Public Health Standards and Competences* (Practice Standards Development Committee, 2005) was a collaborative effort of numerous public health social work
practitioners, educators, members of the Association of State and Territorial Public Health Social Workers, community advocates, representatives of national organizations and foundations, policymakers, and consumers. (For a complete list of Standards Development Committee members see www.oce.sph.unc.edu/cetac/phswcompetencies_may05.pdf.) Consultation was provided by Paul Halverson (CDC). Many of those providing input were also members and leaders of the APHA's Social Work section including Loretta Fuddy, Deborah Stokes, and Delois Dilworth-Berry. Funds to publish the resulting brochure were secured by Deborah Stokes from the Health Community Access Program and The Maternal and Child Health Block Grant of the Ohio Department of Health.

Fourteen standards and accompanying performance indicators were identified. The standards define and highlight practice skills across public health functions and essential services. The document defines and provides the application of a social epidemiologic approach to empowerment and resiliency-focused practice models across ecological systems. The competencies' section includes measurement content in the following broad areas: theoretical knowledge base of practice, methodological and analytical processes, leadership and communication, policy and advocacy, and values and ethics. Ongoing evaluation of public health social work standards and competencies is essential for the profession to move forward and continue addressing the many pressing needs of health care across the country.

### BECOMING A PUBLIC HEALTH SOCIAL WORKER

Becoming a public health social worker requires a passion for service, hard work, and a belief that good health should be afforded to all individuals. As you embark on a career in public health social work, employers will expect that you have a sound knowledge base in practice at the micro-, mezzo-, and macro-levels of intervention. Many employers will expect that you will have taken courses not only in social work, but in health as well. You can meet this expectation by enrolling in MSW courses that focus on health care and also by completing a field placement at a public health agency. There are now many dual MSW/MPH degree programs in the United States that help prepare students to enter the field of public health social work (Ruth et al., 2006, 2008). Although many MSW programs do not offer a dual MSW/MPH degree, many offer concentrations in health, gerontology, mental health, and child welfare that are also helpful to prepare you for a career as a public health social worker.

Continuing education programs offer another opportunity to develop and enhance one’s skills. These programs typically charge a fee and can run as long as one day to several weeks. Some offer certificate programs in
various areas that will enhance career opportunities. Professional organizations such as APHA and the Association of State and Territorial Public Health Social Work (ASTPHSW) provide excellent opportunity to develop professional skills and to network with other public health social workers around the country.

Finally, professional journals including the *American Journal of Public Health*, *Health & Social Work*, *The Journal of Social Work and Health*, *Social Work in Health Care*, and *Social Work in Mental Health* are excellent sources of up-to-date research studies that will help you to fine-tune your skills as an effective public health social worker.

**THE PURPOSE AND STRUCTURE OF THIS BOOK**

For this book, well-respected public health social work practitioners and scholars collaborated to produce a volume that we hope will educate the reader about today's practice realities in the field of public health social work. Social work educators will likely find the book useful for either undergraduate or graduate-level social work classes in social work practice, human behavior and the social environment, and social work/welfare policy courses. The chapters are structured in such a way as to, provide background on the core functions of public health including assessment, assurance, and policy development; link to relevant *Healthy People 2020* objectives; educate the readers on disparities in health care among racial and ethnic groups; discuss relevant public health social work standards and competencies; provide exercises and case scenarios for class discussions; and provide useful websites for additional reading.

The book is divided into six sections: The first section provides an overview of public health social work, the second section focuses on public health social work across the lifespan, the third section focuses on chief medical topics public health social workers face, the fourth section is devoted to public health social work in selected settings, the fifth section takes a look at public health social work administration and policy, and the sixth section considers the future of public health and public health social work practice.

Unlike many social work health texts that focus on the social worker as a member of an interdisciplinary/transdisciplinary team, this book focuses on the role of the public health social worker as an independent professional who, while working collaboratively with other professionals has a skillset and a set of resources to call upon. As with any good professional, the public health social worker's skills are always in development and require continuous updating. Health care in the United States requires the public health social worker to be continuously working on developing skills and
practice methods to be an effective practitioner. This chapter provides web-based resources to be of help to students interested in pursuing rewarding and fulfilling careers as public health social workers. We hope this book is useful to each of you as you move forward in your careers in the field of public health social work.

APPENDIX 1.A

ABRIDGED PUBLIC HEALTH AND SOCIAL WORK MILESTONES

- 1872 APHA founded
- 1874 Society for the Prevention of Cruelty to Children founded
- 1875 APHA 1st Annual Meeting—Dr. Elisha Harris pushes for a birth registration system in the United States, and a mechanism for vaccinating infants against smallpox
- 1887 First American Settlement House (NY Neighborhood Guild) established
- 1889 Hull House established in Chicago
- 1892 Milk stations open in New York City
- 1893 Jane Addams provides medical care to the indigent—dispensary in Hull House
- 1894 School-based medical services initiated in Boston
- 1895 Reports linking contaminated milk to disease in children leads to pasteurization
- 1896 The National Association of Colored Women (NACW) was co-founded by Mary Church Terrell and Josephine St. Pierre Ruffin. Among the agenda items for NACW members was advocacy for community development
- 1897 Compulsory vaccinations in New York City schools
- 1902 United States Public Health Service founded, replaces the Marine Hospital Service
- 1902 Committee on the Prevention of TB headed by Edward T. Devine, editor of Charities and The Commons and Executive Director of NY Charities Organization Society
- 1902 Meeting of 32 settlement house representatives (subsequently known as the National Child Labor Committee) to discuss child labor in NYC. The meeting was hosted by Lillian Wald (www.nwhm.org/education-resources/biography/biographies/lillian-wald/) and Florence Kelley (florencekelley.northwestern.edu)
- 1903 First comprehensive analyses of TB cases in the United States. The study was conducted and data were collected by social workers. The results led to social action and policy formulation on sanitation initiated by Hull House residents and Charity Organization Society members
- 1906 National Health Insurance Program proposed by Progressive Party members, including Jane Addams, contained a public health agenda
1908 NYC Health Department establishes program to eradicate contagious disease in children
- Lugenia Burns Hope (www.georgiaencyclopedia.org/nge/Article.jsp?id=h-3513) opens the Neighborhood Union in Atlanta, Georgia. Mrs Hope is further credited with pioneering satellite maternal and child health clinics, neighborhood schools, and adult education for Blacks
- 1909 First White House Conference on the Care of Dependent Children
- 1910 The Sociological Section of APHA is organized, “to bring social workers and health officer into closer touch . . .” (John M. Glenn, Russell Sage Foundation)
- 1911 Mother’s Pension in Illinois
- 1912 Children’s Bureau headed by Julia Lathrop a former Hull resident (social worker) national birth registration initiated
- 1912 Theodore Roosevelt and the Progressive party endorse social insurance as part of their platform to include health insurance
- 1912 Jane Addams endorses Theodore Roosevelt’s presidential nomination because of his agenda to sanction a National Health Service and social insurance programs, if elected
- 1918 Compulsory Education mandated nationwide
- 1920 Jessie O. Thomas, Lugenia Burns Hope, and E. Franklin Frazier are credited with establishing the first School of Social Work for Blacks in the United States at Atlanta University
- 1921–1929 Sheppard-Towner Act (previously introduced by Jeanette Rankin, a social worker and 1st woman in Congress)
- 1921–1934 Grace Abbott represented United States on the League of Nations’ Advisory Committee re: the Traffic in Women and Children
- 1930 Social Workers preempt coup to remove Title V programs from Children’s Bureau
- 1931 Jane Addams awarded Nobel Peace Prize
- 1932–1935 New Deal programs shaped by Harry Hopkins, a social worker
- 1935 Under Franklin Delano Roosevelt’s leadership, the Social Security Act passed by Congress and includes grants for Maternal and Child Health
- 1938 Fair Labor Standards Act—abolishes child labor nationally and ends racial discrimination in hiring practices of federal agencies, defense-related industries were specifically targeted with this mandate; Lenroot (www.columbia.edu/cu/lweb/archival/collections/ldpd_i079022/) and Abbott (www.americaslibrary.gov/jb/gilded/jb_gilded_abbott_1.html) were among the architects who crafted and secured this legislation
- 1941 Lenroot convened a conference that led the way to day care for working mothers
- 1944 Social Security Board calls for compulsory national health insurance as part of the Social Security system
- 1946 President Harry Truman signs National Mental Health Act
- 1949 President Harry Truman signs the Housing Act
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- 1953 Federal Security Agency made a cabinet level agency and renamed as the Department of Health Education and Welfare (DHEW)
- 1954 President Dwight Eisenhower signs Vocational Rehabilitation Act
- 1963 President John Kennedy signs into law the Community Mental Health Centers Act
- 1964 Great Society Programs/War on Poverty inspired by Whitney Young's (a social worker) proposal for a domestic Marshall Plan
- 1964 President Lyndon Johnson signs the Economic Opportunity Act
- 1965 President Lyndon Johnson signs into law the Medicare and Medicaid programs
- 1965 President Lyndon Johnson signs Head Start Program
- 1969 The Public Health Service (PHS) takes over the administration of Title V with the organization of the Department of Health Education and Welfare, child welfare and health were and remain separated. An earlier coup to overtake Title V from the Children's Bureau was pre-empted by social workers in 1930
- 1955–1969 Virginia Insley is named Chief, Medical Social Work Section, U.S. Children's Bureau
- 1969–1973 Chief, Medical Social Section, Maternal and Child Health Services, USPHS
- 1973–1980 Chief, Medical Social Work Section, Bureau of Community Health Services, USPHS
- 1970 The Social Work section established as a free-standing section of APHA
- 1972 President Richard Nixon signs the Social Security Amendment extending Medicare coverage to those under 65 who have long-term disabilities or end-stage renal disease
- 1972 WIC program established as part of the Child Nutrition Act on 1966
- 1974 President Richard Nixon signs Child Abuse Prevention and Treatment Act enacted
- 1980 President James Carter signs Adoption Assistance and Child Welfare Act
- 1986 President Ronald Regan signs into law the Omnibus Budget Reconciliation Act giving workers and their families who lose health benefits to continue receiving benefits for a certain period of time
- 1997 The State Children's Health Insurance Program extends health coverage to children from low-income families that do not qualify for Medicaid
- 1995 Health Resources and Services Administration (HRSA) provide funding to establish the Center for School Mental Health Assistance, Maternal and Child Health Bureau
- 1996 AFDC program ends
- 1997 TANF program begins
- 2003 President George W. Bush signs the Medicare Prescription Drug Improvement and Modernization Act (i.e., Medicare Part D)
- 2009 President Barak Obama extends the State Children’s Health Insurance Program through 2013
- 2010 President Barak Obama signs into law the Affordable Care Act

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