A History of Social Work in Public Health

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Social work is a core health profession with origins deeply connected to the development of contemporary public health in the United States. Today, many of the nation's 600 000 social workers practice broadly in public health and in other health settings, drawing on a century of experience in combining clinical, intermediate, and population approaches for greater health impact. Yet, the historic significance of this long-standing interdisciplinary collaboration—and its current implications—remains underexplored in the present era. This article builds on primary and contemporary sources to trace the historic arc of social work in public health, providing examples of successful collaborations. The scope and practices of public health social work practice are explored, and we articulate a rationale for an expanded place for social work in the public health enterprise. (*Am J Public Health.* 2017;107:e1–eXXX. doi: 10.2105/AJPH.2017.304005)

In 1926, Harry L. Hopkins, then director of the New York Tuberculosis Society, who would go on to be one of Franklin Delano Roosevelt's closest advisers and an architect of the New Deal, wrote, "The fields of social work and public health are inseparable, and no artificial boundaries can separate them. Social work is interwoven in the whole fabric of the public health movement, and has directly influenced it at every point."[1] Ninety years later, the *American Journal of Public Health* republished a 1966 article by John Stoeckle, illustrating the public health value of social work in a medical clinic.[2] As noted in a letter of response, social workers have been deeply involved in addressing social determinants of health for more than a century.[3] However, although some older writings attest to social work's historical relationship to public health, its contemporary significance is sometimes overlooked. The purpose of this article is to trace the arc of social work's involvement in public health over the past century, highlight examples and examine forces that both drove and hindered social work in public health, and illuminate how contemporary social work can add value to public health.

President Franklin Delano Roosevelt

Social work in the United States is a large, diverse profession of 600 000 practitioners, approximately half of whom are employed in health.[4] Dedicated to improving human well-being, social workers use ecological, clinical, and biopsychosocial approaches to work at multiple levels of society, ranging from individuals and families to neighborhoods, organizations, and government.

The umbrella of health social work includes numerous subdisciplines, such as public health, behavioral health, oncology, nephrology, and palliative care social work. Most health social workers serve in direct care roles, such as counseling, health education, and crisis intervention. However, social workers also practice at intermediary levels as navigators and care managers and at the macro level in health administration, prevention and health promotion, research, advocacy, and policy.[5]

A note on terminology: no one term describes health-related social work. Where indicated, we use the terms of the era to describe social work practice. To promote clarity, the term *health social work* describes contemporary practice within health and *public health social work* refers to the subdiscipline that integrates public health into social work.

PROGRESSIVE ERA

Although public health predates social work, both fields evolved into their contemporary forms during the early 20th century. Reflecting Progressive Era values, they shared an overlapping commitment to health and social well-being and, by the second decade of the 20th century, collaborated on issues such as maternal and child health, influenza epidemic response, and venereal disease control.[4]

Social work drew its inspiration from two primary sources:

first, the community-oriented settlement house movement, made famous by activists such as Jane Addams, who used place-based interventions to address poverty, overcrowding, immigration, and child labor, and second, the charity organization movement, which used casework to help individuals overcome poverty and avoid dependence on society for aid.

Tensions regarding social work's goals have affected the profession since its inception. From the beginning, social work explicitly elevated social justice as a key value and goal. However, the definition, function, and practice of social justice were, and remain, contested. The nascent profession struggled to identify a unified approach to encompass seemingly incongruent aims, ultimately settling on two major methods that have coexisted, often uneasily, under the banner of social work. Dubbed the "dual heartbeat," these methods evolved into casework, or clinical social work, and community, or macro, social work. Casework addressed the social and, later, psychological needs of individuals and families, and community or macro social workers engaged in cause-based or structural reforms intended to improve community well-being.[6]

Social work's early efforts in health used both approaches. Social workers carefully demarcated their scope of practice by limiting its focus to the "social side of illness," leaving disease and disease control to medicine and public health, respectively. Hospitals, and the doctors who controlled them, were initially unconvinced of the need for social services. Hospital social work pioneer Ida Cannon and visionary physician Richard Cabot faced significant resistance from doctors and nurses in their first efforts at Massachusetts General Hospital. However, once the positive impact of assisting patients with the consequences of illness became clearer, hospital social work grew rapidly. Because few of the rampant diseases, such as tuberculosis and syphilis, were curable, social work offered valuable and pragmatic psychosocial assistance.[7] The founders of one Boston-area hospital social work department, established in 1910, described their purpose as follows:

> Sickness is rarely an isolated fact, but is related to conditions under which people live. Thus the aim of the department is to find out the *social causes of the trouble,* to cooperate with the hospital in remedying the case, to prevent its recurrence and by doing so, safeguard the community, as well as aid the individual. By rendering social aid, for which the hospital itself has no time, the hospital is saved much expense and the individual and community are greatly benefited.[8] [emphasis added]

Although hospitals were an important venue for early health social work, social work in public health—or public health social work, as it was later known—had its genesis in the community. Local public health departments integrated casework into infectious disease programs to facilitate reaching the hard to reach and to promote family coping in the face of unemployment and extended hospitalization.[9]

In a 1912 presentation to the American Public Health Association, Homer Folks, a sociologist and social welfare advocate, described the alliance between the two fields. Folks noted that community, more than the hospital, was the focal point: "Health officers and social workers have met because their work brings them to the same place, namely, the home

Children's Bureau Leadership. Library of Congress, Prints & Photographs Division, LC-DIG-hec-05755

in which there is both communicable disease and poverty."[10] Folks's enthusiasm for how public health and social work could join forces—without turf battles—promoted collaboration in infectious disease control, maternal and child health, and prevention of poverty.[10]

The successful transdisciplinary campaign to reduce infant mortality serves as the clearest example of social work's impact in public health. During an era in which women could not yet vote, Lillian Wald and Florence Kelley, former settlement house activists, social workers, and civic leaders, successfully advocated for the establishment of the federal Children's Bureau. The agency's purpose was to call attention to women's and children's issues, such as shockingly high maternal and infant mortality rates, widespread child labor, orphaning of children, and lack of a comprehensive birth registration system.[11]

Julia Lathrop

The Children's Bureau reflected social work's growing visibility. Beginning with Julia Lathrop, five of its first directors were social workers, as were many staff. Lathrop directed the bureau's first efforts toward building scientific understanding of infant and maternal mortality. Lathrop was outspoken in her belief that infant mortality was not merely, or even primarily, a medical issue, but one that was socially constructed and influenced by preventable social, economic, and family conditions.[12] Using an epidemiologically sophisticated investigation, which included house-to-house field research and prospective surveys in eight cities and rural areas, bureau workers gathered data. The bureau released a series of reports enumerating the magnitude of infant and maternal morbidity in the United States; simultaneously, it commenced multilevel prevention efforts, reaching deeply into households and communities to raise awareness, promote sanitation, and educate about health. Simultaneously, the bureau engaged in vigorous legislative advocacy aimed at garnering federal, state, and local funds for improvement of social conditions.[13]

These efforts epitomized the convergence of social work and public health, helping to define the early characteristics of public health social work: willingness to investigate social factors as causes of poor health, combined use of epidemiologically informed casework and community-level interventions, and policy advocacy and change efforts to bring about structural change. During the years that the Children's Bureau focused on infant mortality, the rate was halved. Although many factors contributed to its decline, analyses have affirmed that the Children's Bureau's efforts were key.[11]

These early successes, fueled by Children's Bureau data and advocacy, set the stage for enactment of the 1921 National Maternity Act, also known as the Sheppard–Towner Act. The Sheppard–Towner Act provided the first-ever federal funding for innovative prevention programming and laid the groundwork for later federal–state collaboration in maternal and child health. The successful reforms, however, were opposed by numerous entities, including the American Medical Association, antisuffragists, business, and anti-Communist groups. Although initially successful in resisting accusations of subversion, the Sheppard–Towner Act fell victim to allegations of fostering socialized medicine and expired in 1929. Nonetheless, it served as an important precursor to future maternal and child health programs, such as Title V of the Social Security Act, and it illustrated social work's leadership capacity in public health.[14]

PROFESSIONALIZATION OF SOCIAL WORK

As social work grew, it branched into subdisciplines with divergent, often competing interests and organizations. By 1918, hospital social workers had created the American Association of Hospital Social Workers and, like much of the field, became interested in the professionalization of social work.[7] By the 1920s, a notable split between medical and psychiatric social work occurred as a result of a variety of influences, including Freudianism and the trend toward professional specialization.[15] Medical social work, initially inclusive of all social work in health, began to focus more

tightly on individually focused casework. Although Cabot's original vision had conceptualized social work as the bridge between hospital and community, casework increasingly focused exclusively on patients' social and psychological problems while they were in the hospital.[16]

This trend continued, and by 1934 the newly renamed American Association of Medical Social Workers defined medical social work as casework aimed at addressing the relationship between the patient's disease and social maladjustment.[17] By midcentury, although medical social work continued to articulate a person-in-environment approach, the earlier focus on community linkage lessened. This reflected 20th-century advances in curing disease and medical technology, which had strengthened the public's confidence in hospitals and medicine and made recovery more attainable. Anxious to secure its role, hospital social work garnered acceptance by adapting to the medical model, embracing its auxiliary role, and focusing on supporting patient recovery within the institution's walls.[18]

The devastation of the Great Depression for a time resulted in greater cooperation among disparate social work groups as they struggled to respond. Whereas some labored strenuously for the establishment of a national social welfare system, others questioned the profession's evolution in capitalist society and became active in community organizing, labor unions, and radical political movements.[19] Social workers Harry Hopkins and Francis Perkins, director of Federal Emergency Relief Administration and US Secretary of Labor, respectively, provided key leadership in Franklin D. Roosevelt's economic stabilization efforts and helped to establish the New Deal and the Social Security Act of 1935. The prominence of social work leaders in federal positions enabled the profession to shape the myriad social welfare programs—Maternal and Child Health, Child Welfare, and Crippled Children's Services—that emerged.

Milk Depot in New York

Social work in public health grew as well. By the 1920s, social work was integrated into the US Public Health Service (USPHS), providing services that define public health social work today: direct clinical services; case finding and consultation; program planning; and research, training, and prevention in a public health framework. Through the USPHS, social work expanded to include specific roles in heart disease, venereal disease, tuberculosis, and mental illness.[20]

Social work expansion continued during and after World War II, when social workers served in the military and were integrated into rehabilitation and veterans' services. By the 1950s, broad federal actions had established the National Institutes of Health and the Centers for Disease Control, funding health research and treatment, including social work.[13] As public health and social welfare modernized, social work in public health expanded. Social work developed innovative roles in medical clinics, engaged in the first efforts at disaster and crisis social work, and created nontraditional social work in areas such as dentistry.[21,22]

As social welfare state functions evolved in the mid-20th century, the profession considered new roles. Before the 1960s, most social work in public health focused on secondary prevention; however, interest in primary prevention gradually intensified. Elizabeth Rice, social worker and Harvard School of Public Health professor, vehemently supported an explicit emphasis on primary prevention and urged social workers to "understand, solve and prevent [health problems]."[23(p87)] Like many public health social workers, then and now, she lamented that much of social work still seemed "to be working on

a patient-by-patient basis in clinical services," neglecting the "potentialities that exist for the more comprehensive practice of social work."[23(p88)] Milt Wittman argued for a new preventive social work. Wittman, who rose through the ranks of the National Institute of Mental Health, presided over a federal task force on social work education and was the first social work professional liaison officer for the US Public Health Commissioned Corps, wrote,

> The profession stands today at the brink of a vast opportunity to make good its greatest usefulness to society. The field should work diligently to develop . . . *preventive social work*. . . . Only in this way can a new generation of social workers learn to apply social work skills in an attack on the roots of social problems. This move is long overdue and should have our serious, considered attention.[24(p28)] [emphasis added]

Despite these appeals, however, public health and prevention were not widely reintegrated into social work education or practice. Most of social work remained centered on casework.

The 1960s civil rights, women's, and other social movements renewed social work interest in activism, and, predictably, tensions resurfaced regarding the profession's roles. Intense debates surrounded the value of casework; disconnected from social change efforts, some viewed it as ineffectual or destructive.[25] Scholars and practitioners engaged in vigorous discussions regarding the profession's role in systems change versus service provision. Systems-level social work proliferated through opportunities made possible by the War on Poverty, the Great Society, and the establishment of Medicaid and Medicare.[26] Social workers engaged in community development, set up preschool programs, and promoted economic opportunity and civil rights. Meanwhile, social work education broadened to include a stronger focus on social problems. The movement to community health—although not wholly advantageous to medical social work—offered public health social work new opportunities.[17] Boston-based public health social worker Ruth Cowin observed, "We are in the midst of a social revolution and adaptations in traditional practice . . . have to be made; experimentation and innovation are the order of the day."[27(p860)] She presided over the successful integration of "indigenous workers"—a precursor to community health workers—into a family health center.

Despite substantive advances in social work education, training, and practice, the idealism and funding that fueled the Great Society waned as the Vietnam War ground on; gradually, fiscal cutbacks undercut progress in many aspects of social welfare. Although social work practice in public health continued, 1970s disinvestment gutted many innovative health and social programs, and community-oriented social work jobs decreased. As the conservative climate strengthened, the larger profession redirected its attention to advancing social work survival through licensure, third-party reimbursement, and private practice.[26]

FUNCTIONAL SURVIVAL

By the 1980s, escalating health costs unleashed market-driven cost containment efforts throughout the health arena. Lacking the needed data to prove their financial value, many hospital social work departments were decentralized or eliminated; the roles of hospital-based social workers shifted from counseling to discharge planning and case management, and some traditional social work tasks moved to allied professionals.[27] Medical social work entered a protracted phase of self-justification, contracting into a state of functional survival.[28]

The turbulence led to a search for solutions to enhance the profession's visibility and impact, including appeals to redirect the profession toward prevention and public health.[29,30] The USPHS's Division of Maternal and Child Health held a Public Health Social Work Forward conference in 1985 to facilitate integration of public health concepts into social work.[4] Some educators embraced the charge, introducing epidemiology and prevention into social work education.[14] The first Master of Social Work–Master of Public Health (MSW–MPH) programs were launched at this time, building on the natural synergy between the fields.[4] Community prevention partnerships grew, highlighting the value of social work skills in community outreach, cultural responsiveness, and capacity development, and a small body of prevention research emerged.[31]

Still, as the millennium approached, there was an unmistakable air of concern regarding recognition of social work's role in public health. When the National Academy of Science, Institute of Medicine released a major report, *The Future of Public Health*,[32] Ruth Knee, a veteran public health social worker who had served in the USPHS and National Institute of Mental Health, was the only social worker to participate on the panel. The report acknowledged

broad disarray in the public health field, including funding and workforce issues; lack of coordination with primary care, mental health, and social services; and mounting challenges such as AIDS.[33] Knee believed that social work, with its proven track record of leadership, had an important role to play in strengthening public health. She urged the profession to more clearly articulate its value and function in public health.[18]

Yet, many questioned whether the broader field, now heavily focused on therapeutic work with individuals and families, could refocus on public health. Rosenberg and Holden acknowledged the field's limited understanding of its actual or potential roles:

> We urge social work educators, practitioners and researchers to engage in a dialogue to find ways to focus the profession away from pathology and towards prevention, [and] population [health] practice.[30(p11)]

Bracht, tracing the arc of support for social work in public health and prevention, concluded,

> The structural, educational, philosophical and incentive bases of practice are so ingrained at the individual treatment level as to inhibit either quick or major changes. . . . The 'will to change' [first] needs to be rekindled.[29(p6)]

RENEWED INTEREST IN PUBLIC HEALTH

As Bracht[29] predicted, the convergence of numerous factors gradually rekindled the profession's interest in public health. By the century's end, the nation's half million social workers had grown frustrated; they labored in a fragmented system that emphasized disease treatment over prevention, used a maze of bureaucratic structures to contain spiraling costs, produced gross health inequities, and failed to meet the needs of a significant portion of their clients.[31] The national tragedy of 9/11 and its ongoing effects reaffirmed new health concerns such as bioterrorism, disasters, and community trauma. Social workers were close witnesses to the changing social, environmental, and economic determinants of health as mental illness, violence, suicide, trauma, chronic disease, and substance use increased. An ever-expanding array of studies highlighted health disparities, particularly racial inequalities, and articulated the need for upstream social work interventions.[34]

Public health's broadened focus on social sciences, social determinants, and ecological frameworks increasingly reconnected to the interests of the social work profession. Social work responded early and forcefully to the HIV epidemic, engaging broadly in outreach, advocating for destigmatization, and crafting culturally responsive preventive interventions. Collaborations between the fields expanded to include community-based efforts in substance abuse and HIV prevention, chronic disease management, child abuse prevention, and toxic waste activism.[4,35] Social work researchers began to systematically use the powerful tools of public health, such as epidemiology, to inform the profession's long-standing commitment to serving vulnerable populations.[4] Major research findings on the impact of adverse childhood experiences, the global burden of mental illness, and the potential for prevention of mental disorders affirmed the profession's long-standing focus on trauma and mental health, igniting interest in social work as a preventive force.[36] The US Department of Health and Human Services' health goals, known as *Healthy People,* enabled the profession to better locate its work within the nation's health framework, which in turn strengthened the science of social work.[12]

Finally, recent health reform efforts issued a clarion call to the profession to once again widen its lens for greater impact. Although the future of health reform remains uncertain, the expanded integrated health social work model that emerged in response emphasizes care coordination, prevention, community engagement, and interprofessional teamwork; these are all areas of deep practice expertise that began a century ago and are still deeply needed.[26,36,37]

THE BRIDGE: PUBLIC HEALTH SOCIAL WORK

Public health social work serves as an important base for a new era of health social work in two critical ways. First, it provides a century's worth of experience in how to marry clinical, intermediate, and population approaches for greater impact; second, it serves as the interprofessional bridge between public health and social work. The rebuilding of this bridge is now evident across a wide range of professional activities: membership in the Public Health Social Work Section of the American Public Health Association has doubled, a new *Social Work in Public Health* journal was launched in 2007, and prevention has been integrated into educational and practice standards. The American Academy of Social Work and Social Welfare has established a dozen Grand Challenges for the field, the majority of which require public health approaches.

Some 43 MSW–MPH programs produce graduates who practice in all core public health services, from community mobilization and health promotion to program evaluation and surveillance.[4] The integration of public health content into social work is not limited to MSW–MPH programs; a recent review of health content found that 38.5% of MSW programs (n = 86) now offer wide-lens public health content.[38]

FUTURE OF SOCIAL WORK IN PUBLIC HEALTH

Harry Hopkins may have believed that these two fields were inseparable and in firm possession of common ground, but a century later it appears necessary to remind ourselves of the past and to assess the continuing validity of his assertion. Clearly, social work and public health have much in common: shared Progressive Era roots, a joint commitment to social justice, and a history of collaboration. Yet, despite clear evidence of past and potential synergies between the two fields, social work's foothold in public health has never been fully established.

We suggest some of the historic reasons for social work's lack of visibility as a public health actor, including choices regarding professionalization, the dominance of clinical interventions, and a failure to articulate its public health history. Despite Hopkins' perspective a century ago, social welfare and health were cleaved into separate domains. Today, however, there is a growing understanding of how the unmet social needs of humanity detract from health

and produce inequitable health outcomes. Clearly, efforts to advance health equity will be undermined if these two domains are not consciously reconnected. Social work, with its depth of involvement across all of social welfare, is vital to these efforts.

The challenges facing the two fields—health inequities, racism, climate change, violence, mental illness, persistent infectious and chronic diseases, and economic inequality—are profound, pressing, and intractable. Even this brief historical review reminds us that changing society at the level of social determinants is never easy and is nearly always controversial, even today. Our predecessors' resolute efforts to improve health were, by necessity, transdisciplinary, cross-sectoral, political, and closely linked to the expansion of social welfare.

If social work's past is truly prologue, the stage is now set for an important shift in trajectory. Within a decade, the number of social workers employed in health is expected to swell to 75% of the field. Moreover, those not directly involved in health are already engaged in addressing the social determinants of health through long-established efforts in housing, education, child welfare, and the promotion of racial and other forms of social justice. There is an emerging awareness that "*All social work is health work*"[39(p453)] [emphasis added]. Through this lens, social work can be viewed as a vast but underused component of the public health workforce—one whose abilities to engage in community health work, prevention, advocacy, integration, and coalition building are vital to public health's success

Recently, *AJPH* debuted a new column dedicated to "a public health of consequence," focused on what matters now.[40] As Hopkins knew a century ago, social work, with its deep roots and ongoing pragmatic presence in public health, is a sister profession of consequence, involved in addressing what matters now. It is time to recognize its historic significance, value its current capabilities and contributions, and provide leadership to expand its place in the broader public health enterprise. AJPH

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