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**Social Construction, Knowledge Utilization, and the Politics of Poverty: A Case Study of
Washington State's General Assistance Reform**

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ABSTRACT

This paper addresses a gap in welfare reform literature by investigating the social constructions of poor people in state policymaking within the context of diminishing General Assistance (GA) after the Great Recession. Using Social Construction and Policy Design Theory and thematic content analysis of Washington State's legislative archives, I found that the negative constructions of GA recipients as deviants with undesired psychological and behavioral problems were associated with the reform direction toward a regulated, punitive model. These constructions, intersecting with the ideologies of personal responsibility and work ethic, contribute to the dismantling of the social safety net for the Washington's poorest residents.

INTRODUCTION

Social construction of a social problem influences the policies designed to address the problem and the public resources allocated to different social groups (Schneider & Ingram, 1997; Schneider & Sidney, 2009). Thus, social policy scholars have paid attention to how public discourses construct poor people and how welfare reform legislations enforce social norms (Amundson, Zajicek, & Kerr, 2015; Applebaum, 2001; Compbell, 1999; Guetzkow, 2010; O'Connor, 2009; Quadagno, 1999; Rose & Baumgartner, 2013; Watkins-Hayes & Kovalsky, 2016). Yet an understudied program in the welfare reform research is General Assistance (GA)—the “safety net of last resort” for those with the least access to federal cash benefits in the U.S. social welfare system (Anderson, Halter, & Gryzlak, 2002, p. 249). GA programs, typically funded and administered by the states, provide income support to poor individuals who do not qualify for federal social assistance or whose benefits from other programs are insufficient or exhausted. Target populations of GA vary across states, but normally fall into three categories: (1) elderly and unemployable adults who are ineligible for Supplemental Security Income; (2)

employable adults with children ineligible for Temporary Assistance for Needy Families; (3) employable adults without children (Chang, 2017).

Over the past few decades, many states have restricted eligibility and reduced benefits for their GA programs, and some states have even eliminated their programs altogether (Gallagher, 1999; Schott & Hill, 2015). The decentralized aspect of GA and the lingering economic impact of Great Recession (2007–2009) on states' revenues contributed to an accelerated shrinking trend in GA (Chang, 2015). By 2015 only 26 states still had a GA program, down from 53 programs in 1960 (Social Security Administration, 2000), and benefit levels had shrunk severely to an average amount below half of the federal poverty level (Schott & Hill, 2015).

GA's erosion has dismantled the "safety net of last resort" for the poorest people in the United States. However, little is known about how the social constructions of GA recipients played a role in GA reforms at the state level. Social work professionals have committed to "advocate for changes in policy and legislation to improve social conditions in order to meet basic human needs and promote social justice" (National Association of Social Workers, 2017, p.30). Particularly after the welfare reform of 1996, policy decisions have been considerably devolved to state capitals, where social workers are more able to influence policies than at the federal level (Schneider & Netting, 1999). Thus, studies on state-level welfare reform legislations should inform social workers' advocacy work.

This study contributes to welfare reform literature by investigating how policy actors constructed GA recipients to inform legislative reforms in the wake of Great Recession. I used Social Construction and Policy Design Theory and thematic content analysis to examine the GA reforms in Washington State during the 2009–2011 period. Findings reveal the interplay between social construction and knowledge utilization in the welfare reform process—how positive and

negative constructions of target populations influence policy proposals. I conclude with implications for making socially just policy changes in anti-poverty programs.

Social Construction and Knowledge Utilization in the Policy Process

Political scientists have theorized how problems are brought to the government, how policy actors inform policy solutions, and how policies are implemented, evaluated, and changed (Sabatier, 2007). Ann Schneider and Helen Ingram's (1997) *Social Construction and Policy Design Theory (SCPDT)* is particularly relevant to social welfare studies because it places meaning-making at its center to analyze how policy designs reflect social norms. In contrast to Institutional Rational Choice Theory, which assumes that problems are objectively presented and that policy decisions are rationally assessed (Ostrom, 2007), SCPDT argues that problems are socially constructed and policy decisions are politically charged (Schneider & Ingram, 1997; Schneider & Sidney, 2009).

The "target population proposition" of SCPDT suggests that the positive or negative social constructions and the stronger or weaker political power of different social groups determine how policymakers allocate benefits and burdens to different target populations. Groups of poor people, which have weaker political power in a society, may be viewed as either "dependents" or "deviants" in the policymaking process. Dependents (e.g., children) are positively constructed in the public discourse and assumed to be deserving of public benefits, while deviants (e.g., criminals) are negatively constructed and often receive punishments rather than benefits. Through policy actors' social constructions of target populations, policy designs replicate unequal social and power relations (Schneider & Ingram, 1997; Schneider & Sidney, 2009).

In a recent review of research drawing on SCPDT, Schneider and Sidney (2009) indicate that future policy scholars should expand SCPDT by exploring the relationship between social

construction and knowledge utilization in the policymaking process. The social construction of knowledge involves “processes of problem definition, interpretations of cause and effect, characterizations of knowledge and information as relevant or not relevant to a policy issue, as technical and scientific are contrasted with anecdotal and impressionistic” and “the role of experts in policymaking and the type of knowledge that causes an actor to be considered an expert” (Schneider & Sidney, 2009, p. 108). This insight encourages me to examine how policy actors use knowledge to construct a social problem, craft policy solutions, and influence final decisions.

Researchers of evidence-based policymaking have argued for considering a broader knowledge base as evidence in the policymaking process (Epstein, Farina, & Heidt, 2014; Glasby, Walshe, & Harvey, 2007; Head, 2008). Policy analysis scholar Brian Head (2008) outlines three types of evidence specifically—scientific, political, and professional knowledge—each of which should be influential, rather than deterministic, in policymaking. Scientific knowledge includes systematic analysis of past and current circumstances and of causal effects of specific interventions; political knowledge, also called political judgement, includes priorities, persuasion, messages, ideologies, trade-offs and compromises; professional knowledge refers to information about everyday problems of program implementation and client service. Head’s model of integrated, evidence-based policymaking supplements SCPDT to explain how policy actors use different types of knowledge to construct the target populations and the corresponding solutions, and is central to the present research.

Social Construction of Poor People and the Politics of Welfare Reform

Social constructions of poor populations involve the attribution of poverty to various causes, assumptions about the characteristics of poor people, and judgements about how

deserving a population is of receiving public resources (Guetzkow, 2010). Attributing poverty to individual or structural causes each tells a different story about why poor people are poor, hence suggesting different policy responses to poverty (Applebaum, 2001; Rose & Baumgartner, 2013). Examining the development of poverty knowledge and the changes in social welfare policies in the twentieth century, O'Connor (2009) found that the “cultural pathology” attribution, with a focus on individual behavior and traits among poor people, has been prevalent in academic research, policy agendas, and public opinion since the 1960s. This dominant individual attribution of poverty, interacting with the social constructions of the characteristics of poor people and their deservingness for public benefits, shifted the main responsibility for poverty from governments to individuals in welfare reforms in 1980s and 1990s. In the neoliberal context of welfare reforms, policymakers seeking to weaken the government role in social protection strategically emphasized personal responsibility to shift public discourses on social welfare (Quadagno, 1999). The most significant federal welfare reform legislation of that era was the 1996 Personal Responsibility and Work Opportunity Act (PRWOR).

The most notable policy change under the PRWOA was replacing Aid to Families with Dependent Children (AFDC) with Temporary Assistance for Needy Families (TANF), which imposed strong work requirements for its target population—single mothers. Driving this change was a negative construction of the term “welfare queen,” in which poverty was portrayed as a problem of welfare dependency among unmarried, low-income, African American single mothers. The “welfare queen” image did not resonate with the mainstream values of work ethics and good motherhood (Clawson & Trice, 2000), reinforcing the group’s construction as undeserving. The goal of the PRWOA moved away from ending poverty toward ending welfare dependency. Underlying the PRWOR was a welfare ideology that emphasized the individual

causes of poverty and enforced the continual movement of poor people off the welfare rolls and ostensibly back to work (Jurik & Cowgill, 2005; Schram & Soss, 2011).

Although past research has examined the roles of scientific knowledge and political knowledge in shaping welfare reform directions (e.g., Guetzkow, 2010; O'Connor, 2009; Schram & Soss, 2001; Szanton, 1991), the questions of how policy actors use knowledge to construct poor people, and how these constructions play into the legislative process, are still underexplored. Moreover, most welfare reform studies have focused on federal legislations, with little attention to the state-funded General Assistance (GA) programs that typically serve poor people with least federally-funded income support (Noy, 2009). The post-Recessionary period is an important context for examining GA reforms because facing budget shortfalls, state policymakers' discussions leading up to cuts in welfare revealed how they drew on different forms of knowledge and constructions of poor people in the legislative reform process.

To fill these gaps in welfare reform literature, the present research draws insights from Schneider and Ingram's (1997) Social Construction and Policy Design Theory and Head's (2008) knowledge-based policymaking model to examine three research questions: (1) How did policy actors in the post-Recessionary period in Washington State use different forms of knowledge to construct the GA populations? (2) How did these policy actors use different forms of knowledge to craft policy proposals? (3) How did the constructed knowledge about the GA populations and proposed policy solutions influence the state's GA reform decisions?

METHODS

Case Selection and Data Sources

I selected the Washington State Legislature as a research site because it passed two reform bills in a three-year time frame (2009–2011)—HB 2782, replacing the GA program with

the Disability Lifeline (DL) program, and HB 2082, making changes to the DL program. The associated legislative activities provide substantial materials with which to examine state GA reforms. The Washington State Legislature maintains video archives of all legislative meetings, which are publicly available on the Washington State Public Affairs Network (<http://www.tvw.org/>). My primary data sources were 26 videos regarding GA or DL, including nine work sessions where issues were reviewed by a committee, six public hearings where interest groups gave testimony and expressed concerns, six executive sessions where the committee decided how a bill should be reported to the full House, and five floor actions where legislators debated the bills and voted on final passage. I supplemented these videos with relevant text sources (e.g., the legislature's bill analyses and presentation slides used in meetings, and research reports and policy briefs published by relevant agencies). I used the qualitative software ATLAS.ti 7 to managed all data sources. Appendix A lists these data sources and their corresponding legislative activities. (Hereafter, data sources are cited using the document number found in the right column of Appendix A, followed by the number of a specific quotation from a document in ATLAS.ti. For example, P1:5)

Analytic Approach

Using both deductive and inductive coding techniques (Fereday & Muir-Cochrane, 2006), I developed a hierarchical coding scheme that organized codes into main categories and subcategories (Friese, 2014). My preliminary categories were theory-driven codes derived from Schneider and Ingram's (1997) concepts of policy design elements and Head's (2008) concepts of policy-relevant knowledge. The initial coding scheme was modified, expanded, and re-sorted by incorporating inductive, data-driven codes that emerged during data analysis, particularly terms that were repeatedly used to describe problems and justify policy solutions. I finalized the

coding scheme after three rounds of developing, applying, and merging codes, when codes achieved consensus between analyses.

I adopted thematic content analysis—an approach that emphasizes the qualitative nature and narratives of the data, in contrast to conventional content analysis, which focuses solely on counting attributes in the data (Smith, 1992; Vaismoradi, Turunen, & Bondas, 2013). This approach is suited to the present research’s examination of how social construction occurs in the policy process. To enhance the “trustworthiness” of my interpretations (Lincoln & Guba, 1985), I discussed the preliminary findings with policy practitioners who have substantive knowledge and experience about the state legislative process and anti-poverty policy advocacy. I also disseminated the preliminary findings in two national conferences and one public lecture, and incorporated welfare policy researchers’ and practitioners’ insights into my interpretations.

RESULTS

To examine the relationship between social construction of GA/DL recipients and the policy changes in GA/DL, this section first introduces the policy background and then synthesizes the major themes related to constructing problems, crafting solutions, and making decisions, to address the three research questions, respectively.

Policy Background

Washington State’s GA prior to 2009 was a means-tested program providing cash and medical assistance for poor adults who did not qualify for other federally-funded income supports and who were “unable to engage in gainful employment” (P33:1). During the Great Recession, the GA caseload increased from 50,817 individuals in 2007 to 59,962 in 2009 (Washington State Department of Social and Health Services, 2018). Despite the growing need, Governor Chris Gregoire’s 2009–2011 budget plan proposed to eliminate both cash and medical

provisions for the largest of three GA subcategories, known as GA-Unemployable (GA-U) (Office of the Governor, 2008). From 2009 to 2011, the legislature made several attempts to cut GA-U. In the 2010 legislative session, the GA program was replaced by the similar Disability Lifeline (DL) program when the Governor signed the Security Lifeline (HB 2782) into law. DL served the same subpopulations as those in GA, but its monthly cash benefit for DL-U (formerly GA-U) was cut substantially. In the following year, the legislature passed a second reform bill (HB2082), which replaced DL with three new programs—Essential Needs and Housing Support, Aged, Blind or Disabled Assistance, and Pregnant Women Assistance—that provide disparate provisions to different target populations of the original GA program (P32).

Constructing Problems

In work sessions and public hearings leading up to these bills' passages, policy actors from various interest groups and government agencies cited research, made political judgments, and used professional knowledge to construct the characteristics of GA/DL recipients. Analysis of these narratives revealed three key themes: distinguishing GA/DL-U recipients from other GA/DL recipients, pathologizing and criminalizing GA/DL-U recipients, and overlooking the commonality of economic hardship across the diverse GA/DL-U recipients.

1. Distinguishing GA/DL-U recipients from other GA/DL recipients

The problem construction of how people come to need GA began with characterizing three pre-existing subcategories in the program. The first category was GA-Unemployable (GA-U), which targeted women who were pregnant and not eligible for TANF and adults who were unemployable for more than 90 days due to “physical or mental incapacity.” The GA-U population represented just over half (51.5%) of the GA clients. The second category was GA-Expedited Medicaid (GA-X), which targeted elderly people and people with disabilities who

were presumptively eligible for the federally-funded Supplemental Security Income (SSI) and Medicaid but were not yet enrolled in those programs. The third category, GA-Other, targeted elderly people and people with disabilities who were not eligible for SSI due to non-citizen status or other eligibility requirements. The monthly cash grant for three GA subcategories were the same, \$339 for one person (P33).

As the three subcategories were discussed and distinguished from one another, government officials and policy analysts pinpointed GA-U clients as the most difficult and expensive to serve among three groups. They highlighted GA-U clients' health characteristics and the increasing cost of healthcare. A policy evaluation noted, "GA-U clients are expensive users of inpatient hospital services and those with mental illness and/or substance abuse are relatively frequent visitors to hospital emergency rooms" (Joesch et al., 2011, p.3); an official analysis produced for the legislature stated, "GA-U medical program expenditures are among the fastest growing of DSHS medical programs" (P35:5).

2. Pathologizing and criminalizing GA/DL-U recipients

During the reform process, GA/DL-U recipients were often portrayed as drug addicts or as people with complex mental or behavioral problems. Table 1 shows that homelessness, mental illness, and chemical dependency were the most frequently mentioned characteristics for GA/DL-U recipients in quotations relevant to problem construction. However, in fact only about 25% of them were homeless, about 35% had been diagnosed with a mental illness, and about 32% of had been identified as having substance abuse issues (P34). The Social Construction and Policy Design Theory suggests that these characteristics, compared with pregnant women, domestic violence victims, and people with physical disabilities, are more likely to be negatively

constructed in the policymaking process (Schneider & Ingram, 1997; Schneider & Sidney, 2009).

Table 1. Frequencies of Characteristics of the GA/DL-U Populations Mentioned in Quotations by Legislative Activity

Characteristics of the GA/DL-U	All legislative activities	Work sessions / Public hearings	Executive sessions / Floor actions
Homelessness	65	49	16
Mental illness	51	42	9
Substance abuse	50	36	14
Physical illness	20	16	4
Criminality	19	18	1
Poverty	12	11	1
Veteran	10	8	2
Domestic violence	8	8	0
Pregnancy	5	3	2
Immigration	2	2	0
Total	242	193	49

Policy actors negatively constructed GA/DL-U recipients by manipulating statistics to highlight the most socially undesirable health characteristics and by linking these characteristics with criminal activities that threaten public safety. For example, health service practitioners, researchers, and legislative staff repeatedly presented a Venn diagram of “co-occurring diagnoses” (Washington State Department of Social and Health Services, 2006), in five out of nine work sessions, to underscore the mental illness and substance abuse problems among the GA-U clients (see the Venn diagram in Appendix 2). Despite the fact that having a chronic physical condition was the primary qualifying characteristic of GA-U clients (69%), and that only about 15% of GA-U clients had all three conditions (i.e., chronic physical condition, mental illness, and substance abuse), narratives overwhelmingly emphasized that GA/DL-U clients “have complex co-occurring diagnoses” (P2:15, P3:5, P34, P35, P36), “often have more than one incapacity including substance abuse” (P28) or “face greater challenges when their health conditions are complicated by substance abuse problems” (P3:14, P35). Policy actors then

seamlessly linked mental illness or substance abuse to criminality that threatens public safety.

The bill sponsor of HB 2782 stated: “Most mentally ill people don’t represent a danger, but there are some who do. And I think it’s a quite frankly scary thought to have them on the streets without medications, without a home (P15:2).”

3. Overlooking the common economic hardship among the diverse GA/DL-U recipients

By policy design, GA/DL-U provided both cash and medical benefits for low-income working-aged adults who were unemployable. Given that GA/DL-U recipients were disproportionately white (65%), male (63%), and with an average age of 40, policy actors relied on and amplified a stereotype of GA/DL-clients as middle aged white males who could not follow the social norm of showing a “work ethic” and did not fit the conventional image of the “deserving” poor (P3:14; P22; P28, P35). Community advocates attempted to emphasize the diversity of GA/DL-U recipients, but their attempts were not frequent enough to challenge the prevailing negative constructions. It was not until the 2011 session that domestic violence victims gained legislators’ attention. A practitioner testifying in a public hearing said: “I also want to remind the members of this committee [domestic violence victims] are often the forgotten group of clients that access this program.....[They] have no place to go and no resources to be able to access to safety.....For people [who] don’t have children, this is the program to support them” (P23:12). However, practitioners and government staff failed to convince lawmakers of the diversity and deservingness of the GA/DL-U population (P23:25). In the midst of the competing constructions of who GA/DL-U clients were and the various purported causes of their poverty, their common defining characteristic—economic hardship—was barely mentioned.

Crafting Solutions

Responding to the Governor's proposed budget cut to both cash and medical provisions of GA-U, policy actors from different interest groups actively participated in work sessions and gave testimony in public hearings to shape the policy proposals. Two themes summarize the patterns of knowledge utilization for crafting solutions: contrasting professional and scientific knowledge regarding cash benefits, and united knowledge for retaining medical benefits.

1. Cutting cash benefits: Professional, anecdotal knowledge contrasted with the absence of quantitative scientific research

Advocates against cutting cash benefits mostly relied on their professional experience and values to justify their positions. For example, practitioners described the GA-U program as “the only safety net for these [truly needy] people” (P2:9), as a “gateway to medical care” and other services (P3:5), and as a path to “returning to a productive life” (P22:15). Practitioners also presented clients' stories (P2, P34) and brought clients to convey the importance of GA in their lives. One client testifying in a work session said: “GA retains my dignity, gets me off the street...GA allows me to pay my cell phone. Without this I would not be able to stay in touch with my family and friends, and would not be able to make medical appointments” (P2:24).

However, the major challenge to retaining the cash benefit was the lack of scientific evidence to support the cash provision. The legislature's research division—the Washington State Institute for Public Policy (WSIPP)—conducted a systematic assessment and concluded that it was unknown whether the GA cash benefit was a cost-effective policy approach because there was “no rigorous, empirical research on the provision of general assistance” (P5:7, P36:14). The professional knowledge and values-based arguments brought forward by advocates could not overpower the perceived absence of scientific support for GA cash assistance.

While qualitative research has documented the negative impacts of cutting GA cash grants on clients' daily lives in other states (e.g., Halter, 1992; Coulton & Crowell, 1993), this line of research was not included in the review conducted by WSIPP. This pattern of scientific knowledge utilization by authority highlights a problem of the hierarchy of scientific knowledge, in that quantitative evidence, or even the lack of it, was considered more strongly than qualitative evidence, which could be dismissed as biased or as "merely" anecdotal.

2. Retaining medical benefits: Scientific, political, and professional knowledge united

In contrast to the elimination of the cash provision, the medical provision was expanded for GA-U clients in 2009 and then remained unchanged until 2011 (Joesch et al., 2011). In November 2009, Washington State launched a statewide GA-U Medical Integration Program that emphasized managed care. This expansion was won through the advocacy efforts of a health service coalition that used evidence from a pilot managed care program implemented in two counties in 2004 to inform the GA reform decisions (P28).

Interest groups advocating for the Medical Integration Program ranged from frontline health service agencies to academic health researchers. These policy actors not only provided their professional knowledge, but also presented quantitative research evidence, supplemented with client stories, to justify the managed care approach. They often framed the proposed program as a "successful evidence-based model" to address the "complex, high-cost GA-U recipients." Specifically, they continually used research evidence to persuade policymakers that this approach was "more cost effective than usual care" throughout the 2009–2011 legislative sessions (P2, P3, P4, P6, P11, P20, P22). For instance, to illustrate the impacts of the managed care model, a professor of psychiatry at the University of Washington presented his research on the integrated mental health care model, in an assertive and definitive tone:

This is an evidence-based intervention, a five-year study of integrated care with a randomly assigned experiment design that has desired outcomes of clients' improvement and saving cost.....The data is compelling.....This is the best research outcome. (P2:18)

He also provided successful case stories to support his argument. The chair of the policy committee commended the professor's testimony as being "very important and valuable" (P2), even though the research findings were solely based on patients with depression, who represented a minority of GA-U recipients.

In addition to academic researchers, policy analysts from WSIPP and a left-leaning state policy think tank, the Washington State Budget and Policy Center (WSBPC), also sent consistent messages in favor of retaining medical benefits. Two of the reports they submitted concluded with statements lauding the financial benefits of the integrated medical service:

Research evidence suggests that client and taxpayer finance outcomes can be improved by providing treatment services to individuals diagnosed with mental illness or substance abuse disorders. (Pennucci et al., 2009, p. 1)

Without this program, costs in other areas of the state budget will undoubtedly rise including use of emergency rooms for health care, programs that assist the homeless, and public safety resources. Conversely, by making smart investments in this valuable public structure, the state can save money and improve outcomes for recipients. (Schultz, 2009, p. 6)

Taken together, policy messages regarding the cost effectiveness of medical provision implied that the integrated medical service was not only good for clients, but also good for the state budget. Emphasizing the benefits for the state budget by using scientific, political, and professional knowledge, policy actors made deservingness less relevant to benefit receipt and succeeded in retaining medical benefits for GA/DL-U client.

Making Decisions

The constructions of target populations and of policy solutions in the work sessions and public hearings carried over to the legislative decision-making meetings (i.e., executive sessions and floor actions). In these settings, where legislators were the only actors, they drew on

knowledge informed by work sessions and public hearings, along with their own political ideologies, to influence fellow legislators' voting decisions. Three themes that emerged in the decision-making process were: reinforcing the undeservingness of the GA/DL-U population, transforming the GA-U from an entitled cash model to a regulated care model in the DL-U, and restructuring GA/DL into three new programs with disparate provisions.

1. Reinforcing the undeservingness of GA/DL-U recipients by claiming budget priorities

The narratives about GA/DL-U clients' undeservingness were related to political judgements around budget priorities. For instance, a Republican House Representative reiterated his concern about budget priorities:

When I looked at the population. They are predominately white, male, aged 35-36, without dependents. They are not women, not minorities...if we have to make a difficult decision about cutting service to most vulnerable people, I prioritized those who are seniors, children, most struggling... truly most vulnerable. (P10:12)

This narrative asserted that the GA/DL-U clients were neither deserving nor truly in need because their characteristics did not fit the conventional "deserving poor." Some legislators opposed any kind of public resources allocated to GA/DL-U clients (including medical services), highlighting their purported substance abuse problems and emphasizing the legislators' accountability to all citizens and taxpayers (16:9; 25:7). Another Republican House Representative expressed her objection to allocating benefits and public dollars to the DL-U clients in HB 2082 as follows:

Alcohol and substance abuse is the primary reason that some of these people are involved in the Disability Lifeline ... I just want at some point, for all of us on this House floor, as good stewards of the public dollars and the welfare and well-being of citizens of this state, to really look holistically at what we are doing and how we are doing it ... What we want to make sure is that we are not duplicating efforts [and] that people are not abusing our public assistance. (P25:7)

The political claims about budget priorities relied on and reproduced the negative construction of GA-U recipients as substance abusers who have overused the public resources and do not deserve the GA/DL-U benefits.

2. Transforming GA-U from an entitled cash model to a regulated care model in DL-U

The original GA reform bill (HB 2782) introduced by the House in 2010 primarily focused on establishing procedures that moved qualified GA-U clients to other federally-funded programs (e.g., SSI and Veterans' benefits) to save state dollars; it did not propose any time limits, reduced benefits, or restrictions of the GA-U cash provision. However, the final passed bill with all these elements was a political compromise due to continuous attacks against cash provision from the Republican camp (P39, P40, P43). As the bill traveled through the Senate, the time limit rule and the restriction on cash benefits were included. Lawmakers argued that the new "care model"—which replaced the old "cash model"—would improve GA-U clients' self-sufficiency and prevent GA-U clients' "misuse" of cash benefits through spending on drugs and alcohol (P12:3). The Senate bill sponsor illustrated the philosophy of the new DL program:

Another significant change in this bill is a portion of the care instead of cash philosophy that we instituted in our policy committee. Approximately 18–30% depending on the research tells us these people are homeless..... This bill creates a voucher program for those homeless people that have chemical dependency or mental health issues because it's clear from the data that if these people do not have a home to go with their treatment then their treatment doesn't work. And again, if they refuse treatments, they won't get the voucher or the cash..... Giving them the help they deserve but not enable bad behaviors by continuing to give them the cash grant. (P16:3)

The passed DL program instituted a time limit of 24 months in a 5-year period, a reduced monthly stipend of \$50, with additional housing vouchers for homeless recipients, and a sanction of terminating cash benefits for people who refused to participate in a housing program, substance abuse treatment, or vocational rehabilitation recommended to them by a case manager. In replacing the simple cash benefit with regulated care provisions, this first passed GA reform

bill imposed behavioral requirements in line with the negative construction of recipients as addicted, irresponsible, untrustworthy and undeserving.

3. Restructuring GA/DL into three new programs with disparate provisions

In the following 2011 session, a reiterated theme around GA/DL was rearranging the cash and medical provisions for different target populations in the context of the federal health care reform. To reduce state expenditure on GA/DL-U, policymakers proposed eliminating the cash provision while sustaining the medical provision through a three-year transitional bridge waiver (2011-2013) supported by the federal government (50% match rate), as an early Medicaid expansion option under the Patient Protection and Affordable Care Act (P21, P20, P48, P49).

The Legislature eventually passed the second GA/DL reform bill HB 2082, which eliminated the entire GA/DL program and instead established three new programs with disparate provision to different groups: (1) Essential Needs and Housing Support (ENHS); (2) Aged, Blind or Disabled Assistance (ABDA), and (3) Pregnant Women Assistance (PWA). GA/DL recipients who were predominantly constructed as “undeserving” would now be served by the ENHS, which did not include any cash grants to clients. Instead, grants were distributed to local homeless and housing agencies to support expenditures on services for the homeless clients. The ENHS continued to suffer under budget cuts in the subsequent years (Burkhalter, 2013; Justice, 2013). In contrast to the ENHS, the ABDA and the PWA, which targeted positively-constructed “deserving” GA/DL recipients, have retained a maximum monthly cash grant of \$197 (for single person) since 2011 (P50). Overall, these three new programs now serve a much smaller share of Washington’s poor residents than was the case earlier in the GA program’s recent history—from 9.5% of the Washington’s poor residents in 2006 to 6.5% in 2016 (author’s calculation using Washington State Department of Social and Health Services, 2018 and U.S. Census Bureau,

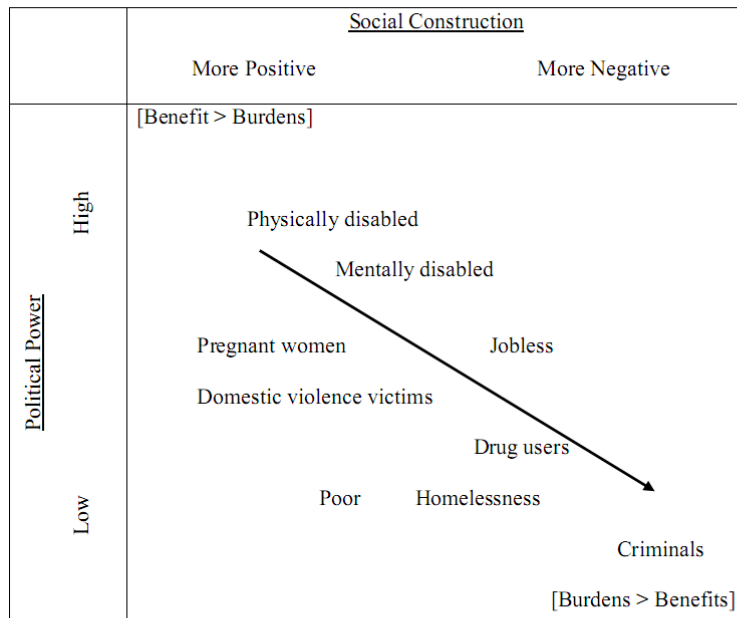
2018). Poor people who were deemed “undeserving” and could not comply with mental health/substance abuse treatments, vocational rehabilitation, or housing placements got left out of the state social safety net system.

DISCUSSION AND CONCLUSION

Social constructions of target populations influence how policymakers understand social problems and allocate public resources. This research examined how social construction interplayed with knowledge utilization in the GA/DL legislative reforms in post-Recession Washington State. It supports the “target population proposition” of the Social Construction and Policy Design Theory (SCPDT) —target populations positively constructed as deserving and “dependent” receive benefits while those negatively constructed as undeserving and “deviant” receive burdens (Schneider & Ingram, 1993; 1997). To illustrate my findings, I lay out the relative positions of different social groups that compose the General Assistance/Disability Lifeline (GA/DL) populations by using the framework of SCPDT (see figure 1). I argue that overgeneralizing the undesired problems of mental illness, homelessness, substance abuse, and criminality to GA/DL clients laid the groundwork for policy solutions that focused on mental health services, substance abuse treatment, conditional housing vouchers, and vocational rehabilitation, in replace of cash aid. The stereotypes and negative constructions of GA/DL-U shaped the reforms that moved from an entitled cash model to a regulated care model, which imposed behavioral regulations and punitive sanctions on the state’s poorest residents. During the 2009–2011 legislative reform process, Washington’s GA program evolved into three smaller programs that further reproduced the distinctions between the “underserving” and the “deserving” poor for cash benefits. By the end of the three-year GA reform, the economic need of the original GA-U target population—low-income working-age adults who were unable to

engage in gainful employment—was no longer addressed through direct cash aid. The economic hardship became a less significant issue than the presumed addiction, mental illness and criminality.

Figure 1. Social Construction and Political Power of the General Assistance Populations



Note. 1. This figure is adapted from Schneider and Ingram (1997, p. 109) and Schneider and Sidney (2009, p. 107). 2. The direction of the arrow indicates the finding that overgeneralizing the undesired problems of mental illness, homelessness, drug abuse, and criminal behavior to all GA populations shaped the reform direction that allocated more burdens (e.g., behavioral regulations and punitive sanctions) than benefits (e.g., entitled cash provision).

Regrettably, voices from the politically powerless GA/DL-U population were overlooked in the reform process. Without changing their stereotypes and the powerless position, one can expect a continued diminishing trend in GA across states through a policy learning or diffusion mechanism (Schneider & Ingram, 1988). For example, most recently, lawmakers proposed several bills to reform Maine’s General Assistance Program in April 2017 (Doyen, 2017). Consequently, the social safety net of last resort in the United States will likely continue to be dismantled in a “degenerative policy making system” that harms democracy and social justice (Schneider & Ingram, 1997). This finding highlights the power relation between the dominant group (policymakers) and the oppressed group (the target population) in the regulatory practices

of the government (Naples, 1999). Future research could consider examining how the changing political power of a target population relates to the changing social constructions of the group in welfare reform movements.

This research has implications for social work policy practice in a broad welfare reform context. It is timely given many proposed policy changes that may exacerbate economic hardships among working-age poor people. For example, current policymakers are attempting to further dismantle federal structures of social assistance programs such as the Supplementary Nutrition Assistance Program through a block grant that devolves program decisions to states (Rosenbaum & Keith-Jennings, 2016), which will then be free to impose behavioral restrictions on recipients such as those seen in Washington State's GA/DL reforms. Another current social policy debate is centering around setting work requirements for Medicaid recipients. Since March 2017, eight states have submitted waiver requests to the Center for Medicare and Medicaid Service to impose work requirements (Hahn et al., 2017). This policy change is driven by a construction of Medicaid recipients as able bodied and not working, which actually represents a small proportion of current recipients. The administrative hurdles of proving eligibility will likely lead to many eligible people losing benefits.

Social work professionals are not only the direct social and human service providers for economically disadvantaged populations, but are also key players in analyzing, informing, and influencing social policies. Findings from this research suggest that combining both scientific evidence and anecdotal client stories can strengthen the rationale for budgetary allocation to economically disadvantaged populations. To advance the economic wellbeing of the communities we serve, social work practitioners should draw awareness to the implicit constructions of populations in policy conversations and play a leadership role in using scientific,

political, and professional knowledge to challenge the misconceptions of poor populations and promote socially just welfare reforms at both state and federal levels.

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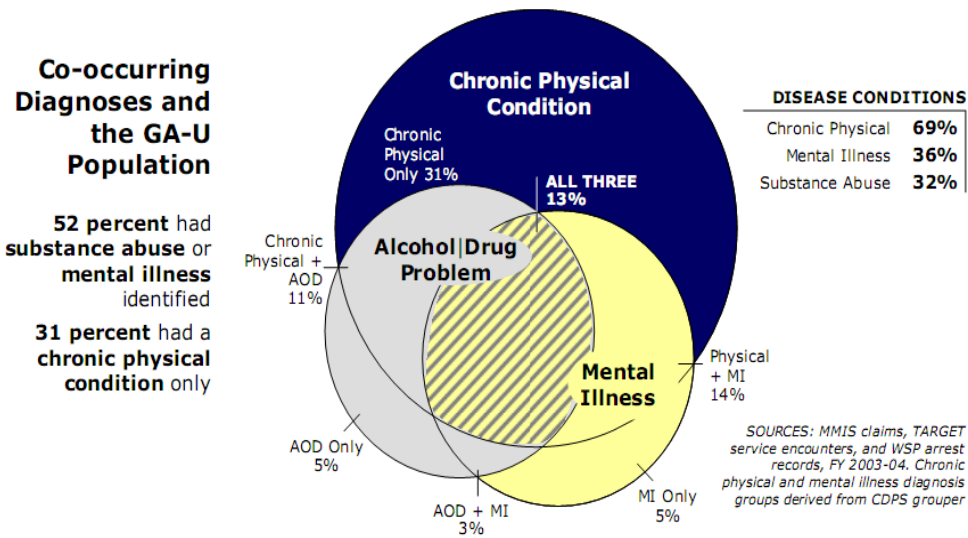
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APPENDIX 1. A list of legislative video archives and related documents.

Date & Type	Committee	Agenda	Length	Document(s)
01/12/2009 WS	HCHS	General Assistance-Unemployable: Overview and Briefing	0:31:35	P1 ^v , P33 ^p WA DSHS (2006)
01/22/2009 WS	HCHS	General Assistance-Unemployable: in-depth look at services and resources	1:20:10	P2 ^v , P34 ^p
02/11/2009 WS	SCWM	General Assistance-Unemployable (GAU)	1:23:35	P3 ^v , P35 ^p
12/04/2009 WS	HCHS	Savings and efficiencies in the GA	20:00	P5 ^v , P36 ^p , Pennucci et al. (2009)
01/21/2010 PH	HCHS	HB 2782 reorganizing delivery of services to recipients of public assistance	1:07:53	P6 ^v , P38 ^b
01/28/2010 ES	HCHS	HB 2782 1st substitute bill be substituted	8:26	P7 ^v , P39 ^a
02/06/2010 PH	HCWM	HB 2782 reorganizing delivery services to recipients of public assistance	0:33:30	P8 ^v
02/09/2010 ES	HCWM	HB 2782 2nd substitute bill be substituted	8:18	P9 ^v , P40 ^b
02/12/2010 FA	The House	House floor debate	0:59:33	P10 ^v , P41 ^a
02/23/2010 PH	SCHSC	2SHB 2782 Concerning the Security Lifeline Act	0:59:01	P11 ^v , P42 ^b
02/25/2010 ES	SCHSC	2SHB 2782 Concerning the Security Lifeline Act	0:06:01	P12 ^v
03/02/2010 PH	SCWM	2SHB 2782 Concerning the Security Lifeline Act	0:23:32	P13 ^v , P43 ^b
03/08/2010 ES	SCWM	2SHB 2782 Security Lifeline Act	0:04:07	P14 ^v , P44 ^b
03/19/2010 FA	The House	2SHB 2782 Security Lifeline Act	0:39:46	P15 ^v
03/22/2010 FA	The Senate	Floor debate on pending legislation E2HB 2782	0:26:47	P16 ^v , P45 ^a
03/23/2010 FA	The House	E2SHB 2782	9:05	P17 ^v
12/07/2010 WS	HHHSAC	Disability Lifeline Program Implementation Update	0:25:32	P18 ^v , P46 ^p
01/11/2011 WS	HCELHS	Implementation of E2SHB 2782	1:22:59	P19 ^v , P49 ^p
01/12/2011 WS	SCHLCC	Disability Lifeline	0:23:00	P20 ^v , P47 ^p
01/26/2011 WS	SCHLCC	Bridge waiver for Basic Health Plan and Disability Lifeline: Medicaid Purchasing Administration	0:14:54	P21 ^v , P48 ^p
01/31/2011 WS	SCWM	Overview of Disability Lifeline Cash & Medical Assistance Programs	0:53:02	P22 ^v , P28 ^p (Joesch et al., 2011)
05/05/2011 PH	HCWM	HB 2082 Making changes to the Disability Lifeline program	0:46:39	P23 ^v , P29 ^b
05/11/2011 ES	HCWM	HB 2082 Making changes to the Disability Lifeline program	0:23:35	P24 ^v , P30 ^b
05/13/2015 FA	The House	HB 2082 Making changes to the Disability Lifeline program	0:22:04	P25 ^v
05/18/2011 PH	SCWM	ESHB 2082 concerning the long-term Disability Assistance program and the Essential Needs and Housing Support (ENHS) program	0:29:52	P26 ^v , P31 ^b
05/23/2011 ES	SCWM	ESHB 2082 concerning the long-term Disability Assistance program and the ENHS program	0:09:16	P27 ^v , P32 ^b , P50 ^b

Note. 1. WS: work session; PH: public hearing; ES: executive session; FA: floor action. 2. HCHS: House Committee on Human Services; SCWM: Senate Committee on Ways and Means; HCWM House Committee on Ways & Means; SCHSC: Senate Committee on Human Services & Corrections; HHHSAC: House Health & Human; SCHLCC: Senate Committee on Health and Long-Term Care Committee; 3. ^a: Amendment; ^b: bill analysis or bill report; ^p: presentation slide; ^v: video archive.

APPENDIX 2. Co-occurring Diagnoses of GA-U Clients.



Note: This Venn diagram is retrieved from Washington State Department of Social and Health Services (2006). *GA-U Clients: Challenges and Opportunities* (Report 6.54).