Students' attitudes and experiences at a free clinic

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Abstract: This paper addresses the experiences of social work students who offered social work services to clients at a clinic offering free medical care to those who are indigent and lack health insurance in a community in the United States. The study found that students' attitudes toward poverty were challenged from the micro to the macro level. Utilizing the structural explanation of poverty, structural social work and Freire's pedagogy of oppression, the study explored how students' attitudes toward poverty were affected as they provided services to clients who are hovering at or below poverty level.

Keywords: individual explanation of poverty; structural explanation of poverty; service learning; structural social work; Freire's pedagogy of oppression

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Introduction

According to the U.S. Census Bureau, 40.6 million people in the United States lived in poverty in 2016 (Semega, Fontenot, & Kollar, 2017). In 2015, 15.9% of people in Texas lived below the federal poverty threshold (Center for American Progress, 2017). Weaver and Yun (2011) suggest that poverty places individuals and families at greater risk for a range of barriers to maximum functioning (p. 4). Consequently, 'Poverty and its etiology have been major subjects of concern for the social work profession throughout its history' (Weiss-Gal et al., 2009, p. 125). In fact, the National Association of Social Workers' (NASW) (2017) Code of Ethics states that the 'primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty' (Preamble, para. 1). Similarly, the International Federation of Social Workers (IFSW) (2018) states 'Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people' (Global Definition of the Social Work Profession). Both organizations identify social justice as a core professional value/principle. As such, social workers are responsible for serving the poor. Given the profession's focus on poverty, social work educators are particularly concerned with students' attitudes toward this population (Weaver & Yun, 2011).

There are two main paradigms that represent the general population's explanations for poverty. The individualistic explanation stresses individual/personal shortcomings as the primary cause of poverty, while the structural explanation focuses on the lack of equality of resources and opportunities available within a market economy. Some research suggests that people in North America are more likely to take an individualistic perspective, blaming the poor for their situation. For example, Cozzarelli, Wilkinson and Tagler (2001) found that '[s]tereotypes about the poor' in their sample of college students were 'significantly more negative than stereotypes about the middle class' (p. 225). However, other studies indicate that social work students may begin their studies believing that the causes of poverty are more structural than individual (Gasker & Vafeas, 2003; Rosenthal, 1993). Nevertheless, students' attitudes in this area remain of high concern for educators. Rehner, Ishee, Salloum, and Velasques (1997) found that while social workers in Mississippi had fairly positive attitudes

toward the poor, these were related to years practicing in the profession as well as personal experiences with poverty. They argue that a 'structural view of poverty must be held with enough conviction to sustain social workers' effort to create empathetic policy, reshape agency cultures, model sensitive and supportive attitudes, and maximize opportunities available to those they have been charged to serve' (conclusion section, para. 3) and that this may be particularly important for bachelor level social workers who have the 'least experience, the most negative working conditions, the lowest pay, and the most difficult clients' (conclusion section, para. 2).

Previous research has shown that social work education can play a role in students developing a more structural attitude toward poverty (Weaver & Yun, 2011). Although social work students are introduced to the aspects and effects of poverty in their undergraduate classrooms, service learning may be a better way to expose them to the realities of the experience of living in poverty.

'Service-learning links academic study and civic engagement through thoughtfully organized service as a means for students to learn in practice what they are learning in theory in the classroom' (Texas Tech University, 2018). Service learning provides opportunities for students to appreciate the discipline while enhancing their sense of civic responsibility. Service learning can be an intentional step that supports diversity and economic justice to move society toward equality (Daughtery and Donaldson, 2011). Best practice of service learning emphasizes a relational approach that addresses how we can work together, versus a transactional approach that emphasizes power and control of the student over the client (Gilbert & Gerstenblatt, 2014). While certainly not a comprehensive review, research has demonstrated that service learning can contribute to changing attitudes in social work students (see Nadel, Majewski, & Sullivan-Cosettti, 2007), including attitudes towards low-income people (Sanders, McFarland, & Bartolli, 2003). The authors have used service learning as a pedagogy, working with undergraduate students at a clinic that offers free medical care to people of low-income and without health insurance in one community in the southern United States.

In the United States, '[h]ealth insurance is a means for financing a person's health care expenses. While the majority of people have private health insurance, primarily through an employer, many others obtain coverage through programs offered by the government. Other individuals do not have health insurance at all' (Barnett & Berchick, 2017, p. 1). Free clinics such as the focus of this research, have 'limited resources and service

capacity' (Garfield, Majerol, Damico, & Foutz, 2016, p. 12) and are therefore unable to meet the need of all those without access to affordable healthcare. Nevertheless, such community clinics are a 'crucial health care safety net' (Garfield, Majerol, Damico, & Foutz, 2016, p. 12).

Despite significant gains in the rate of insurance coverage among non-elderly adults in the United States following the Patient Protection and Affordable Care Act (ACA) of 2010, twenty-eight million people in the United States remained uninsured in 2016 (Barnett & Berchick, 2017). Further, the poor and people of color continue to be the most likely to lack insurance coverage. While also more likely to accumulate medical debt, people without health insurance are more likely to postpone or go without needed medical care because of the cost (Garfield, Majerol, Damico, & Foutz, 2016). Additionally, some medical providers refuse care to those without coverage. Consequently, 'uninsured people are less likely to receive preventive care, are more likely to be hospitalized for conditions that could have been prevented, and are more likely to die in the hospital than those with insurance' (Garfield, Majerol, Damico, & Foutz, 2016, p. 2). About 2.6 million people without coverage in 2015 lived in states that opted out of the Medicaid expansion, a major component of the ACA. These low-income citizens have incomes too high to be eligible for Medicaid but too low to qualify for the subsidies in the ACA Marketplace (Garfield, Majerol, Damico, & Foutz, 2016). Texans accounted for one quarter of those adults falling into this gap in coverage and 67% of these Texans were people of color (Garfield & Damico, 2015). In the area served by the free clinic that is the focus of this research, about 19% of residents live below the poverty line (U.S. Census Bureau, 2018).

Theoretical framework

Paulo Freire's pedagogy of oppression and structural social work theoretically frame the research presented in this article. Freire (1971) suggests the 'struggle for humanization includes emancipation of labor; overcoming alienation, affirming men and women as persons' (p. 44). Poverty and oppression, the central focus of the social work profession, are main culprits that lead to dehumanization. Price, Desmond, Snyder, and Kimmel (1988) found that students in health care professions with little experience working with the poor thought that low income persons were

less likely to understand, or comply with medical care, and that they were not appreciative of medical care. Reutter, Meager-Steward, and Rideout (2004) indicated that students should have face to face experiences with people who are poor to better understand their health concerns and the realities of their circumstances. Providing services at a free clinic provides students with this type of opportunity to interact and serve those of lower socio-economic status.

Structural Social Work, a moral theory, focuses on unearthing the underlying causes of social problems that stem from differential control of resources and political power (Mullaly, 2006). The primary goal of structural social work practice is to reduce social inequality and emancipate those who have been oppressed and can be achieved by targeting the relationships between individuals and the socio-ecological structures in which they function as well as those social structures influenced by the material circumstances of the service providers (Weinberg, 2008). According to Wood and Tully (2006), structural social work practice includes: connecting people to needed resources, changing social structures where feasible, helping 'people negotiate problematic situations,' and assisting them to 'deconstruct sociopolitical discourse to reveal its connections to their daily struggles' (p. 21). While learning about social work methods and techniques in the classroom and practicing these entry level skills at the free clinic, the social work students in our program are exposed to and grapple with these foundational ideas and issues regarding poverty and oppression in their own community. The research reported in this article sought to explore their perceptions and attitudes towards service users following participation in the service learning experience at the free clinic.

Service learning at the free clinic

Our free clinic is housed in a community service agency's facility and is operated entirely by volunteers, primary faculty and students from a local university. The collaboration provides basic medical services at no cost to those who are uninsured and of low-income. The clinic operates one weekday evening, providing care to about 25 patients each week. While the original intention was to provide only acute care for new patients, some clinic patients are long-term, returning each month to refill their medications, receive treatment for new conditions or monitor chronic

illnesses. Primary leadership is comprised of 2nd year medical students who ensure the smooth functioning of clinic activities; undergraduate 'pre-med' students coordinate the participation of medical care volunteers. Services provided have expanded significantly since the clinic's inception and now include common diagnostic testing such as blood work, imaging, medical education, eye exams, and a full-service pharmacy, as well as social work services. In addition to the critical services provided to this underserved population, the clinic provides opportunities for medical, nursing, and social work students to observe professionals in action and practice beginning-level skills. Some students participate on a purely volunteer basis, while others are fulfilling course requirements. Social work students observe and conduct basic interviews with patients, assessing gaps in basic needs and making appropriate referrals to other community agencies and services. Students have also participated in other related activities including researching available community resources and making improvements to clinic space.

Methods

This study was approved by the Institutional Review Board for Research with Human Subjects at Texas Tech University.

Sample

Thirteen participating students were enrolled in a practice-focused social work course with a service-learning component that required students to spend several hours providing supervised brokering services at the clinic. Of these, 10 completed surveys both before and following the service-learning experience. Twelve students provided responses to the open-ended questions included in the qualitative analysis.

Of the 13 students in the class, 11 were female. Eight (62%) self-identified as white, six (46%) as Latino, and two (15%) as Native American (respondents were able to choose more than one ethnic category). Three (23%) reported that their family-of-origin was of low or very low income, 4 (31%)) indicated middle income, and six (46%)), high-middle or very high income. About 46% of the students reported that they had provided 11 or more hours of service related to the clinic; the others reported fewer hours.

Data collection and measurement

Students completed an anonymous online survey provided via RedCap. The surveys included items about demographics and attitudes about people in poverty, as well as five open-ended questions related to students' experience at the clinic (end-of-semester survey only). The students were given the opportunity to complete the surveys during class time in a nearby computer lab as well as submit their name for raffles for agency t-shirts at the beginning of the semester and $5 gift cards to a coffee shop at the time of the post-test.

A short form of Atherton et al.'s (1993) Attitude Toward Poverty (ATP) scale was used as a quantitative measure of students' general attitudes of poverty. Research by Yun and Weaver (2010) identified three factors in the original scale and found that reducing the number of items from 37 to 21 resulted in a scale with adequate levels of reliability and validity. The scale asks respondents to indicate a level of agreement, on a five-point Likert-type continuum, with statements about poverty and the poor. Fifteen of the items are suggestive of an individualistic explanation of poverty, such as *unemployed poor people could find jobs if they tried harder*, while the remaining items offer a structural explanation, such as *poor people are discriminated against*. In calculating total scores for the 21-item ATP, 6 items are reverse-scored resulting in higher scores indicating a more structural perspective of poverty. In addition to the modified ATP, we included four items from Smith-Campbell (2005) that specifically addressed poverty attitudes related to healthcare.

Data analysis

The quantitative dataset was created by the RedCap software program. SPSS was used to calculate statistics. An alpha of .05 was used for all inferential tests. Responses to the qualitative questions were collated by question asked and then independently examined by two members of the research team. Summaries of responses and most representative quotes were agreed upon for each group of responses.

Results

Quantitative analysis

We began our analysis by examining changes in students' responses on the standardized attitudinal items. As can be seen in Table 1, the group means shifted by at least one point on the Likert scale on nine of the ATP items. One of these items, *I believe poor people have a different set of values than do other people*, changed in a negative direction while the others moved toward a more structural perspective on poverty. Considered as a scale, total possible scores on the 21-item ATP could range from 21-105. Among our ten students who completed both pre and post-tests, pre-test total scores were relatively high (61-101), demonstrating tendency towards a more structural explanation of poverty overall even prior to the free clinic experience. A dependent sample t-test comparing the pre (M=75.3, SD=10.22) to post (M=78.11, SD=9.44) total scores was non- significant ($p>.05$).

Similarly, little change was indicated among the items relating specifically to poverty and healthcare as shown in Table 2. Only one item, *to keep the poor from abusing the healthcare system, they should be required to pay a small fee for the health services they receive*, indicated a change in magnitude of one Likert-scale point from pre to post-testing. The mean score indicated less agreement with this statement at post-test.

Qualitative analysis

At the end of the semester, students were asked five open-ended questions about their service-learning experience at the free clinic. They were invited to share anything they had learned, what they found rewarding and challenging, how they believed the experience might benefit their career, and what they would tell a student starting their own service at the clinic. Twelve students completed the qualitative section of the posttest resulting in 64 statements. Three contrasting themes emerged from the qualitative analysis, including (1) structural versus individual perceptions of poverty, (2) respect versus judgment, and (3) rewards versus frustrations of the experience.

Table 1
Attitudes toward poverty questions and statistics

Attitudes Toward Poverty (ATP) Scale strongly agree=1, agree=2, neutral=3, disagree=4, strongly disagree=5	Pre- M(SD) N=10	Post-M(SD) N=12
Poor people are different from the rest of society.	3.7(1.3)	3.4(1.1)
Poor people are dishonest.	3.8(1.3)	4.3(0.5)
Most poor people are dirty.	2.5(1.1)	4.1(0.8)
Poor people act differently.	4.0(1.2)	3.1(1.0)
Children raised on welfare will never amount to anything.	3.5(1.0)	4.7(0.5)
I believe poor people have a different set of values than do other people.	4.4(1.2)	3.5(1.0)
Poor people generally have lower intelligence than non-poor people.	3.1(1.5)	3.8(0.8)
There is a lot of fraud among welfare recipients.	2.5(1.2)	3.7(1.0)
Some 'poor' people live better than I do, considering all their benefits.	3.8(1.1)	3.7(1.1)
Poor people think they deserve to be supported.	3.4(1.2)	3.6(0.7)
Welfare mothers have babies to get more money.	3.0(1.5)	4.3(0.6)
An able-bodied person collecting welfare is ripping off the system.	2.4(1.1)	3.5(1.2)
Unemployed poor people could find jobs if they tried harder.	3.5(1.0)	3.3(0.8)
Welfare makes people lazy.	3.8(1.0)	3.7(0.8)
Benefits for poor people consume a major part of the federal budget.	1.9(0.9)	3.4(1.0)
People are poor due to circumstances beyond their control.*	3.5(1.1)	2.4(0.8)
I would support a program that resulted in higher taxes to support social programs for poor people.*	2.9(0.9)	2.6(1.0)
If I were poor, I would accept welfare benefits.*	2.5(1.3)	2.0(1.0)
People who are poor should not be blamed for their misfortune.*	3.5(0.9)	2.1(0.8)
Society has the responsibility to help poor people.*	3.5(0.9)	2.5(1.0)
Poor people are discriminated against.*	1.6(0.5)	1.7(0.7)
*Item reverse-scored for composite scale		

Table 2
Smith-Campbell healthcare questions and statistic

Smith-Campbell Questions strongly agree=1, agree=2, neutral=3, disagree=4, strongly disagree=5	Pre- M(SD) N=10	Post-M(SD) N=12
Poor patients are less likely than most to be able to understand verbal directions given to them regarding their care.	3.5(1.1)	3.8(1.1)
Free health care for the poor causes the poor to be less motivated to engage in preventative health behavior.	3.6(1.3)	4.2(0.4)
Medicare and Medicaid programs have taken care of most of the health needs of the poor.	3.4(1.3)	3.8(0.7)
The quality of care that poor patients receive is equivalent to the care that all other patients receive.	4.0(1.2)	3.9(0.8)
To keep the poor from abusing the healthcare system, they should be required to pay a small fee for the health services they receive.	3.0(1.3)	4.1(1.0)

Structural versus individual perceptions of poverty

Students commented on their exposure to the structural challenges faced by 'real' people living in poverty including barriers to wellbeing, 'I learned how expensive medications are and how hard it is for some people to get the medication they need in order to survive.' Another student mentioned 'the majority of people there needed health care because they could not get insurance or Medicare [Medicaid] because of their current economic situation.' Indicating a change from an individual to structural perspective of poverty, another student stated:

> *Before [the service learning experience] I had a mindset that poor people put their selves in their own predicaments and if they tried harder things would be different for them. Now I realize sometimes the situation is out of their control due to our welfare system or our economy.*

One student discovered that particularly vulnerable populations face additional barriers; 'I learned the struggles that people with felonies face in trying to find decent housing.' Other students mentioned their recognition

of 'the wide range of factors that play into the lives of people,' and 'different situations that prevent themselves from furthering themselves in their lives.'

However, a few statements indicated that people are responsible for their life situations. One student expressed the belief that if clients would co-operate with offers of help, their problems would be resolved, 'they thought we could solve all their problems for them without them doing the work. That was frustrating because what we would suggest could truly help them in the long term.' Others suggested that the poor are somehow different from people with higher incomes, 'I found it rewarding to work with the lower class population because I learned a lot more about them and their values.'

Respect versus judgmen

Overall, students' comments reflected respect for persons living in poverty. One student suggested to incoming students, 'do not judge the clients because you do not know what they have gone through. Social work is not about judging it's about helping.' Another reflected, 'I appreciated hearing about people's survival and coping techniques. It reinforced my belief in the strength of people.' One comment echoed classroom discussion of social work values 'be very open minded. . . and learn from the clients themselves.'

Although infrequent, a few responses suggested judgmental attitudes; one, however, stood out, 'what challenged me the most at the Free Clinic was not being able to say what I wanted to say to some client's. Some were adamant that they didn't do anything wrong, but didn't utilize the face [fact] that they came to the Social Workers for help, not for, 'You're doing perfect'.'

Rewards versus challenges

The two of the most frequently mentioned rewards of the service learning experience were development of knowledge and skills that students anticipate will be useful in their careers. Beyond enhancing knowledge and skills through practice, every student identified ways the service-learning experience personally benefitted them whether by gaining confidence or learning about benefits and limitations of organizations. They expressed gratification by having the opportunity to provide assistance, whether emotional, 'being able to help people feel less confused about a certain situation was always rewarding' or material by providing resource information or taking action on behalf of a client. For example, one student found it to be rewarding 'when we opened the food pantry for emergencies.' Students also mentioned how much they appreciated the

gratitude expressed by patients as one respondent stated, 'the pride you get from knowing that you could help someone.' Six students commented about how the experience contributed to personal and professional growth in addition to having gained new knowledge or improved skills. Two commented on enhanced self-awareness; one stated, 'I did learn things about myself as a social work student.' Four others recognized the fallacy of previously held prejudicial beliefs and becoming more open to new views of persons living in poverty.

Most (8) responding students identified challenges related to the reality of social work practice. Frustrations included not having resources available to meet client needs, uncertainty about how to address client situations particularly those that could not be handled with available information. One respondent stated, 'I found it challenging at times that I couldn't do more to help people. . .and that was hard for me.'

Some became aware that it can be difficult to engage clients either because the student could not speak the client's language or that sometimes clients are reluctant to participate, 'Some clients kept to themselves and do not want to discuss their situation [It was] harder to find out exactly what they were looking for.' One student commented on how the associated social stigma can sometimes inhibit people from accepting services, 'Sometimes the social worker would need to suggest that they get temporary assistance, even if they [clients] think they don't deserve it.'

Discussion

In this study, we sought to examine a group of social work students' experiences participating in a service-learning project. Quantitative and qualitative data was used to illuminate participating students' experiences and attitudes toward the poor and oppressed while providing services in the context of a medical clinic which provided free care to people without health insurance..

Quantitative results indicated that overall our students began the experience adhering to a more structural perspective on the causes of poverty, aligning with other reported research in the area (Weinberg, 2008). These results are nevertheless reassuring, particularly as most of our students' families-of-origin are politically and socially conservative, as is the community and state in which we teach. Further, our results

suggest that modest gains were yet made over the term period. While there was no statistically significant change in the total ATP scale scores, students endorsed fewer ideas suggestive of individual responsibility for a person's impoverished condition or that service recipients frequently commit fraud to receive benefits. Finally, the post-test means indicated more agreement that assistance to the poor is a social obligation.

The qualitative statements provided at the end of term suggest that responding students believed they had gained knowledge and felt the experience was beneficial. Of particular interest to us, the students' statements clearly indicated that they were able to better recognize the complexity of the interface between micro, mezzo, and macro level systems in the patients' lives, including those elements related to oppression and poverty. It appears that this direct interaction with the poor and oppressed helped our students better recognize the extra burdens carried by people of low income and other oppressed groups living in our communities, the importance of avoiding making assumptions, and how mezzo and macro level context and policies can increase, rather than alleviate, obstacles to human wellbeing. The social reality of living in poverty became more apparent to the students as they listened to clients' stories and attempted to act as brokers.

For example, our local county has an indigent health care program for people who are not eligible for Medicaid (a program providing access to healthcare for the very poor), yet make no more than 200% of the federal poverty income guideline. It is a frequent referral made at the clinic. However, in addition to the income eligibility criteria, the program requires a valid state identification card and proof of county residence. One must have a birth certificate to obtain a state identification card, both of which have associated fees. In addition, our county has a very limited public transportation system, making travel to offices to make applications an additional challenge for anyone without a car. Therefore, while attempting to connect clients with available resources, students encountered the reality that the ability to apply for assistance is hampered by lack of funds, the very thing necessitating that need for assistance. While they begin with beliefs about the variety of social programs for those of low-income, they soon learn that eligibility does not equate access. This example and others like it, open students' eyes about the realities of social service benefits in society.

The real-world examples of the issues giving rise to the theoretical perspectives of Freire's pedagogy of the oppressed (Gottesman, 2010) and

Structural Social Work practice activities (Wood & Tully, 2006) appeared to help students better understand these ideas. Students identified at least three structures in the local environment (healthcare, transportation, and community resources) that hindered their clients' well-being. They met patients with complicated, chronic, or life-threatening medical conditions that were unable to attain access to needed care and/or were ineligible for government health programs. They learned about resources that required documentation of employment while at the same time refusing services when a client's income was just above income limits. They spoke with patients who had to walk miles home from the clinic because local public transportation is not available after 6pm. They learned about employers who did not offer health insurance benefits at all or whose premiums were completely out of reach for low-income workers. Not only did they educate clients about community resources, but they were confronted by their own inaccurate assumptions about what services exist, who is eligible for them, or what steps are needed to attain access.

Despite these positive results, some of the students' responses did indicate individualist explanations for poverty. At post-test, the group means indicated that students agreed more that poor people have different values than others and a few of the qualitative statements also indicated that the poor are different and/or are somehow responsible for their condition. One possible explanation for this phenomenon is related to numerous patients that are well-known to the clinic but are unfortunate enough to be experiencing uncontrolled mental illness coupled with homelessness. This situation might be referred to in textbooks, but most students had not had previous interaction with a person with these challenges. While aggressive behavior is usually controlled and quickly dissipated at the clinic, students are sometimes disturbed by the interactions. If not actively psychotic or a danger to self or others, the possibility of securing public mental health services in our county is minimal. Therefore, for numerous homeless and mentally-ill clients, their only access to care is in our free clinic. Since the clinic cannot adequately meet the needs of these patients, mental illness can be like a low hum at the clinic - distracting but ever-present. This struggle can have a big impact on our students.

Limitations

This research had several limitations and therefore the results should be interpreted with caution. This service-learning experience took place in the context of a small undergraduate social work program. With only 12 social work students participating in the study and the use of a one-group pre-test post-test design, we cannot generalize these findings to other social work students. Additionally, we only successfully collected pre and post data from 10 students in a class of 13, which threatens our findings. When examining the data for individual items, it became clear that those two missing students could have impacted our results had they been included in the dependent sample comparison. Additionally, while students' participation in the study was clearly separated from their participation in the associated class, it seems probable that some response bias may have been present.

Conclusion

As indicated in literature, students' attitudes toward poverty remain of high concern for educators. Service learning experiences, such as the one described here, can give students an opportunity to experience first-hand the challenges faced providing assistance to people of lower socioeconomic status. The context of a free medical clinic allowed our students to practice skills and increase their understanding of the 'person-in-environment,' including multiple system levels. The students examined the socio-ecological world of clients as they tackled basic needs such as food, transportation, and health care.

The struggle for humanization includes emancipation and liberation and demands a foundation of compassion and empathy (Freire, 1970). The end result is the emergence of a new person, who can overcome alienation and affirms men and women as persons (Freire, 1970). The idea of humanization fits well with the basic values of the social work profession, such as respecting the inherent dignity and self-worth of the individual. Social work students participating in a service learning experience at a free medical clinic showed beginning skills toward humanization by exercising patience and listening to the clients' survival stories and coping techniques. This experience, while primarily micro level intervention, gives

students frontline experience with the reciprocal impact of micro, mezzo, and macro level systems as they develop more understanding of how the implementation of social orders, policies and plans impacts individual and groups within the socio-ecological structure. Faced with 'real' people sharing personal stories of struggle and strength, students see the interface between clients and the mezzo and macro environment. They then better recognize how the macro environment often hinders, rather than improves, client well-being. In the context of this free clinic collaboration effort, students gained valuable insight into the effects of poverty and oppression and the need to pursue social justice at multiple system levels.

References

Atherton, C. R., Gemmel, R. J., Haagenstad, S., Holt, D. J., Jensen, L. A., O'Hara, D. F., and Rehner, T.A. (1993) Measuring attitudes toward poverty: A new scale. *Social Work Research and Abstracts,* 29, 4, 28-30

Barnett, J.C. and Berchick, E.R. (2017) *Current Population Reports, 60-260, Health Insurance Coverage in the United States: 2016*, U.S. Government Printing Office, Washington, DC. Retrieved from https://www.census.gov/library/publications/2017/demo/p60-260.html

Center for American Progress (2017) Talk poverty: State by state. Retrieved from: https://talkpoverty.org/state-year-report/texas-2016-report/

Cozzarelli, C., Wilkinson, A. V., and Tagler, M. J. (2001) Attitudes toward the poor and attributions for poverty. *Journal of Social Issues*, 57, 2, 207-227

Daughtery, L, and Donaldson, L. (2011) Introducing asset-based models of social justice into service learning: A social work approach. *Journal of Community Practice,* 19,1, 80-99

Freire, P. (1970, 2000) *Pedagogy of the oppressed: 30th anniversary.* New York: Bloomsbury Publishing

Garfield, R., Majerol, M., Damico, A., and Foutz, J. (2016, November) *The Uninsured: A Primer.* Kaiser Family Foundation. Retrieved from: http://files.kff.org/attachment/Report-The-Uninsured-A%20Primer-Key-Facts-about-Health-Insurance-and-the-Unisured-in-America-in-the-Era-of-Health-Reform

Garfield, R. and Damico, A. (2016) *The Coverage Gap: Uninsured poor adults in states that do not expand Medicaid – An update [Issue Brief]*. The Henry J. Kaiser Family Foundation. Retrieved from: http://files.kff.org/attachment/issue-brief-the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-

expand-medicaid-an-update-2

Gasker, J. A., and Vafeas, J. G. (2003) Starting where the student is: Adapting social justice curricula to poverty attitudes. *The Journal of Baccalaureate Social Work*, 9,1, 93-110

Gilbert, D.J., and Gerstenblatt, P. (2014) Framing service learning in social work: An interdisciplinary elective course embedded within a university-community partnership. *Social education,* 33,8, 1037-1053

Gottesman, I. (2010) Sitting in the waiting room: Paulo Freire and the critical turn in the field of education. *Educational Studies,* 46, 4, 376-399

Ickes, M.J. (2011) The Freirean model – a place in health promotion and education. *American Journal of Health Studies,* 26, 1, 18-24

International Federation of Social Workers (2018, June 1) Global definition of social work. Retrieved from: http://ifsw.org/get-involved/global-definition-of-social-work/

Mullaly B. (2006) *The new structural social work: Ideology, theory, practice, 3rd ed.* New York: Oxford University

Nadel, M., Majewski, V., and Sullivan-Cosetti, M. (2007) *Social Work and Service Learning*: *Partnerships for social justice*. New York: Rowman and Littlefield

National Association of Social Workers. (2018, June 01) *Code of Ethics of the National Association of Social Workers* (Approved 1996, revised 2017). Retrieved from: https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

Price, J. H., Desmond, S. M., Snyder, F. F., and Kimmel, S. R. (1988) Perceptions of family practice residents regarding health care and poor patients. *The Journal of Family Practice*, 27, 6, 615-621

Rehner, T., Ishee, J., Sallour, M., and Velasques, D. (1997) Mississippi social workers' attitudes toward poverty and the poor. *Journal of Social Work Education*, 33, 1, 131-142

Rosenthal, B. S. (1993) Graduate social work students' beliefs about poverty and attitudes toward the poor. *Journal of Teaching in Social Work*, 7, 1, 107-121

Sanders, S., McFarland, P., and Sunday, J. (2003) The impact of cross-cultural service-learning on undergraduate social work students' perceptions of culture, race, and economic justice. *The Journal of Baccalaureate Social Work*, 9,1), 19-40

Semega, J.L., Fontenot, K.R. and Kollar, M.A. (2017, September) *Current Population Reports, P60-259: Income and poverty in the United States: 2016*. U.S. Government Printing Office, Washington, DC, Retrieved from https://www.census.gov/content/dam/Census/library/publications/2017/demo/P60-259.pdf

Smith, J. C., and Medalia, C. (2015) Health insurance coverage in the United States: 2014. Current Population Reports. *U.S. Census Bureau*. Retrieved from

http://www.census.gov/

Smith-Campbell, B. (2005) Health professional students' cultural competence and attitudes toward the poor: The influence of a clinical practicum supported by the National Health Service Corps. *Journal of Allied Health*, 34, 1, 56-62

Sword, W., Reutter, L., Meagher-Stewart, D., and Rideout, E. (2004) Baccalaureate nursing students' attitudes toward poverty: Implications for nursing curricula. *Journal of Nursing Education*, 43, 1, 13-19

Texas Tech University. (2018, June 01) Service learning. What is service learning? Retrieved from: https://www.depts.ttu.edu/calue/servicelearning.php

U.S. Census Bureau (2018, June 1) Quick Facts: Lubbock County, Texas. Retrieved from: https://www.census.gov/quickfacts/fact/table/lubbockcountytexas/PST045217

Wallerstein, N., and Bernstein, E. (1988) Empowerment education: Freire's ideas adapted to health education. *Health Education Quarterly,* 15, 4, 379-394

Weaver, R. D., and Yun, S. H. (2011) Analyzing the attitude of undergraduate students toward poverty and impoverished persons: Does social work education make a difference? *Journal of Teaching in Social Work*, 31,1, 3-20

Weinberg, W. (2008). Structural social work: A moral compass for ethics in practice. *Critical Social Work,* 9, 1 Retrieved from: http://www1.uwindsor.ca/criticalsocialwork/structural-social-work-a-moral-compass-for-ethics-in-practice

Weiss-Gal, I., Benyamini, Y., Ginzburg, K., Savaya, R., and Peled, E. (2009) Social workers' and service users' causal attributions for poverty. *Social Work*, 54, 2, 125-133

Wood, G.G. and Tully, C.T. (2006) *The Structural Approach to Direct Practice in Social Work, 3rd ed*. New York: Columbia University Press

Yun, S. H., and Weaver, R.D. (2010) Development and validation of a short form of the attitude toward poverty scale. *Advances in Social Work*, 11, 2, 174-187