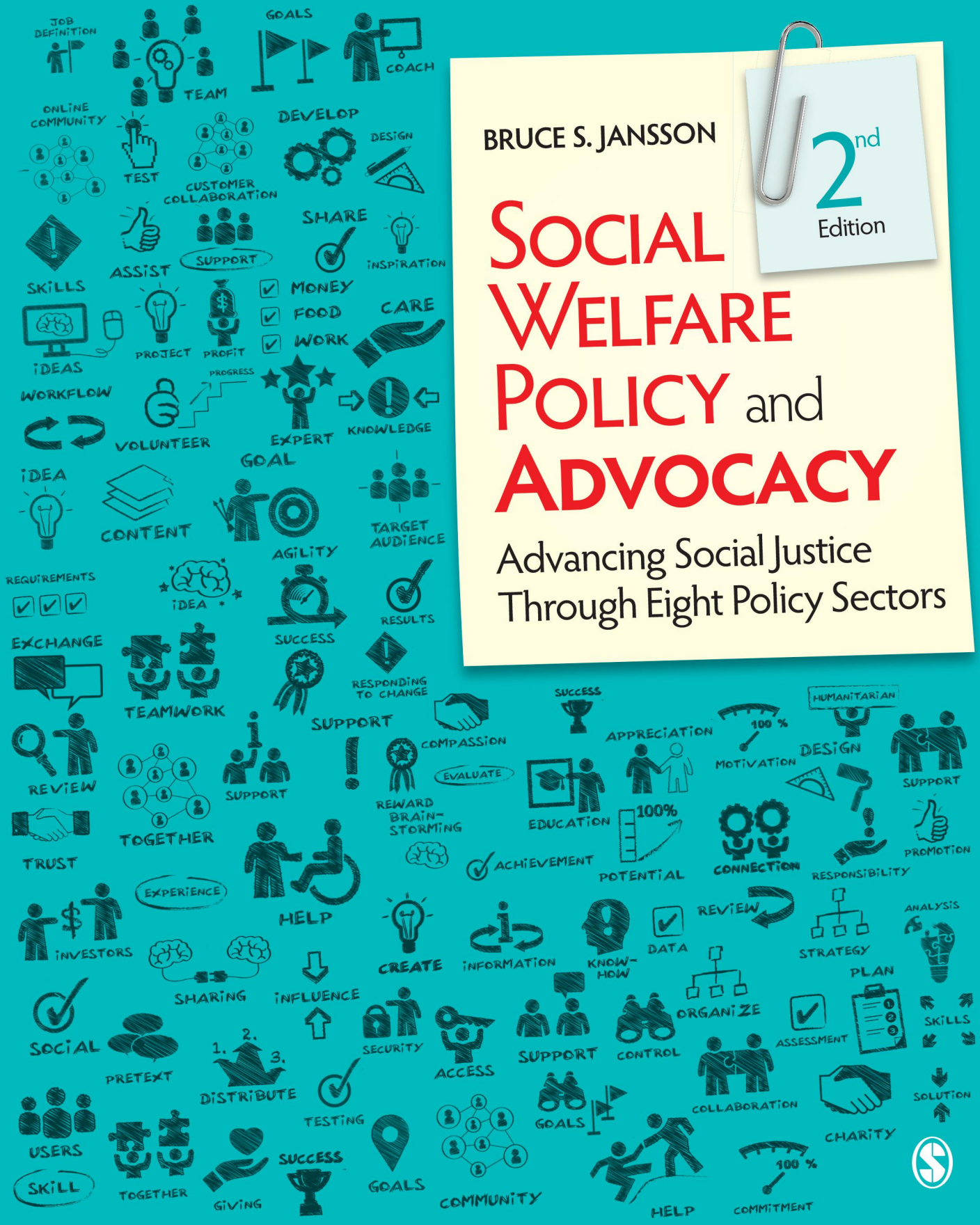
BRUCE S. JANSSON
2nd Edition
SOCIAL WELFARE POLICY and ADVOCACY
Advancing Social Justice Through Eight Policy Sectors

Social Welfare Policy and Advocacy

Second Edition

This book is dedicated to social workers who engage in micro, mezzo, and macro policy advocacy.

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Social Welfare Policy and Advocacy

Advancing Social Justice Through Eight Policy Sectors

Second Edition

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PREFACE

I published the first edition of this book in April 2015. It was the first text to present a multilevel policy advocacy framework that links micro policy advocacy, mezzo policy advocacy, and macro policy advocacy—and demonstrates how these three kinds of advocacy can and should be used by social workers in the health care, gerontology, safety net, child and family, mental health, education, immigration, and criminal justice sectors. It was the first text that identified "Red Flag Alerts" that highlighted opportunities for policy advocacy at three levels in each of the eight policy sectors.

The imperative to engage in policy advocacy at three levels stems not only from the Code of Ethics of the National Association of Social Workers (NASW) but from policy shortcomings in each of the eight sectors where most social workers are employed. Underfunded programs in the *safety-net sector* are partly responsible for extreme economic inequality that is approaching levels of the Gilded Age of the 1890s. Millions of children lack sufficient or adequate childcare, and thousands of children graduate from foster care only to become homeless in the *child and youth sector.* Persons with chronic mental conditions lack sufficient community-based services to help them in the *mental health and substance abuse sector* where epidemics of drug abuse, alcoholism, anxiety, and depression are inadequately addressed. Roughly one-half of minority students fail to graduate from many high schools in the *education sector*, and relatively few of them graduate from junior colleges and colleges. The nation has not prepared sufficient numbers of social workers, nurses, and gerontologists to help roughly 30 million baby boomers as they become older in the *gerontology sector.* Warehousing of inmates and lack of preventive programs have contributed to high rates of recidivism in the *criminal justice sector.* The United States has readily used immigrants for labor in agricultural, tourism, construction, and caregiving for seniors but has often failed to provide them with adequate human services and violated their human rights in the *immigration sector.* Moreover, the Code of Ethics of NASW *requires* social workers to engage in policy advocacy with respect to vulnerable and marginalized populations.

I've made a number of changes in this edition. I place the multilevel advocacy framework in Chapter 1 rather than in Chapter 3 to highlight it. This framework was first introduced in the first edition of this book. This framework informs the discussion in every succeeding chapter unlike many other texts on policy sectors that restrict policy advocacy to a single chapter or section of a chapter. I discuss how policy advocates can move between micro, mezzo, and macro levels with case examples in Chapter 1. I discuss Red Flag Alerts that are specific manifestations of the core issues such as "a clinic or hospital fails to link its patients to community-based preventive services" under Core Problem 7 in the health sector.

I discuss in Chapter 1, as well, how I developed the multilevel policy advocacy framework in three phases. By examining 800 articles and books, I identified seven core issues

discussed in health literature and research. These seven core issues include (1) ethical rights, human rights, and economic justice; (2) the quality of services and programs; (3) cultural responsiveness of services and programs; (4) preventive strategies and programs; (5) the affordability and accessibility of social programs; (6) the scope and effectiveness of programs that address consumers'/clients' mental distress; and (7) linkages between social programs and services with clients' households and communities. Qualitative interviews with hospital social workers and other frontline professionals confirmed that they frequently address the seven core issues in their advocacy interventions. My work in Phase 1 led to the publication of *Improving Healthcare Through Advocacy* (John Wiley & Sons, 2011) that Dr. Gary Rosenberg, the director of the Division of Social Work and Behavioral Science at Mount Sinai Hospital in New York City, called "by far the best advocacy book I have seen."

In Phase 2, I engaged in quantitative research that was funded by the Patient-Centered Outcomes Research Institute (PCORI). This grant funded the gathering of data from 300 frontline health professionals in eight hospitals in Los Angeles County that include social workers, nurses, and medical residents. The survey confirmed that frontline professionals frequently engage in policy advocacy on micro, mezzo, and macro levels with respect to the seven core issues. The data showed that these professionals engaged in micro policy advocacy for each of the manifestations of the seven core issues. Data was gathered, as well, about the extent to which the 300 frontline health professions engaged in macro policy advocacy with respect to each of the seven core problems. As I suspected, respondents reported far lower levels of macro policy advocacy as well as with respect to mezzo policy advocacy, but significant numbers *did* engage in mezzo and micro policy advocacy as I discuss in Chapter 1. I cite four peer-reviewed articles in Chapter 1 that discuss validated scales that measure frontline professionals' engagement in micro and macro policy advocacy as well as validated scales that predict the extent specific frontline health professionals engage in micro and macro policy advocacy.

In Phase 3, I approached experts in mental health, child welfare, gerontology, education, and criminal justice sectors to see if the multilevel advocacy framework describes the advocacy interventions of frontline professionals in their areas. They responded in the affirmative as can be seen in chapters on these sectors in this text that contain many Red Flag Alerts that describe social workers' micro, mezzo, and macro policy advocacy with respect to the seven core issues in these various sectors.

I also discuss in Chapter 1 how the Code of Ethics of NASW requires social workers to engage in policy advocacy at micro, mezzo, and macro levels and requires social workers to engage in advocacy with vulnerable populations, such as the 18 ones I identified in *The Reluctant Welfare State* (Cengage, 2018), including women; African Americans; Asian Americans; seniors; Native Americans; Latinos; children and adolescents; persons with physical and mental disabilities; persons with substance abuse and mental health challenges; lesbian, gay, bisexual, and transgender persons; persons accused of violating laws and residing in or released from correctional institutions; immigrants; low-income persons; homeless people; and white low-income and blue-collar people in rural areas.

I devote Chapter 2 to the seven core issues that provide the basis for policy advocacy. I discuss how ethicists, the United Nations, religious leaders, researchers, courts, the Code of Ethics of NASW, historical events, and cultural anthropologists analyze them.

I've inserted a chapter on the evolution of the American welfare state in Chapter 3 of the second edition for several reasons. I discuss why policy advocacy is particularly needed in a nation that currently lags behind the social policies of 20 other industrialized nations. I discuss the pendulum swings between relatively liberal and conservative periods in the United States, such as the relatively liberal New Deal of the 1930s and the Great Society of the 1960s as well as the relatively conservative Gilded Age of the late 19th century and the presidencies of Ronald Reagan in the 1980s and Donald Trump in the contemporary period. I introduce them to social workers who engaged in policy advocacy during both periods, including Jane Addams, Harry Hopkins, Whitney Young, Representative Ron Dellums, Senator Barbara Mikulski, and Senator Debbie Stabenow. I also identify many advocates who worked closely with social workers and their causes, including Eleanor Roosevelt, Frances Perkins, Martin Luther King, and Cesar Chavez. I want contemporary social workers to realize that social reforms emanate from the efforts of thousands of policy advocates in both liberal and conservative periods. I discuss how the Social Work Code of Ethics requires social workers to engage in micro, mezzo, and macro policy advocacy no matter the political milieu while also suggesting that social workers can seek to move the nation toward humane policies.

I've retained Chapters 4, 5, and 6 of the first edition that respectively discuss micro policy advocacy, mezzo policy advocacy, and macro policy advocacy. They discuss policy practice skills at each of these levels. They provide vignettes that illustrate policy advocacy strategies and skills, including deciding whether to proceed, assessing the context, placing issues on agendas, engaging in policy analysis, implementing policies, and evaluating policies.

Each of the eight policy sector chapters is organized in the following way. They begin with "empowerment" sections that discuss how social workers can assume critical advocacy roles. I discuss some key policy defects in each sector as well as promising policy reforms including evidence-based initiatives. Each sector chapter contains a historical timeline that describes how policies evolved and how the nation's extreme income inequality impacts clients in each sector. I discuss the political economy of each sector by identifying key players, key interest groups, and important advocacy groups. Each of the sector chapters identifies and discusses Red Flag Alerts under each of the core problems. They all end with a challenge to students to think big by proposing major policy initiatives.

This is a user-friendly book. It begins with the multilevel policy advocacy framework that is illustrated by scores of vignettes that show how specific social workers engaged in micro, mezzo, and macro policy advocacy with respect to many Red Flag Alerts in each of the policy sector chapters. The text identifies numerous controversies in each of the sectors while pointing the way to possible solutions. I updated the policy sector chapters to include recent policy enactments during the presidency of Donald Trump.

I describe this book as an "advocacy passport" to different policy sectors. It allows social workers to obtain an overview of different sectors as they move among them during their careers and as they make referrals to clients who need services and resources from different policy sectors. Although this text has extensive materials about policy advocacy practice, it also contains information about scores of policies that impact the lives of clients.

ACKNOWLEDGMENTS

The first edition of this book, published in April 2015, presented the first multilevel policy advocacy framework. This second edition presents empirical findings from 300 frontline health professionals that validate this framework in a federal research project and four published articles in refereed journals.

Many people helped me develop innovations in this book that include identification of seven core problems that exist in each policy sector, Red Flag Alerts, and the division of policy advocacy into three elements: micro, mezzo, and macro policy advocacy. They also helped me embed these innovations in specific policy sectors and gather empirical data that support the innovations in this second edition.

I am indebted to Dr. Sarah-Jane Dodd, Ph.D., associate professor at the Silverman School of Social Work at Hunter and the CUNY Graduate Center. Her dissertation on advocacy by social workers and nurses at the Suzanne Dworak-Peck School of Social Work was a precursor to the funded research and research articles that I led between 2013 and 2016 as well as the first edition of this text.

I linked case advocacy (or patient advocacy) with macro policy advocacy in my book, *Improving Healthcare Through Advocacy* (John Wiley & Sons, 2011). I thank Dr. Gary Rosenberg, former Edith J. Baerwald Professor of Preventive Medicine at the Icahn School of Medicine at Mount Sinai Hospital, for his review of this book.

I gathered empirical data from roughly 300 frontline health professionals in a research project funded by the Patient-Centered Outcomes Research Institute (PCORI) to test concepts in the aforementioned book. The members of the PCORI research team and coauthors of four published articles in referred journals included:

- Gretchen Heidemann, MSW, Ph.D., adjunct instructor, USC School of Social Work, and special projects manager, USC Department of Psychiatry
- Lei Duan, Ph.D., biostatistician at the University of Southern California Hamovitch Research Center
- Adeline Nyamathi, Ph.D., professor in the School of Nursing, University of California at Los Angeles
- Charles Kaplan, Ph.D., associate dean of Research Hamovitch Center, USC Suzanne Dworak-Peck School of Social Work

I trial tested the concept of Red Flag Alerts with doctoral students as well as the division of policy advocacy into micro, mezzo, and macro policy advocacy. I also trial tested concepts in the first edition of this book with MSW students.

I would like to thank the following persons for demonstrating in the first edition of this book that micro, mezzo, and macro policy advocacy are deeply embedded in social workers' practice in (at least) the eight policy sectors discussed in Chapters 7 through 14 of this book:

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A BRIEF BIO-SKETCH OF BRUCE S. JANSSON

Bruce S. Jansson is currently the Margaret W. Driscoll/Louise M. Clevenger Professor of Social Policy and Social Administration, Suzanne Dworak-Peck School of Social Work, University of Southern California. He has made these contributions to the theory and practice of policy advocacy during his career:

- Invented the term "policy practice" in *The Theory and Practice of Social Welfare Policy* (Wadsworth, 1984, pp. 24–28)—and then continued to refine his reconceptualization of policy practice in two subsequent editions of *Social Welfare Policy: From Theory to Practice* (1990, 1994 Brooks/Cole) and in six editions of *Becoming an Effective Policy Advocate: From Policy Practice to Social Justice* (Brooks/Cole, 1999, 2003, 2008, 2011, 2012, 2014, and 2018).
- Analyzed the evolution of the American welfare state in nine editions of *The Reluctant Welfare State* from 1988 to 2019 so that social workers can critically analyze and seek to reform it with use of a multidisciplinary and strategic framework (Brooks/Cole/Cengage).
- Wrote the first critical analysis of budget priorities in the United States during seven decades from FDR through Clinton in *The Sixteen-Trillion-Dollar Mistake: How the U.S. Bungled Its National Priorities From the New Deal to the Present* (Columbia University Press, 2001)—and linked these priorities to inadequate funding of American social policies and programs. This book received the Red Star Review from Publishers Weekly and many positive reviews from historians and political scientists.
- Wrote the first detailed analysis of patient advocacy and policy advocacy in the American health care system in *Improving Healthcare Through Advocacy: A Guide for the Health and Helping Professions* (John Wiley & Sons, 2011) that was called the "best advocacy book by far that I have seen" by Dr. Gary Rosenberg, director of social work and behavioral science at Mount Sinai School of Medicine.
- Obtained funding for a research project titled "Improving Healthcare Through Advocacy" that was funded by the Patient-Centered Outcomes Research Institute (PCORI).

- Wrote *Reducing Inequality: Addressing the Wicked Problems Across Professions and Disciplines* (Cognella Academic Press, 2019) that analyzes why the United States has greater income inequality than 20 industrialized nations and how policy advocates can develop and fund policy proposals to reduce it.
- Wrote *Social Welfare Policy and Advocacy* (SAGE, 2016 and 2020) that developed the first multilevel policy advocacy framework that analyzes how social workers engage in micro, mezzo, and macro policy advocacy in eight policy sectors where most social workers are employed.
- Wrote many book chapters and articles throughout his career including, most recently, four peer-reviewed articles that created many scales that measured levels of frontline health professionals' micro and macro policy advocacy and that predicted levels of health professionals' micro and macro policy advocacy.

1

BECOMING A POLICY ADVOCATE IN EIGHT POLICY SECTORS

LEARNING OBJECTIVES

In this chapter, you will learn to:

1. Engage social welfare policy whether you are micro or macro
2. Conceptualize policy practice
3. Understand how a multilevel policy advocacy framework was developed
4. Link the multilevel policy advocacy framework to eight policy sectors
5. Use this book as a road map for your student and professional career
6. Contrast micro, mezzo, and macro policy advocacy with clinical practice
7. Understand how the social workers' code of ethics requires micro, mezzo, and macro policy advocacy
8. Use policy advocacy to help marginalized and vulnerable populations
9. Analyze a multilevel policy advocacy framework
10. Provide policy advocacy at three levels
11. Link three levels of advocacy for pregnant teens and teen mothers
12. Develop policy advocacy Red Flag Alerts at three levels

Social workers engage in humanitarian work in many kinds of social agencies. They work with people from all social classes, racial and ethnic groups, genders, ages, and nationalities. They work with active and retired military personnel. They work with residents of urban, suburban, and rural areas. They work with people with myriad social problems.

They often encounter obstacles as they engage in their work such as adverse social policies and difficult work environments that stem from insufficient funding, punitive policies, and heavy workloads. Their clients, too, are often impacted by hardships, such as poverty, mental illness, disability, excessive incarceration, deportation, and discrimination—and large numbers of them live in the lower 50% of the economic distribution.

ENGAGE SOCIAL WELFARE POLICY WHETHER YOU ARE MICRO OR MACRO

Because their clients are profoundly impacted by social policies that emanate from social agencies, communities, states, the federal government, and courts, social workers often engage in three kinds of policy advocacy:

- helping their clients navigate social policies in eight sectors that personally impact them (*micro policy advocacy*)
- reforming dysfunctional agency and community policies in eight sectors (*mezzo policy advocacy*)
- changing policies that emanate from local, state, and federal governments as well as courts (*macro policy advocacy*)

After providing orienting materials about social policy in its first three chapters, this book provides in-depth discussion of micro policy advocacy in Chapter 4, mezzo policy advocacy in Chapter 5, and macro policy advocacy in Chapter 6. It applies the multilevel policy advocacy framework to health, gerontology, safety net, mental health, child and family, education, immigration, and criminal justice sectors in Chapters 7 through 14. Because you will probably work in one or more of these sectors and will often refer clients to programs in different sectors, this book provides a road map to your career.

Social policy was widely viewed *not* as a practice discipline but as a descriptive and analytic discipline prior to the 1980s. Social work scholars described myriad policies at local, state, and federal levels. They evaluated many of these policies by engaging in policy analysis. They focused on government policies with little attention to agency policies or policies impacting communities. These activities have merit, but they failed to make social policy sufficiently relevant to many social work students. This book aims to open up social policy to *all* social workers including to ones in direct service, community organization, and administration.

Three changes took place in social policy that expanded its relevance to all social workers: conceptualizing policy practice, developing a multilevel policy advocacy framework, and linking this framework to eight policy sectors.

CONCEPTUALIZING POLICY PRACTICE

The term *policy practice* first emerged in social work in 1984 to describe policy as a *practice* discipline (Jansson, 1984). Discussion of ways that social workers could participate in *making* social policies hardly existed in the profession's scholarly literature prior to 1984. Rather, existing policy literature was mostly confined to defining social policy, studying the history

of policy, analyzing the philosophical underpinning of policy choices, and policy analysis. These topics are important, but do not sufficiently discuss how social workers work to change policies in different venues, such as agencies, communities, and government entities.

Policy practice describes roles, tasks, skills, and strategies that policy practitioners need to read contexts as well as develop, propose, enact, implement, and evaluate policies in specific settings. It describes different styles of policy practice, such as ones that involve social action, rational deliberations, implementation of polices, or combinations of these and other styles. Emerging policy practice literature discusses how social workers read the context to identify constraints that can be surmounted or opportunities that they can seize. It discusses how to place issues on policy agendas, develop policy proposals, engage in policy analysis, enact policies, implement policies, and evaluate policies. It describes skills needed by policy practitioners, including analytic, ethical, political, and interactional ones. It describes different models of policy practice, such as ones that emphasize analytic skills (such as think tanks), political skills (such as campaigns to pressure public officials to enact specific policies), interactional skills (such as developing coalitions to develop and pressure public officials to enact a policy), and ethical skills (such as developing policies that advance social justice).

This redefinition of policy as a practice discipline raised its stature in a profession oriented to *practice*, whether direct service or clinical practice, administrative practice, or practice of community organizers. It facilitated social workers' engagement in policy practice in community-based agencies; community boards; government agencies at local, state, and federal levels; legislatures; and political campaigns. The Council of Social Work Education mandated that schools of social work include policy practice in their curriculums in the 1980s—a requirement that currently exists in its accreditation standards for schools of social work. A national organization of social work policy faculty, known as Influencing State Policy, was established in the 1980s to encourage the teaching, research, and practice of social policy. To clarify that important social policies are developed not just at the level of states but also at levels of local and federal governments, this organization changed its name to Influencing Social Policy (http://www.influencingsocialpolicy.org). It maintains a website and convenes an annual national conference where it awards prizes to the best policy advocacy projects of BSW, MSW, and doctoral students.

Policy practice also includes involvement in political campaigns whether working on campaigns, running for office, or voting. Elected officials develop policies that shape and fund American social policies. Social workers need to work to improve these policies by placing pressure on elected officials, helping elect promising ones, or running for office themselves. The Nancy A. Humphreys Institute for Political Social Work at the School of Social Work at the University of Connecticut, for example, trains hundreds of social workers to work in campaigns, to run for political office, and to hold leadership positions in local, state, and federal governments.

UNDERSTANDING HOW A MULTILEVEL POLICY ADVOCACY FRAMEWORK WAS DEVELOPED

A multilevel policy advocacy framework was developed in a book that was published in April 2015 but copyrighted in 2016 that describes the policy advocacy of social workers no matter in which sector they are employed (Jansson, 2016). It includes *micro policy*

advocacy at the level of individuals and families, *mezzo policy advocacy* at the level of organizations and communities, and *macro policy advocacy* at the level of government agencies, legislative and executive branches of government, and political campaigns.

This framework was developed in three stages. First, a review of 800 citations in health care literature identified seven core issues that frontline health professionals address in their professional work, including social workers, nurses, and medical residents:

- protecting patients' ethical rights
- improving patients' quality of care
- helping patients receive culturally competent health care
- helping patients receive preventive health care
- helping patients finance their health care
- helping patients obtain mental health services
- helping patients link their health care to their households and communities (Jansson, 2011)

Second, empirical research was initiated to measure the extent frontline health professionals engage in micro, mezzo, and macro policy advocacy with respect to these seven core issues with a grant obtained from the federally funded Patient-Centered Outcomes Research Institute (PCORI). A research team surveyed 300 frontline health professionals in eight major hospitals to measure the extent they engaged in micro policy advocacy with respect to the seven core problems. These health professionals included 100 social workers, 100 nurses, and 100 medical residents. It also measured their involvement in mezzo policy advocacy because health literature frontline professionals and patients often navigate and contend with hospital policies as well as policies of community agencies. It also measured their involvement in macro policy advocacy to change policies of local, state, and federal agencies, courts, and accreditation bodies.

The data obtained from the PCORI survey demonstrated that frontline professionals help patients at the micro policy advocacy level frequently as can be seen in Table 1.1 (Jansson, Nyamathi, Heidemann, Duan, & Kaplan, 2015a). They frequently help patients get their ethical rights honored; find evidence-based treatments; receive culturally responsive care; receive preventive treatments; finance their medical bills; obtain mental health services; and receive medical care linked to their households and neighborhoods.

Third, with assistance from an expert panel, the research team identified four to seven manifestations of each of the core problems as can be seen in Table 1.1, in which they are numbered from 1 to 33 (Jansson et al., 2015a). The expert panel identified five manifestations of Core Problem 1 (patients' or clients' rights), for example, such as whether patients need assistance in obtaining "informed consent to a medical intervention," "accurate medical information," protection of "confidentiality of (their) medical information," "advance directives," and "care from professionals with competence to make medical decisions" (see Items 1 through 5 in Table 1.1 where asterisks signify half or more of the 300 respondents selected "sometimes," "frequently," or "always").

TABLE 1.1 ■ Frontline Health Professionals' Patient Advocacy Engagements Regarding 33 Types of Patients' Unresolved Problems in Seven Categories

Item	Mean (SD)	Never	Seldom	Sometimes	Frequently	Always
Core Problem 1: Patients' Rights	**2.97 (0.99)**					
1. Informed consent to a medical intervention	2.81 (1.3)	61	66	68	67	33
*2. Accurate medical information	3.26 (1.18)	24	54	88	78	51
3. Confidential medical information	2.81 (1.31)	52	85	66	50	42
*4. Advance directives	2.95 (1.38)	62	52	71	60	50
*5. Competence to make medical decisions	3.0 (1.28)	45	60	83	63	44
Core Problem 2: Quality Care	**2.49 (0.90)**					
6. Lack of evidence-based health care	2.3 (1.12)	88	87	71	41	8
7. Medical errors	2.22 (1.1)	88	104	64	27	12
8. Whether to take specific diagnostic tests	2.62 (1.17)	66	64	99	48	18
*9. Fragmented care	2.95 (1.21)	46	56	90	74	29
10. Non-beneficial treatment	2.37 (1.15)	81	86	81	31	16
Core Problem 3: Culturally Competent Care	**2.87 (0.90)**					
*11. Information in patients' preferred language	3.3 (1.2)	24	58	68	95	50
*12. Communication with persons with limited literacy or health knowledge	3.38 (1.1)	16	46	90	95	48
13. Religious, spiritual, and cultural practices	2.68 (1.15)	49	82	103	35	26
14. Use of complementary and alternative medicine	2.12 (1.07)	105	91	68	22	9
Core Problem 4: Preventive Care	**2.98 (1.02)**					
15. Wellness exams	2.28 (1.35)	120	63	44	44	24
*16. Extent factors known to cause poor health not addressed	3.51 (1.26)	32	31	58	103	71
*17. Chronic disease care	3.58 (1.17)	23	28	68	107	69
18. Immunizations	2.55 (1.44)	104	52	50	51	38

(*Continued*)

TABLE 1.1 ■ Frontline Health Professionals' Patient Advocacy Engagements Regarding 33 Types of Patients' Unresolved Problems in Seven Categories (Continued)

Item	Mean (SD)	Never	Seldom	Sometimes	Frequently	Always
Core Problem 5: Affordable Care	**3.04 (1.15)**					
*19. Financing medications and health care needs	3.36 (1.28)	30	49	67	82	67
*20. Use of publicly funded programs	3.18 (1.34)	44	51	69	70	61
21. Coverage from private insurance companies	2.57 (1.32)	77	82	60	42	34
Core Problem 6: Mental Health Care	**2.67 (1.10)**					
22. Screening for specific mental health conditions	2.83 (1.33)	63	59	81	50	42
23. Treatment of mental health conditions while hospitalized	2.72 (1.31)	65	71	79	41	39
24. Follow-up treatment for mental health conditions after discharge	2.52 (1.33)	85	75	65	36	34
25. Medications for mental health conditions	2.47 (1.24)	82	76	78	35	24
*26. Mental distress stemming from health conditions	3.08 (1.38)	49	62	62	61	61
27. Availability of individual counseling and or group therapy	2.6 (1.36)	80	76	60	41	38
28. Availability of support groups	2.48 (1.29)	80	89	62	33	31
Core Problem 7: Community-Based Care	**3.12 (1.12)**					
*29. Discharge planning	3.49 (1.32)	36	31	60	89	79
*30. Transitions between community-based levels of care	3.04 (1.33)	51	53	72	71	48
*31. Referrals to services in communities	3.25 (1.34)	41	49	66	74	65
*32. Reaching out to referral sources on behalf of the patient	3.13 (1.37)	48	54	66	66	61
33. Assessment of home, community, and work environments	2.71 (1.39)	76	68	62	45	44

As can be seen in Table 1.1, the research team with a panel of experts also identified multiple manifestations for the other six core problems, such as five manifestations under Core Problem 2. Advocacy interventions with respect to each of the 33 manifestations of the seven core problems are *micro* policy advocacy because they take place at the level of individuals and families. All of these manifestations are widely discussed in evidence-based literature, hospital accreditation standards, and public statutes. With respect to Core Problem 1, for example, federal policies and statutes, as well as ethical experts in health care, require health professionals to help patients obtain their rights regarding each of the five manifestations of patients' rights, such as giving their informed consent to a medical intervention (Manifestation 1).

The PCORI data demonstrates that micro policy advocacy lies at the heart of frontline professionals' work in hospitals as illustrated by data in Table 1.1. For example, more than half of the respondents selected sometimes (3), frequently (4), or always (5) with respect to the each of the five manifestations of patients' rights over a two-month period as can be seen, for example, with respect to Items 1 through 5 under patients' rights in Table 1.1. We discovered similar findings for each of the manifestations of the remaining six core problems.

Fourth, the researchers anticipated that frontline professionals in the PCORI project measured the extent frontline professionals engage in mezzo and macro policy advocacy. They hypothesized they would engage in lower levels of mezzo and macro policy advocacy than micro policy advocacy because frontline health professionals see many patients each month that need micro policy advocacy assistance with the 33 manifestations of the seven core problems in Table 1.1. Many of these micro policy engagements are relatively brief, such as ones that require only short discussions. By contrast, mezzo and macro policy engagements involve talking with many people, attending meetings, gathering information, and developing strategy. They do not usually occur multiple times in a given day. The researchers therefore asked frontline professionals to indicate the frequency of their mezzo and macro policy interventions over the prior six months rather than the two-month interval that was used to measure the frequency of micro policy advocacy engagements.

The data confirmed that frontline health professionals engaged in mezzo and macro policy advocacy with less frequency than micro policy advocacy. Yet it also confirmed that considerable numbers of them engaged in mezzo and macro policy advocacy during the prior six months. It also confirmed that many frontline health professionals want to engage in mezzo and macro policy engagements, mostly believe they have the requisite skills, and mostly believe they are effective.

Recall that social workers engage in mezzo policy advocacy when they seek to change agency policies. Whereas large majorities selected "never" or "seldom" with respect to discussing a hospital policy with an administrator (67%), developing a protocol to improve patient services (70%), or developing a multi-professional training program (84%), the remaining respondents said they had engaged in these kinds of mezzo policy advocacy. Although not measured in this survey, health policy literature identifies community-based projects where frontline professionals have major roles, such as organizing health fairs where community residents receive free medical tests; community services to educate patients about diet, exercise, and other strategies for improving their health; and visits to homes of patients, such as seniors, to gain information about their ability to engage in daily activities.

When asked whether they had engaged "sometimes, frequently, or always" in macro policy advocacy with respect to the seven core problems in the prior six months, 37% said they had engaged in macro policy advocacy with respect to patients' rights, 60% with respect to quality care, 46% with respect to culturally competent care, 42% with respect to affordable or accessible care, 40% with respect to mental health, and 42% with respect to linking hospital care to the patients' households and communities. The PCORI project developed variables that predict the extent to which frontline professionals engage in micro policy advocacy (Jansson et al., 2016) as well as a scale that measures their engagement in micro policy advocacy (Jansson et al., 2015). A majority of the frontline health professionals ranked the extent they possessed 13 skills often linked to mezzo and macro policy advocacy in existing literature at relatively high levels (Jansson, 2011). For example, more than 75% selected "somewhat," "quite a bit," and "a great deal" when asked if they could "influence other people to work with me to change specific policies," "mediate conflicts," and "discuss specific kinds of unresolved patient issues with hospital administrators" whereas more than 60% of them gave these rankings to "initiate policy changing interventions," "negotiate or bargain to achieve my policy goals," "help patients become policy advocates," and "develop better coordination between units or departments of my hospital." More than 50% gave these high rankings to their ability to "communicate with public officials," "change policies in my hospital," and "establish multidisciplinary training sessions in my hospital." They gave far lower rankings to "make budget suggestions in my hospital" (29%) and "changing protocols or operating procedures in my hospital" (41%).

Respondents generally expressed ethical commitment to micro, mezzo, and macro policy advocacy. For example, almost all respondents selected "quite a bit" or "a great deal" to characterize their belief that members of their profession "have an ethical duty to engage in micro policy advocacy (patient advocacy)," "are mandated by (their) profession's code of ethics to engage in mezzo policy advocacy," "should change organizational policies, including their budgets and procedures, to make patient advocacy less likely," "should develop multidisciplinary training programs to enhance policy advocacy skills," and "should work to correct flaws in current public policies."

When asked to indicate to what extent they believe mezzo and macro policy advocacy are effective at organizational, community, and government levels, more than 90% of respondents selected "somewhat," "quite a bit," and "a great deal"—and 85% selected these responses with respect to government policies.

Macro policy advocates work on many fronts: They try to influence public policies in local, state, and federal governments; initiate court proceedings to protect patients' rights; work to change specific government regulations; and seek additional funding for specific services from external sources. Staff in public and not-for-profit agencies cannot work on elections and campaigns due to federal laws that prohibit this activity during their work hours but can engage in political activities on their own time. They can inform residents about initiatives on ballots if they do not recommend that they vote for or against them. The PCORI project developed a scale to measure macro policy advocacy engagement by frontline health professionals (Jansson, Nyamathi, Heidemann, Duan, & Kaplan, 2015b) as well as methods of predicting levels of macro policy advocacy engagement among frontline health professionals (Jansson et al., 2016).

As discussed subsequently, I call "manifestations" of the seven core problems in Table 1.1 "Red Flag Alerts" to draw social workers' attention to them. Experts in the remaining seven sectors in this book identified Red Flag Alerts in those sectors based upon their professional work in them and professional and research literature as I now discuss.

LINKING THE MULTILEVEL ADVOCACY FRAMEWORK TO EIGHT POLICY SECTORS

The PCORI data demonstrated that micro, mezzo, and macro policy are integral to the work of frontline health professionals in hospitals. It did not tell us, however, to what extent social workers engage in micro, mezzo, and macro policy advocacy in sectors other than the health sector, including gerontology, mental health, child and family, education, safety net, immigration, and criminal justice ones.

Because it was not possible to replicate the PCORI survey in these sectors, I turned to experts in each of the remaining seven sectors to gauge to what extent social workers engage in micro, mezzo, and macro policy advocacy in them. I gave experts in these seven sectors the same list of seven core issues that we used in the PCORI project. (I list these experts at the bottom of the first page of each of the chapters in each of these sectors.) I asked them to list specific manifestations of the seven core issues in each of these sectors based not only on their own professional experience and expertise in them but from relevant research and practice literature as well. I asked them to select ones that frontline social workers frequently encounter. Their findings are presented in Chapters 8 through 14 in this book, except for immigration and safety net sectors, where I drew upon existing research and professional literature.

USING THIS BOOK AS A ROAD MAP FOR YOUR STUDENT AND PROFESSIONAL CAREER

Consider this book, then, to be a road map for your student and professional career because social workers often work in several sectors during their careers and often work across sectors when they make referrals. You can use it as a guide to your fieldwork placement, no matter in which sector it is positioned. You can use it when you make referrals that cross sectors, such as when you might refer clients from the mental health sector to the health sector—or when you might refer a child in the child welfare sector to the mental health or health sectors.

CONTRASTING MICRO POLICY ADVOCACY WITH CLINICAL PRACTICE

Micro policy practice and clinical practice are different. Clinicians do not usually view themselves as advocates because they focus on helping clients improve their mental condition within the counseling relationship including their personal emotions, beliefs, and

actions. Clinicians often seek internal changes in their clients, such as helping them resolve conflicts, develop personal strategies, and surmount fears. Or they help them address conflicts within families. By contrast, policy advocates help consumers of service obtain widely accepted services or rights, such as the manifestations of seven core problems in Table 1.1. Or they try to change organizational policies that prevent clients' receipt of manifestations of the seven core problems. Clinicians do not usually view themselves as representing clients or populations as they deal with service providers or governments unlike micro policy and macro policy advocates. I devote Chapter 4 to micro policy advocacy because it is rarely discussed in direct-service social work literature, as content analysis of widely used textbooks reveals (Gambrill, 2006; Perlman, 1971; Hepworth & Larsen, 2006; Woods & Hollis, 1990). The fullest discussion of micro policy advocacy exists in Jansson (2011, pp. 23–57), Schneider and Lester (2000), Sunley (1983), and Ezell (1991). Some authors used the term "cause advocacy" to describe "macro policy advocacy" (Schneider & Lester, 2000; Sunley, 1983).

UNDERSTANDING HOW THE NASW CODE OF ETHICS REQUIRES USE OF MICRO, MEZZO, AND MACRO POLICY ADVOCACY

The social workers' code of ethics, promulgated by the National Association of Social Workers (NASW), asks social workers to engage in micro, mezzo, and macro policy advocacy. I place some text from the code under the headings of micro, mezzo, and macro policy advocacy. (You can access the full code at https://www.socialworkers.org/About/Ethics.)

Micro Policy Advocacy. "Social workers promote social justice and social change with and on behalf of clients. . . . Social workers' primary goal is to help people and to address social problems. . . . Social workers treat each person in a caring and respectful fashion mindful of individual differences and culture and ethnic diversity. . . . Social workers respect and promote the right of clients to self-determination (and) when appropriate (to) valid informed consent. . . . Social workers should ensure that (their) colleagues understand social workers' obligation to respect confidentiality. . . . Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to client's culture."

Mezzo Policy Advocacy. "'Clients' is used inclusively to refer to individuals, families, groups, organizations, and communities. . . . Social workers' activities include community organizing (and) administration. . . . Social workers should advocate for resource allocation procedures that are open and fair. . . . Social workers should work to improve employing agencies' policies and procedures (and) should not allow an employing organization's policies, procedures, regulations, and administrative orders to interfere with their ethical practice of social work. . . . Social workers should act to prevent and eliminate discrimination in the employing organization's work assignments."

Macro Policy Advocacy. "Social workers' activities include social and political action, policy development and implementation. . . . Social workers challenge social injustice. . . . Social workers' social change efforts are focused primarily on issues of

poverty, unemployment, discrimination, and other forms of social injustice. . . . Social workers should promote the general welfare of society (and) should advocate for living conditions conducive to the fulfillment of basic human needs. . . . Social workers should engage in social and political action that seeks to ensure that all people have equal access to the resources, employment, services, and opportunities they require to meet their basic human needs. . . . Social workers should act to prevent and eliminate domination of, exploitation of, and discrimination against any person, group, or class on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity, age, marital status, political belief, religion, immigration status, or mental or physical ability."

USING POLICY ADVOCACY TO HELP VULNERABLE POPULATIONS

Social workers need to prioritize micro, mezzo, and macro policy advocacy to those marginalized populations that encounter many kinds of discrimination. At least 16 of these populations disproportionately reside in the lower economic strata of the United States. They are subject to policy discrimination that fails to fund programs and services they need to improve their condition. They are subject to discrimination in educational institutions in relation to police and courts, employment, voting rights, and segregated housing (Jansson, 2019). Here are some examples:

- It will take 400 years for African Americans to approach economic levels of white Americans because they were denied mortgages from the end of the Civil War until (at least) the 1960s—and it will take 84 years for the average Latino family to make these gains (Holland, 2016).
- The median net worth for Hispanic households was $42,500 in 2014 as compared with $53,700 for all households as compared to $141,900 for white households (Krogstad, 2016).
- Native Americans have the highest rate of poverty at 14.7% of any large racial group in the nation (Wilson, 2014).
- Single mothers experience discrimination in labor markets where they must often work two or three jobs to survive (Law Office of Cohen and Jaffe, 2017).
- Hmong, Bangladesh, and Cambodian citizens, respectively, have poverty rates of 25.6%, 24.6%, and 19.9% (Wilson, 2014).
- Failure to hire and retain ex-felons may cost the U.S. economy as much as $65 billion because they must use safety net programs to survive, do not pay taxes, and are more likely to return to jail (Prison Legal News, 2011).
- Many seniors rely on Social Security benefits that averaged $15,528 in 2014 for single persons and $25,332 for couples when poverty levels were $11,173 for single persons and $14,095 for couples (Jansson, 2014).

- One-third of immigrants' children live in poverty compared with 10% of adults born in the United States (Nisbet, 2013).
- White males who have lost jobs in rural and semi-rural areas have shorter life spans, high rates of addiction to opioids, and high rates of suicide (Chen, 2016; Eberstadt, 2017).
- Disabled people earn on average 37% less than persons without disabilities (American Institutes for Research, 2014).
- High school dropouts come disproportionately from families of color. They are far more likely to be incarcerated, homeless, engage in violence, and have substance abuse problems (GradNation, 2016).
- People become homeless for a variety of reasons, including financial crises, medical emergencies, mental illness, substance abuse, trauma incurred from military service, unemployment, and eviction from rental units (Desmond, 2016).
- LGBTQ persons are subject to many kinds of discrimination including lack of employment protections, inability of transgender persons to use bathrooms consistent with their gender, discrimination in health programs, and bullying in schools and elsewhere (Williams Institute, 2015).
- Fifteen million children live in poverty—or 21% of all children. And 43% of children live in families that lack resources to meet their basic needs (Child Poverty, 2017).
- Millennial persons, born between 1980 and 2000, have higher levels of debt, poverty, and unemployment than the two predecessor generations (Pew Research Center, 2014).

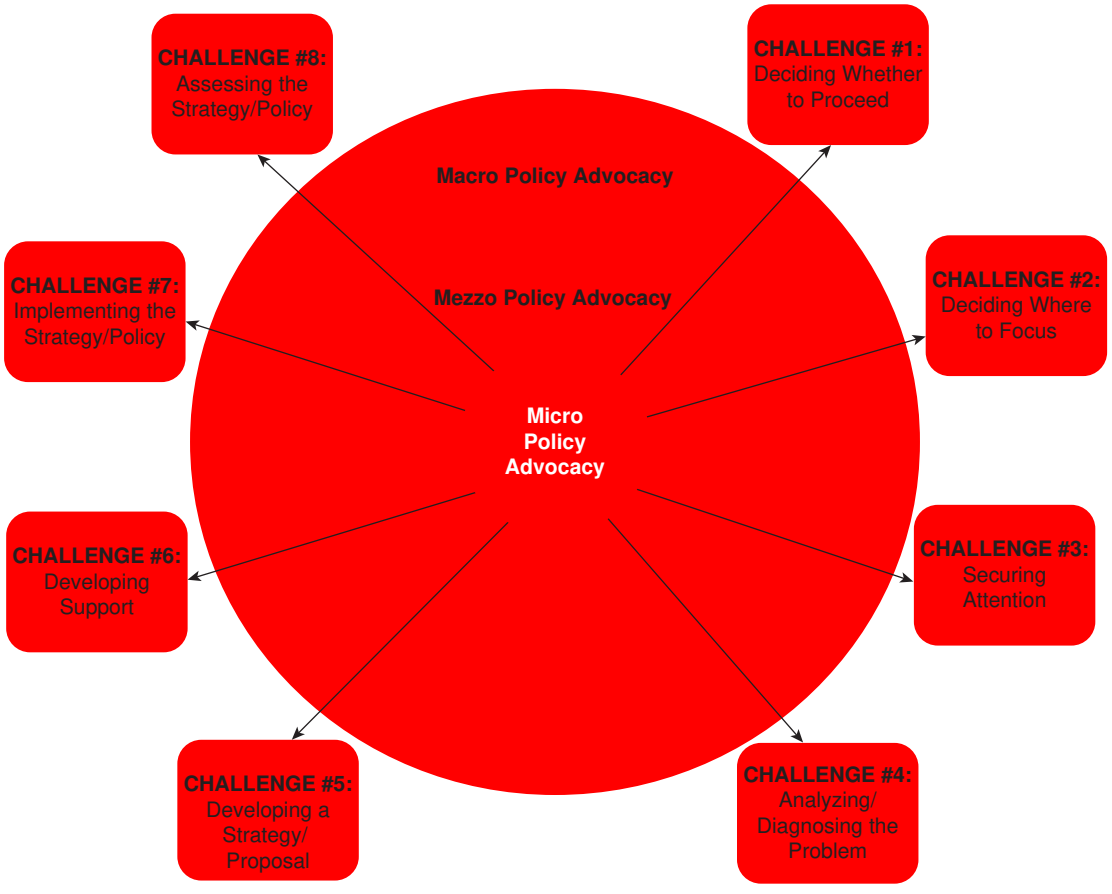
ANALYZING A MULTILEVEL POLICY ADVOCACY FRAMEWORK

A multilevel policy advocacy framework is presented in Figure 1.1 that portrays micro, mezzo, and macro policy advocacy. Advocates at each of these levels do the following:

- Engage in eight tasks, which are portrayed around the outer edge of the circle
- Contend with a policy context that sometimes assists them (assets) and sometimes provides roadblocks (constraints), which are portrayed outside the circle
- Use political, interactional, value clarifying, and analytic skills as they implement each of these eight tasks
- Help persons individually (micro policy advocacy) or collectively (mezzo and macro policy advocacy) surmount the seven core challenges discussed in Chapter 1, including advocating for ethical rights, human rights, and economic justice; improving the quality of social programs; making social programs more culturally responsive; increasing preventive strategies to decrease social problems; improving access to social programs; increasing the scope and effectiveness of mental health programs; and making social programs more relevant to households

Advocates at micro, mezzo, and macro levels undertake eight tasks, including whether to proceed (Challenge 1), where to focus (Challenge 2), obtaining recognition that a client has an unresolved problem from other staff in an agency (micro policy advocacy in Challenge 3) or securing a decision maker's attention for a policy issue or problem (mezzo or macro policy advocacy in Challenge 3), analyzing or diagnosing why a client has an unresolved problem (micro policy advocacy in Challenge 4) or why a dysfunctional policy has developed (mezzo or macro policy advocacy in Challenge 4), developing a strategy to address a client's unresolved problem (micro policy advocacy in Challenge 5) or a proposal to address a policy-related problem (mezzo or macro policy advocacy in Challenge 5), developing support for a strategy to resolve a client's unresolved problem (micro policy advocacy in Challenge 6) or to enact a policy proposal (mezzo or macro policy advocacy in Challenge 6), implementing a strategy (micro policy advocacy in Challenge 7) or an enacted proposal (mezzo or macro policy advocacy in Challenge 7), and assessing whether their implemented strategy (micro policy advocacy in Challenge 8) or policy has been effective (mezzo or macro policy advocacy in Challenge 8).

FIGURE 1.1 ■ A Multilevel Policy Advocacy Framework



Advocates use four kinds of skills as they undertake these—skills that we discuss in more detail in Chapters 4, 5, and 6:

- *Value-clarifying skills* to determine whether to initiate an advocacy intervention in the first place and to conduct their advocacy ethically, such as by not using deceptive or dishonest tactics whenever possible—they should empower persons to be their own advocates whenever possible while realizing that some persons need some or considerable assistance.
- *Political or influence-using skills* to surmount the disinclination of specific persons to agree with specific policy advocacy initiatives at micro, mezzo, or macro levels—resistance to changes sought by advocates can be mild or sometimes intense as illustrated by opposition of many conservatives to President Obama's Affordable Care Act (ACA) and subsequent attempts by many attorneys general to overturn portions of the legislation in 2010 and 2011 as well as involvement by the U.S. Supreme Court. Obama, in turn, countered with use of his own political skills.
- *Analytic skills* to analyze situations and issues to decide what remedies will improve the well-being of specific persons, such as appealing the denial of eligibility to a program by a government official during micro policy advocacy—or to develop policy proposals during mezzo and macro policy advocacy.
- *Interactional skills* to communicate effectively to persuade others to take specific actions—they must decipher the motivations of other persons so that they can speak to their concerns, decrease their anger, and appeal to values, and they must work in and with task groups often formed during advocacy projects.

PROVIDING POLICY ADVOCACY AT THREE LEVELS

Social workers engage in micro policy advocacy when they advocate for specific persons or families to help them obtain services, rights, and benefits that would (likely) not otherwise be received by them and that would advance their well-being. I discuss it more fully in Chapter 4. This kind of advocacy is given to specific clients and families as the following three examples illustrate:

- Parents with an autistic child are concerned about the adverse effects of medication but fear antagonizing the mental health professional who has helped their child. A micro policy advocate helps them understand that they have specific rights as consumers of service—and that getting a second opinion is their legal right as well as consulting other parents with similar concerns.
- A woman with a physical disability is not given workplace accommodations for her condition. A micro policy advocate refers her to a public interest attorney who specializes in cases related to the rights of disabled persons.

- A woman mistreats her elderly husband with dementia by giving him inadequate nutrition and medical care. (The elderly man and his wife have no living relatives.) A micro policy advocate informs his wife about her husband's legal rights and, when no improvement occurs, refers the case to an agency that investigates cases of elder abuse.

Social workers engage in mezzo policy advocacy at the organizational level when they seek to change dysfunctional policies in agencies and communities that may create the need for micro policy advocacy in the first place and that impede the provision of needed services, benefits, and opportunities as well as the protection of clients' rights. These dysfunctional policies can include standard operating procedures, budgets, mission and organizational culture, eligibility requirements, selection of staff, allocation and training of staff, evaluation procedures, planning mechanisms, official organizational policies, and informal policies. We illustrate mezzo policy advocacy with the following two examples:

- A woman does not receive translation services to allow her to understand her transactions with a service provider. A mezzo policy advocate coaches her to request translation services that are mandated by state and federal law.
- Because a health clinic does not use a team approach when helping persons with diabetes, patients fail to receive integrated services needed for their well-being, including physical therapy, occupational therapy, counseling, preventive services, and medical assistance. A mezzo policy advocate works with clinic administrators to develop protocols for integrated services for persons with diabetes.

Social workers who engage in mezzo policy advocacy at the community level seek to change dysfunctional policies in specific communities—policies that include funding, zoning, land-use planning decisions, policies of community-based public agencies, allocation and training of first responders in police and other agencies, community social and other services, housing inspections, and repairing of infrastructure. We illustrate mezzo policy advocacy at the community level with the following two examples.

- A city has no regulations that limit the number of fast-food outlets in specific neighborhoods—leading to disproportionate location of them in low-income areas. Alarmed about high rates of obesity in these low-income areas, a mezzo policy advocate works to allow the city to establish limits on placement of fast-food outlets in low-income areas.
- The well-being of many low-income persons is jeopardized by the failure of a specific city to monitor and enforce housing regulations for their apartments. A mezzo policy advocate establishes a community coalition to pressure the city council and mayor to replace the current director of the city's housing agency, who, they believe, receives kickbacks from some landlords.

We discuss mezzo policy advocacy in more detail in Chapter 5.

Social workers engage in macro policy advocacy when they seek to change dysfunctional policies in government that may create the need for micro and mezzo policy advocacy in

the first place and that impede the provision of needed services, benefits, and opportunities as well as the protection of clients' rights. These dysfunctional policies can include unwise budget priorities and allocations, statutes, regulations, administrative decisions, court rulings, and planning decisions. Macro policy advocates work to change policies and decisions in local, state, and federal governments. We discuss macro policy advocacy in more detail in Chapter 6. We illustrate macro policy advocacy with the following examples:

- A social worker who is the chief lobbyist for Planned Parenthood of Utah lobbies the Utah legislature to enact legislative measures to protect women's reproductive rights, including a law that protects their right to end pregnancies under certain conditions.
- A social worker develops a coalition to raise the rates paid to foster parents with infants to a sufficient level to reimburse the full costs of this care from the current level that only reimburses them for half of this care.
- A coalition of mental health advocates secures the enactment of a proposition on the statewide ballot that sets aside a large and guaranteed sum of money each year for the treatment of persons with mental health problems in that state.
- A state chapter of the NASW endorses candidates who endorse the chapter's policy and budget priorities—and gives them resources to help fund their campaigns.

LINKING THREE LEVELS OF ADVOCACY FOR PREGNANT TEENS AND TEEN MOTHERS

Social workers sometimes move among micro, mezzo, and macro advocacy as illustrated by strategies that social workers have used or could use to improve educational and other services for teenage women who become pregnant.

POLICY ADVOCACY LEARNING CHALLENGE 1.1

PROVIDING MICRO POLICY ADVOCACY FOR A PREGNANT TEENAGER

Many social workers are placed in schools and hospitals where they meet teenage mothers and develop strategies for addressing their needs. When they assess their needs, they discuss their support systems, psychological status, substance abuse history, education, current resources, and any other relevant factors.

Many pregnant teens present themselves at hospitals. In some urban areas, they disproportionately are Latinas from low-income families, have low education, and hold multiple jobs. Many of them did not know about the pregnancy until the fourth or fifth month. Some of them have sexually transmitted diseases. Many of them report they had little sex education that

taught them about risk factors associated with unprotected sex, including from failure to use contraceptives.

Many of them report that they did not seek or obtain prenatal care for fear of deportation and their wish to keep their pregnancy confidential. Many inner-city schools have few nurses.

Many teen moms go to "continuation schools" for students who fall behind in the credits they need to graduate—and because they do not receive support from their regular high school. They often have to travel long distances to reach these schools, requiring them to wake up early in the morning and take two or more buses. Sometimes teen moms are "prodded" to leave their normal school because administrators don't want pregnant moms to walk across the stage before a large audience at graduation.

Teen moms need advocates to help them decide whether to stay in their normal school rather than moving to continuation schools. They mix with students with behavior problems in continuation schools, who often have been dismissed from their normal schools. Continuation schools often do not have college counselors, advanced courses, or work-ahead students. Data is often lacking about the performance of continuation schools as compared with regular schools. Some research suggests many of them have inferior teaching and curriculum (Butrymowicz, 2015). Many teen moms do not know if their state prohibits school administrators from requiring them to attend continuation schools, such as whether a state's education code prohibits discrimination against pregnant teens.

Teen moms need support from social workers. They are subjected to stigma even though they are like other students but just happened to become pregnant. They often need to work part time to support their parents. Immigrants often fear getting medical help because they believe medical staff may convey their names to Immigration Control Enforcement (ICE).

Once teen moms have their children, they run into other challenges. How will they find and fund childcare? Will they receive birth control? Will they receive ongoing advocacy from a social worker as they obtain assistance from Child Protection Services, whose staff make certain that the teen mother and her baby do not experience neglect or abuse. They need to obtain medical help from Medicaid, the Supplemental Nutrition Program for Women, Infants, and Children (WIC) to receive nutritional assistance, diapers, and an infant car seat. They need help from public health nurses, who regularly meet with the teen mom regarding baby care and parenting after discharge from the hospital. Other resources include the Teen Mothers Resource Center and legal aid with respect to the teen's right to remain in or return to her normal school.

Social workers' advocacy with teen mothers may allow some of them to beat the odds. Only 40% of teen moms finish high school. Less than 2% finish college by age 30. Women who give birth while attending community colleges are 65% less likely to complete their degrees than other women. Children of teen moms are 50% more likely to repeat a grade and more likely to drop out of high school than children of older mothers (National Conference of State Legislators, 2013).

Butrymowicz, S. (2015, July 6). Do California's continuation schools really work? *Tribune News Service*. Retrieved from http://www.governing.com/topics/.../do-californias-continuation-schools really-work.html, National Conference of State Legislators. (2013, July 17). Postcard: Teen pregnancy affects graduation rates. Retrieved from http://www.ncsl.org/research/health/teen-pregnancy-affects-graduation-rates-postcard.aspx

POLICY ADVOCACY LEARNING CHALLENGE 1.2

MOVING TOWARD MEZZO POLICY ADVOCACY TO HELP PREGNANT HIGH SCHOOL STUDENTS

Social workers engage in mezzo policy practice to help pregnant high school students when they seek to change policies and procedures in specific high schools or school districts. Despite the importance of teen education and equal education requirements of Title IX, many guidance counselors still informally counsel pregnant students to leave their high school for alternative schools without providing them assistance or resources and telling them they have the option to stay put. Official school policies could be established that prohibit encouraging pregnant students to leave high schools for alternative schools.

Sex education can be improved in specific schools or school districts by making it more effective with teenagers by developing or using models that have been proven to be effective in preventing or delaying teen pregnancy. Do specific policy and program deficiencies impede preventive strategies, such as sex education programs that discuss not only abstinence but also birth control strategies? Do schools have nurses on the premises who distribute condoms? Do schools inform teenagers to consult medical staff if they have unprotected sexual encounters to see if they wish to use medications to avert pregnancy? Are schools linked to Planned Parenthood to obtain information about their options?

Learning Exercise

Address the following questions with respect to mezzo policy advocacy with teenagers in schools:

- Do social workers frequently engage in micro policy advocacy to help pregnant adolescents gain their rights by identifying and addressing systemic defects in organizational policies, such as prejudice by school staff against this population or lack of quality education programs geared to the needs of this population?
- Do pregnant adolescents drop out of a specific school due to hostile treatment by a specific teacher or guidance counselor or due to defective policies in a specific school (organizational factors), in the school district (community factors), or at the State Department of Education (government factors)—or some combination of these factors?
- Did deficiencies in the policy and regulatory context contribute to the problem, such as lack of guidelines to protect the rights to education from the school district, the State Department of Education, or the federal Department of Education?
- Do budgets of specific schools or school districts prioritize services for pregnant teenagers—or sex education or nurses in schools?
- Are pregnant students of color treated differently in specific schools or school districts than white pregnant students? Are low-income pregnant students treated differently than more affluent pregnant students?
- Do schools keep data on the educational paths of pregnant teens?
- Do specific schools give pregnant adolescents special accommodations, allowing them to be tardy or absent when obtaining medical care?
- What policies have specific schools or school districts developed to help young women remain in school after they have given birth, such as assistance with childcare, supportive counseling, and special accommodations?

POLICY ADVOCACY LEARNING CHALLENGE 1.3

MOVING TOWARD MACRO POLICY ADVOCACY TO HELP PREGNANT HIGH SCHOOL STUDENTS

The United States has the highest rates of teen pregnancies of industrialized nations even though the pregnancy rate has markedly declined for teens from age 15 to 19. Only one-third of teen mothers finish high school and only 1.5% have a college degree by age 30.

Public schools differ markedly in their policies regarding pregnant teen mothers partly because of the absence or lack of clear state laws or federal policies. Some send them to continuation schools during their pregnancy where they are separated from their friends, not even inviting them back to their regular school when they have given birth. Continuation schools are of uncertain quality partly because their standards are not well defined by state law. State laws are often unclear about whether adolescents can remain in continuation schools even after giving birth. Laws forbid schools from expelling teen mothers, but they receive little policy guidance otherwise. Little case law enforces or guides the provision of educational services for teen mothers in many localities and states. Some evidence suggests, as well, that African American and low-income pregnant adolescents are treated more harshly than white and affluent adolescents. The laws and policies of some states do not require schools to teach sexual education. Many schools ignore the importance of preventive health education and comprehensive sex education. Many states do not require schools to keep data on the educational trajectories of teen mothers prior to or after giving birth.

Nor is it clear to what extent some states fund special programs for teen pregnant mothers and teen mothers with children. Although some teens can count on support from their parents and relatives, others lack such support—and may particularly need financial assistance from schools for medical care, childcare, counseling, and other assistance.

Nor is it clear what budgetary and policy roles exist for school districts as compared with state educational agencies and policies. Some state officials may wish to cede responsibility to school districts that lack resources and staff to help pregnant teens and teen mothers.

Advocates need to consider, as well, whether and under what circumstances pregnant teens can seek termination of their pregnancies. What laws in their states impact these decisions—and do these laws need to be reformed? What positions do Planned Parenthood and other advocacy groups take in specific states on this issue? These kinds of systemic policy factors can only be addressed through macro policy advocacy.

Identify some dysfunctional policies in your locality, region, or state that might be addressed through macro policy advocacy by social workers working with teenagers in schools or other settings.

Our discussion suggests that advocacy at micro, mezzo, and macro levels can be linked. Discuss how a social worker might move among micro, mezzo, and macro policy advocacy.

DEVELOPING MICRO POLICY ADVOCACY RED FLAG ALERTS

We now return to the seven core problems that we discussed earlier in this chapter. We need to move beyond general descriptions of these seven core problems to identify specific manifestations or examples so that we anticipate them. In the research reported earlier in this chapter, we identified an array of problems and issues that frontline workers

POLICY ADVOCACY LEARNING CHALLENGE 1.4

IDENTIFYING SOME RED FLAG ALERTS IN SPECIFIC AGENCIES

Take any setting that provides human services with which you are familiar, whether your field agency or where you have volunteered or worked. Develop a list of a specific manifestations for each of the seven core problems that are listed in Table 1.1. Then ask a professional who works in the setting to discuss with you the extent your list of manifestations of the seven core problems are relatively common. Also ask whether clients would be adversely impacted if social workers failed to address them. Ask this professional to augment your list with additional problems even as this professional might delete one or more of the problems that you identified from your list.

Learning Exercise

Discuss the following questions:

- Is it possible to develop specific Red Flag Alerts in the setting that you have chosen?
- Would these Red Flag Alerts facilitate the use of micro policy advocacy by social workers in this setting? Or might they facilitate mezzo and macro policy advocacy?
- To what extent did you use research findings, ethical principles, or pragmatic factors to develop these Red Flag Alerts?

are likely to encounter in hospitals with help from a panel of experts, that is, 33 of them as described in Table 1.1. Specific manifestations of the seven core problems become Red Flag Alerts when they occur relatively frequently in a population of clients and when they have negative effects if they are not addressed or resolved.

You can use the same methodology to identify a set of problems and issues in your own practice in any agency—and then change the list as you discover which ones reappear frequently in your practice. Or you can discuss with your supervisor or executives polling social workers and other frontline staff not only to identify a list of manifestations of the seven core problems but also to measure their relative incidence in your agency. You might also convene some consumers of service to obtain their designation of specific issues as ones they frequently encounter in a specific agency or organization. You can designate some as Red Flag Alerts based upon their frequency and their negative impact upon clients when they are not addressed. Frontline professionals can develop workshops to discuss how to help clients/patients address Red Flag Alerts. They can ask whether agency policies might be changed to help staff prioritize them.

DEVELOPING RED FLAG ALERTS AT THREE LEVELS

It is also possible to identify specific manifestations of one of the seven core problems that could require advocacy at micro, mezzo, and macro levels. Let's use an example drawn from schools. Assume that you have read extensive research literature that documents