Chapter 1

ADVANCING SOCIAL JUSTICE IN EIGHT POLICY SECTORS

LEARNING OBJECTIVES

In this chapter, you will learn to:

1. Identify eight policy sectors that deliver services, resources, benefits, and opportunities to millions of residents of the United States
2. Define micro policy interventions, mezzo policy interventions, and macro policy interventions
3. Identify seven core problems that exist in each of the eight policy sectors
4. Recognize how advocacy allows social workers to follow the Code of Ethics of the National Association of Social Workers (NASW)
5. Define social policy and enumerate different kinds of social policies
6. Identify challenges and rewards encountered by policy advocates
7. Understand the reform traditions of the social work profession

Social workers, unlike many high-level officials and policy experts in government positions and think tanks, engage social policy in their daily work. They understand that policy impacts individuals and families because they see how it influences their lives. They see clients and families who do not receive benefits, services, resources, and rights to which they are entitled, such as clients who are wrongly declared ineligible for specific programs. They understand, too, that some policies are dysfunctional, such as those that disqualify women from using public welfare and food programs when they leave prison, even when they have children who depend on these resources. They understand that they are required
by their code of ethics to be advocates of policies that advance ethical principles such as self-determination and social justice.

Social workers, then, interact with policies on three levels. They:

- Help specific clients, families, and communities obtain rights, benefits, opportunities, and services that they need and to which they are entitled (micro policy interventions)
- Reform dysfunctional policies at the organizational and community levels that may create the need for micro policy interventions (mezzo policy interventions)
- Reform dysfunctional policies at the legal and government levels that may create the need for micro policy interventions (macro policy interventions)

This book offers a unique empowerment framework to provide social workers with tools to develop micro policy, mezzo policy, and macro policy interventions in eight policy sectors. It also provides many vignettes that illustrate how social workers have empowered themselves and their clients to work for greater social justice.

REFORMING POLICIES IN EIGHT SECTORS

Most social workers work in eight policy sectors. They work in the child and family sector in child welfare agencies, childcare agencies, child guidance clinics, preschool programs, and other programs; the health sector in hospitals, community clinics, physician practices, public health programs, and other settings; the gerontology sector in hospitals, long-term care agencies, convalescent homes, hospice programs, palliative care programs, retirement homes, day treatment programs, and other settings; the mental health sector in counseling agencies, suicide prevention programs, mental hospitals, places of work, and other settings; the education and job development sector in public and private schools at the preschool, primary, and secondary levels as well as in community colleges, colleges, universities, and vocational education and other job training settings; the corrections sector in prisons, probation and parole agencies, community transition programs, gang-related programs, police departments, juvenile courts, and other settings, and the safety-net sector in local and federal offices of the U.S. Social Security Administration, local and state welfare offices, not-for-profit and faith-based programs that provide food banks and other services to low-income individuals, and other settings. Social workers also work with immigrants in the global sector as well as with international organizations such as agencies of the United Nations, not-for-profit agencies like Oxfam and the Gates Foundation, and faith-based organizations.
Chapter 1  Advancing Social Justice in Eight Policy Sectors

These eight sectors lie at the heart of the American network of social programs and policies. Most social workers work in them, and most programs “belong” to one of these sectors. Each sector has:

- Its own distinctive policies, sources of funds, agencies, programs, and literature
- Its own administrative arrangements
- Its own ways of selecting and deploying its staff
- Its distinctive mission, such as providing services (mental health, education, and health sectors), hard benefits (the safety-net sector), or law enforcement and rehabilitation (the corrections sector) or assisting immigrants and people of other nations (the global sector)
- Subdivisions within it (e.g., some mental health sector agencies address substance abuse while others help people with their overall mental health)

An extensive policy literature exists regarding policies in these sectors. It describes myriad policies within each of the sectors. It evaluates and discusses the historical evolution of a number of these policies. It identifies policy controversies in each of the eight sectors.

A notable omission exists, however, in current policy literature. It fails to sufficiently embed micro, mezzo, and macro policy interventions within each of these policy sectors by discussing how social workers can and should provide these policy interventions within them. It fails to discuss specific tasks and skills that empower social workers to become advocates in each sector. It fails to provide examples of social workers’ policy interventions in these sectors. These omissions risk disempowering social workers who work in these various sectors. They may be able to describe and analyze specific policies in these sectors, but they may not be equipped to develop micro, mezzo, and macro policy interventions within them.

This book addresses these omissions in several ways. Chapter 2 discusses why social workers need to reform policies in the eight sectors. Chapter 3 draws upon an emerging literature on policy practice and policy advocacy to provide a policy advocacy framework describing specific tasks and skills that will allow social workers to develop advocacy interventions at the micro, mezzo, and macro policy levels in any sector, agency, or government. Chapter 4 defines micro policy advocacy as interventions to help clients, families, and communities obtain services, benefits, resources, rights, and opportunities that they need and to which they are entitled, but that they might not otherwise obtain. Chapter 5 defines mezzo policy advocacy as interventions to change dysfunctional policies in organizations and communities. Chapter 6 defines macro policy advocacy as interventions to change dysfunctional policies in court and government settings. And Chapters 7
through 14 discuss how social workers work to advance social justice in each of eight sectors.

This book discusses how micro policy advocacy can lead to mezzo and macro policy advocacy in these eight sectors. If Tip O’Neill, former Speaker of the House of Representatives, argued, “All politics is local,” we can say that “all policies begin with specific individuals, families, and communities.” As social workers provide micro policy interventions to help their clients gain access to Medicaid or the Supplemental Nutrition Assistance Program (SNAP, formerly known as food stamps), they may also decide that dysfunctional policies contribute to this adverse outcome and engage in, for example, mezzo policy advocacy to change the unnecessary complexity of application forms, the requirement that clients frequently recertify their eligibility, the lack of sufficient public service advertisements, and the inaccessibility of eligibility offices. Or they may battle to prevent cuts in SNAP in their states and in the U.S. Congress with macro policy advocacy.

REALIZING THAT MICRO, MEZZO, AND MACRO POLICY ADVOCACY ARE REALLY NEEDED

Social workers engage in policy advocacy as they realize that the well-being of individuals and families is threatened by dysfunctional policies in organizational, community, and government settings. Of course, many programs and policies are meritorious. Health systems save many lives and prevent the emergence or progression of many chronic conditions. Many individuals surmount serious mental problems such as depression and anxiety. The lives of many children who have been subjected to extreme neglect or abuse are saved due to the interventions of child welfare workers. Many elderly individuals are helped to contend with end-of-life issues by hospice and palliative care programs. Some criminal offenders are rehabilitated by community-based programs after they have been released from prisons. Some low-achieving students become high achievers due to help they receive from teachers and counselors.

Remarkable improvements have occurred in each of the policy sectors when they are viewed from a historical perspective. Life expectancy has increased from roughly 68 years for women and 65 years for men in 1960 to roughly 83 and 78 years, respectively, in 2014. Medications such as psychotropic drugs now ease the symptoms of people with severe mental illnesses like schizophrenia. Elderly individuals and people with mental conditions no longer languish for decades in the back wards of state hospitals. Violations of the civil rights of people of color have been reduced by enactment of civil rights legislation at federal and state levels.
Considerable research suggests, however, that seven challenges are often encountered by consumers in the eight policy sectors: (1) violation of their ethical rights, (2) failure to receive quality services, (3) lack of culturally responsive services, (4) insufficient preventive services, (5) lack of access to services and programs, (6) lack of attention to mental problems, and (7) receipt of services not sufficiently linked to consumers’ households and communities.

**IDENTIFYING SEVEN CORE PROBLEMS THAT CUT ACROSS EIGHT POLICY SECTORS**

We now turn to the seven core problems that consumers of services encounter in each of the eight policy sectors.

**Core Problem 1: Advancing Ethical Rights, Human Rights, and Economic Justice**

Ethicists mostly agree that service providers, as well as nations, should meet individuals’ basic survival needs, honor their self-determination, provide them with accurate and honest information, preserve the confidentiality of personal information, treat people equitably, honor individuals’ human rights, and advance social justice (Holland, 2012).

**Meeting Basic Survival Needs**

The United States has made important strides in protecting basic survival needs during the past 60 years. It protected millions of Americans from starvation with cash relief and work relief in the Great Depression as well as formed federal welfare programs and unemployment insurance to supplement welfare programs. It established the Food Stamps Program in 1964 and expanded it in subsequent decades, recently changing its name to the Supplemental Nutrition Assistance Program (SNAP). It established the Medicaid and Medicare programs in 1965 to expand health coverage for low-income individuals and elderly people—and added the Children’s Health Insurance Program (CHIP) for low-income children in 1997. It developed federal housing programs in the 1930s and added other rent subsidy programs in the 1970s. Many private organizations give cash, food, and shelter relief to Americans. The United States also established a federal minimum wage in 1938 that had risen to $7.25 by 2014, and many states have mandated higher wages, such as California with a minimum wage of $9 per hour. It will provide about 32 million additional Americans with health insurance when the Affordable Care Act (ACA) is fully implemented. The United States
has developed federal emergency programs to help residents in the wake of natural disasters.

Much remains to be done to meet Americans’ survival needs. Considerable numbers of people earn income just above, at, or below federal poverty levels (FPL), which are set very low, such as $19,790 for families of three and $23,850 for families of four in 2014. Disparities in income between the bottom fifth of the population and the top fifth have widened since 1978—and the gap between the income of the bottom fifth and that of the top 2% has widened even more since that date. Thomas Piketty, a French economist, published a book in 2014 that revealed that Americans with the top 1% of the nation’s wealth, including their investments and capital, possess 20% of the nation’s wealth—and the top 10% of them possess 50% of the nation’s wealth. These wealth disparities are the most extreme America has seen since the Gilded Age, from roughly 1880 to 1900 (Piketty, 2014). Pickett’s discovery led to widespread debates about the negative implications of extreme economic disparities and how to decrease them, such as by greatly increasing tax rates on the very rich and redistributing resources to people with less wealth. Many Americans are malnourished. Large numbers of Americans do not receive sufficient medical services. The mental health problems of many individuals are not addressed. Many Americans do not use social programs that could markedly improve their well-being. Only about half of eligible individuals use, for example, SNAP, the Medicaid Program, and the Earned Income Tax Credit, as well as the CHIP program—depriving low-income individuals of billions of dollars of income, food, and health resources.

**Providing Individuals With Opportunities**

If people do not receive education, job training, and employment, they can meet their survival needs only through assistance from government or from private charities. Many people rely on welfare and assistance from the private and public sectors during economic downturns, in the wake of disabling health and physical problems, and during bouts of unemployment, but most people should have education and skills to support themselves and their dependents through gainful employment. Their employment should provide sufficient wages to meet their survival needs and to provide them with other amenities, such as savings, recreation, and decent housing. Their employment, too, should give them the ability to steadily improve their wages through time—and should meet other personal needs such as creative expression and fulfillment.

Millions of Americans lack skills to find employment in the global economy. Individuals who possess only a high school education or less are seriously compromised in finding work or in finding employment that meets their basic needs.
The wages of many workers have been relatively stagnant during the past three decades. The quality of education varies widely in the United States. Inner-city schools often have more crowded classrooms and poorer teachers than suburban schools. Many students, particularly low-income, African American, Latino, and Native American students, do not achieve national norms in math and reading. In many inner-city high schools, more than 50% of students drop out; nationally, roughly 25% drop out. About 50% of students who enter community colleges drop out before the second year. Less than 60% of students who enter colleges graduate in six years. People of color disproportionately do not enter educational programs after high school and fail to graduate from them. The learning of many students is compromised by their lack of nutrition, homelessness, and mental conditions.

Many laws protect vulnerable populations from discrimination. The Americans with Disabilities Act (ADA) prohibits discrimination by employers against people with disabilities. The Civil Rights Acts of 1964 and 1965 prohibit discrimination by schools and employers against people of color and women. Some states prohibit discrimination against members of the lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQQ) population in places of employment.

**Honoring Self-Determination**

Many court rulings, as well as writings of ethical philosophers and religious leaders, support the right of individuals to decide whether, when, and how to seek services or use social programs in the United States. The Supreme Court has ruled, for example, that individuals who are cognitively competent can decline medical treatments even when their physicians believe that this decision could cause them physical harm or even death. Specific laws, court rulings, and accreditation standards require agencies and programs to honor self-determination through “informed consent” that informs clients about:

- Likely outcomes of specific treatments
- Likely monetary costs of specific treatments
- Likely side effects or threats to their well-being from specific treatments or courses of action, including death and injury
- Alternative treatments or services
- Evidence-based findings relevant to their treatment

Providers who do not give individuals full and accurate information about treatment options so that they can make informed decisions are liable to incur penalties that can include loss of their licenses. Providers do not have to obtain informed consent in cases where a court has ruled that a specific client is mentally...
incompetent and where the court itself, or a guardian appointed by it, acts in the best interests of that person.

States usually allow parents or guardians to make decisions for minors as long as those decisions advance the children’s well-being. Under the doctrine of *parens patriae*, however, public authorities can investigate whether parents or guardians are neglecting or abusing children and can take custody of them or order specific ameliorating actions or treatment when they discover that children have been harmed or might suffer harm.

Most states allow public authorities to commit individuals involuntarily to hospitals, correctional facilities, or other settings when they are suicidal or have already attempted to harm themselves. They also allow public authorities to restrain or incarcerate individuals who have threatened or harmed others. These actions of public authorities are circumscribed, however, by mandated legal representation for people who are involuntarily admitted to institutions, required reviews of their cases by courts, and other procedural safeguards.

Many obstacles exist to self-determination. Some providers fail to involve their clients sufficiently in the helping process. Providers may be less likely to provide informed consent to individuals from vulnerable populations, such as women and people of color. People with mental conditions, such as schizophrenia, may be viewed as unable to make specific choices even when they are capable of making them. Relatively submissive individuals may not assert their rights.

**Honoring Consumers’ Right to Accurate and Honest Information**

People have an ethical right to know the nature of their mental, health, and other problems in clear and understandable terms. They need to know their prognosis. They need accurate and honest information throughout their treatments or services, such as knowledge of how their condition has changed, outcomes of their current treatments, and whether different treatments should be selected as they progress forward. People also need accurate and honest information from personnel in financial institutions, car dealers, landlords, and employers.

Many obstacles prevent the provision of accurate and honest information. Providers sometimes want to steer people to treatments and facilities that will financially benefit them by giving them higher reimbursements. They may give their patients or consumers false statistics about the success of their services or treatments in hopes that those individuals will be more likely to use them. They may overstate the seriousness of specific conditions or prognoses in order to frighten people into using their services or treatments. They may deceive individuals with low levels of education, such as when car dealers, landlords, and employers victimize their consumers. Providers sometimes do not divulge conflicts of
interest. Many policies, court rulings, regulations, and laws protect people’s right to accurate and honest information by, for example, prohibiting false advertising, requiring disclosure of conflicts of interest, and requiring disclosure of treatment options. Professionals may sometimes give inaccurate information because they are misinformed. Perhaps they are not aware of new research that identifies specific evidence-based treatments.

**Protecting the Ethical Right to Confidentiality**

Consumers of services are entitled to confidentiality—and would likely not seek assistance for many of their problems if they did not trust their providers to maintain it. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects the confidentiality of clients’ information in health systems. It requires health organizations and health personnel to adhere to numerous procedures to protect patients’ confidentiality. Its standards extend to other service delivery systems, such as mental health. Other protections for confidentiality include state laws, accreditation standards, court rulings, and professional licensing standards as well as the Code of Ethics of the National Association of Social Workers (NASW). Other standards protect the confidentiality of students.

Exceptions to confidentiality exist. If someone threatens to injure or kill another person, for example, health and mental health providers are *required* to disclose this information to the specific external authorities, such as the police. Some health information, such as cases of HIV/AIDS infection and tuberculosis, must be disclosed to public health authorities. Social workers must sometimes verify to courts that specific individuals have actually received specific health and mental health services that the courts mandated them to use.

Many factors jeopardize the confidentiality of clients’ information. Some providers are insufficiently aware of the hazards that specific consumers may experience if their private information is divulged to certain individuals or organizations—such as possible loss of employment or disruption of relationships or marriages. Providers are sometimes careless in the ways they transmit information about specific clients to others, such as by telephone in ways that allow third parties to listen in. Hackers can sometimes gain illicit access to clients’ information that is stored electronically.

**Providing Equitable Treatment**

All people have a right to receive the same quality, kind, and duration of services, benefits, and treatments as those that other people with the same problems or conditions receive, regardless of their race, gender, sexual orientation, place of
national origin, age, social class, level of intelligence, religion, disability status, literacy level, ability or inability to speak English, genetic characteristics, mental health, socioeconomic status, or other personal characteristics. Many state and federal civil rights policies prohibit inequitable treatment, including:

- The federal Civil Rights Acts of 1964 and 1965 that prohibit discrimination against people of color, women, and people born in other nations
- The Americans with Disabilities Act of 1990 (ADA) that bans discrimination against people with physical and mental disabilities
- State laws banning discrimination in housing and employment against individuals on the basis of sexual orientation
- State and federal laws banning discrimination in housing for many vulnerable populations
- State and federal laws banning discrimination against individuals with HIV/AIDS
- Policies that require affirmative action and quotas for women, people of color, and veterans
- State and federal laws that protect members of vulnerable populations from discrimination at their places of work

Professionals sometimes discriminate on the basis of prejudice against specific kinds of people. Individuals with schizophrenia often receive inferior healthcare, even when they possess heart disease. African Americans and women are less likely than Caucasians and males to obtain some types of advanced health technology. Disabled individuals are often treated paternalistically, with an emphasis on their physical limitations rather than their strengths. People with a history of criminal offenses are often subjected to discrimination in their places of work. Homeless youth often find it difficult to enroll in secondary education. People of color are more likely to be sentenced to death than Caucasians—and are incarcerated at higher rates and for longer periods that whites for specific offenses. African Americans who use illicit drugs are more likely than Caucasians to receive prison sentences. People of color are subject to more police brutality than Caucasians. Students of color are more likely to be expelled from secondary schools than Caucasian students. Employers often use “race” as a shortcut measure to assess applicants’ capabilities for employment rather than objectively viewing their qualifications. Educators often convey their lower expectations to people of color and low-income whites.

**Honoring Human Rights**

Human rights are broadly defined as basic rights and freedoms, including the right to free speech, the ability to travel without restriction, protection from
human trafficking, freedom from violence, and the right to free association. They include the right to humane treatment by employers and fellow employees in places of work. They prohibit genocide. They include protection of children and others from bullying in schools and places of employment. They include protection against sexual harassment in the workplace, verbal and physical abuse within families, and sex trafficking.

It is difficult to curtail violations of human rights for many reasons. Some behaviors are difficult to change, such as the bullying of children in schools, the sexual harassment of women in places of work, and gang violence. Many people profit monetarily from violating the rights of others, such as pimps and international traffickers of girls and women for prostitution. Violations of human rights often occur in developing nations, such as genocide in Rwanda, the Sudan, and Syria. They often occur in nations with dictatorships where freedom of speech, freedom of movement, and freedom of assembly are often curbed or prohibited.

The fundamental rights of human beings are embodied in international law; constitutions, statutes, and regulations; and court rulings (Barria & Roper, 2010; Gelb & Palley, 2009; Tomuschat, 2008). They include:

- Civil rights laws in local, state, and federal jurisdictions
- Article 1 of the United Nations Universal Declaration of Rights that defines “basic rights and freedoms” in response to atrocities during World War II
- The four treaties and three protocols of the Geneva Convention (1949), which defined rights of combatants and civilians during wars
- The UN Convention Against Torture (1984)
- The International Convention on Protection of the Rights of All Migrant Workers and Members of Their Families (1990)
- The UN Protocol to Prevent, Suppress, and Punish Trafficking in Persons (2000)
- The UN Convention on the Rights of the Child
- The Victims of Trafficking and Violence Protection Act of the United States (2000)

Provisions of the American Constitution include such rights as “due process,” “equal protection under the law,” freedom of speech, freedom of the press, and freedom of association in the Bill of Rights. Many state and federal laws protect human rights, such as anti-trafficking laws, laws prohibiting discrimination against
individuals in their places of work, and laws protecting children and students from bullying in schools.

**Promoting Social Justice**

Social injustice occurs when specific populations, such as women, members of racial minorities, and low-income individuals, are subject to violations of civil and human rights, violations of equitable life conditions, and violations of access to opportunities. We have already discussed disparities in civil and human rights between people of color, women, and the mainstream population.

Social injustice also occurs when specific populations suffer poorer life conditions than others, such as when low-income individuals suffer from greater physical and mental illness, shorter life expectancy, more disabling conditions, higher rates of unemployment, and lower levels of school achievement than relatively affluent individuals. Disabled people have considerably less income, higher rates of unemployment, higher rates of mental illness, and shorter life expectancies than people who are not disabled. Individuals with schizophrenia have an average life expectancy of 63 years, compared to 77.9 years for other Americans. People of color are more likely to reside in crime-infested areas than white individuals, making life hazardous for them on a daily basis. Single female heads of households are among the poorest members of our society—to the point that an academic has coined the term *feminization of poverty*. They often work multiple jobs in a desperate effort to meet their children’s basic needs, which wreaks a toll on their mental and physical health, not to mention their ability to obtain further schooling that might allow them to obtain a higher-wage job.

Social injustice imposes unnecessary costs on society. When specific vulnerable populations are denied equal access to opportunities, they are more likely than other people to need financial and medical assistance from the broader society. They are likely to contribute lower taxes to the revenues of local, state, and federal governments. Extreme inequality breeds social problems because it marginalizes large numbers of people who are acutely aware that they are poorer and sicker than mainstream populations. It breeds desperation in the case of individuals who cannot meet the survival needs of themselves and their children. It decreases participation in elections among low-income individuals—making it harder for them to elect public officials who would work to secure enhancements of their rights, life conditions, and opportunities.

Extreme inequality violates ethical standards established by many religions, professions, and ethicists. It is even more ethically problematic in industrialized nations, such as the United States, that possess sufficient resources to create more egalitarian economic and social systems.
We should not imply that members of vulnerable populations are passive victims of circumstances. Members of these groups often contend with adversity in many ways, such as through churches, small businesses, neighborhood associations, and advocacy groups. Many people better their condition by perseverance and resilience. Members of vulnerable populations often join forces to achieve legislative reforms, such as when African Americans and Latinos oppose efforts to curtail their voting rights.

**Core Problem 2: Improving the Quality of Social Programs**

Consumers of services have an ethical right to services and programs that ameliorate or solve social problems that they possess, but they often do not receive effective services. Perhaps providers give them interventions that have not been empirically evaluated. Perhaps service providers are not sufficiently skilled in providing specific services. Perhaps providers give consumers services that yield substantial revenues but are not effective.

Consumers of services, like taxpayers, have a right to *cost-effective services*—effective services delivered at a reasonable cost. Some medications may prolong life, for example, but only for several months at a cost exceeding $100,000. Some interventions are far more expensive than others that are just as effective or more effective, as was recently discovered when researchers found that acupuncture was more effective and less costly than surgery for some kinds of lower-back pain.

We can sometimes determine whether specific programs, treatments, interventions, or policies are effective or cost-effective by using research methodology. In so-called gold standard research, for example, researchers use randomized controlled trials (RCT) in which they compare the outcomes of groups of patients who receive specific assistance to those of groups that receive different kinds of assistance or no assistance. They might, for example, give one group a specific intervention for depression (the experimental group) and compare its outcomes with a group not receiving this intervention (the control group). Researchers sometimes cannot perform RCTs and instead conduct so-called quasi-experimental research in which they compare two or more groups that do and do not receive a specific intervention. Researchers sometimes use natural experiments to gauge the effectiveness of specific policies, such as determining if motorcyclists’ death rate from accidents declines after the enactment of a state law requiring motorcyclists to wear helmets.

Surveys of consumers’ satisfaction with services provide another measure of their quality. Medicare officials routinely ask patients to evaluate the Medicare services they receive from physicians and hospitals, for example, and place the results on the Internet so that patients can use this information to decide where to seek services.
The quality of services is often impeded by their fragmentation when consumers receive care from specific providers that is not coordinated. Assume, for example, that a child receives help with convulsions that sometimes accompany autism, but not for her emotional outbursts. Or perhaps an elderly person receives medication to control his depression that adversely interacts with other medications prescribed by other physicians. Case-management and navigation models of service have evolved to circumvent fragmentation. Case managers try to orchestrate a package of services for specific consumers, and patient navigators help individuals keep appointments, adhere to medications, and follow treatments. Only a small fraction of consumers of services receive such assistance, however, due to a lack of staff and funding to provide them, even for people with serious problems. Some state and federal laws require providers to develop comprehensive plans for certain clients, such as when they mainstream disabled or developmentally challenged children into the educational system. Comprehensive plans are ineffective, however, if schools and other agencies lack sufficient staff to implement them. Interagency collaborations, such as those developed between schools and mental health agencies, also curtail fragmentation.

Core Problem 3: Making Social Programs and Policies More Culturally Responsive

The United States has been an immigrant nation since its inception, its citizenry having originated from a mixture of forced immigration of slaves, subjugation of native peoples, and voluntary immigration from Europe, Russia, Mexico and Central America, Asia, the Middle East, Africa, and elsewhere over several centuries. In 2007, the U.S. population included 199 million non-Hispanic whites, 45 million Latinos, 37 million African Americans, 13.1 million Asians, 2 million American Indian and Alaska Natives, and 402,000 Native Hawaiians and other Pacific Islanders. Many people have limited English proficiency (LEP).

It is challenging to define “culturally responsive care” partly because it is difficult to define “culture.” Brislin (2000) defines culture as the “shared values and concepts among people who most often speak the same language in proximity to each other . . . [that] are transmitted for generations, and . . . provide guidance for everyday behaviors” (p. 4). Culturally responsive care contains a language dimension. It requires that providers respect the cultural views about health and other social issues held by specific individuals, such as how they view specific health conditions, how they wish to receive healthcare, which terminology they prefer, how they wish to communicate with healthcare providers, and what treatments they wish to have. Culturally competent care is needed in every policy sector.
Culturally competent services must be provided not only to LEPs, but also to people from many groups that differ from mainstream ones, including illiterate or semiliterate individuals, LGBTQQ individuals, elderly people, disabled people, people from different religions, and women. Many people want complementary and alternative medicine (CAM) in healthcare, such as the use of herbs, acupuncture, meditation and yoga, and other nontraditional methods of preventing or treating health problems. They sometimes want CAM instead of traditional medicine and often use CAM and traditional medicine in tandem.

People who do not receive culturally competent services may suffer adverse consequences. They may not seek or return for needed services. They may not adhere to treatments that can improve their condition. They may sue providers, such as when they are not given translation services as required by federal and state laws. They may believe that they have not given informed consent when they are unable to communicate with providers.

Culturally competent care is enhanced when providers are self-aware, respect other cultures, have cultural awareness, possess cultural knowledge, and develop cultural skills where they “negotiate or facilitate relationships between consumers and providers” (Kao & Jansson, 2011, p. 184). Providers need skills that are described by Galanti (2008) as the “4 Cs of culture”:

- **CALL**: What do you call the problem? What do you think is wrong?
- **CAUSE**: What do you think caused your problem?
- **COPE**: How do you cope with your condition? What have you done to make it better? Who else have you been to for treatment?
- **CONCERNS**: What concerns do you have regarding the condition? How serious do you think it is? What potential complications do you fear? How does it interfere with your life or your ability to function? What are your concerns regarding the recommended treatment?

Title VI of the federal Civil Rights Act of 1964 declares that no one in the United States can be excluded from participating in, or denied benefits of, any program or activity receiving federal financial assistance on the grounds of race, color, or national origin, which has been interpreted by courts to include an individual’s primary language (Perkins & Youdelman, 2008; Perkins, Youdelman, & Wong, 2003). Subsequent presidential executive orders have required federal agencies and federally funded programs to provide “meaningful access” to LEP individuals (Kao & Jansson, 2011). Many states have enacted statutes and regulations that also require provision of translation services to LEP people. Accreditation standards of hospitals and clinics require the use of translation services, and in 2010 the ACA mandated collection of more data on race, ethnicity,
gender, primary language, disability status, and underserved rural populations in health settings.

Service organizations should use census materials as well as analyses of their clients to determine their ethnicity and other demographic characteristics. They should hire people from various backgrounds and provide in-service training in cultural competence.

**Core Problem 4: Developing Preventive Strategies to Decrease Social Problems**

Theorists have distinguished between primary, secondary, and tertiary prevention. Primary prevention seeks to prevent the emergence of specific social problems such as cancer, diabetes, truancy, and mental illness. Secondary prevention aims to identify and treat specific problems early in their development, such as by slowing their progress or by curing them—for example, by helping someone slow the progress of his early-stage diabetes. Tertiary prevention has the same goals as secondary prevention, but for more advanced problems, such as helping someone slow the progress of an advanced medical or mental health problem.

Primary and secondary prevention often receive insufficient priority in health and human services. Providers are often diverted to people with advanced and serious problems due to their sheer number and the cost and time required to help them. People often find it difficult to modify lifestyle preferences that cause them to develop social problems, such as poor diet, lack of exercise, substance abuse, and smoking. Health insurance companies often do not fund preventive services at all—or they do so at lower rates than the actual cost of surgery and medications. Tobacco, industrial, and food interests have slowed or blocked policies related to smoking, pollution reduction, and food labeling. Elected public officials often focus on short-term policies rather than long-term preventive ones. They often slash funding for prevention during budget crises and recessions.

Researchers have made considerable progress in identifying promising preventive strategies. They identify “at-risk indicators” that allow them to predict with considerable accuracy who will and will not develop specific problems in future years, that is, “true positives.” (At-risk indicators may include poor habits like smoking, low income, poor diet, obesity, poor lifestyle decisions such as inadequate exercise, abusive treatment by parents, poor education, genetic factors, and many other variables.) Their predictions are limited, however, in that some people who are predicted to develop a specific problem do not (false positives) while others predicted not to develop a problem actually do (false negatives).

We can distinguish between passive prevention and active prevention. Passive prevention seeks to change the human environment so that people are less likely
to develop diseases like lung cancer without requiring individuals to modify their behaviors. When pollution is reduced in the air and water, for example, people achieve health benefits without taking action themselves. By contrast, active prevention succeeds only when individuals take specific actions, such as changing their diets or engaging in more exercise. They often have to work with other people to prevent a problem, such as by participating in a 12-step program to prevent substance abuse.

Policy advocates work on many levels to advance prevention. They convince organizations to fund and implement prevention programs. They convince legislators and government officials to develop regulations and enact statutes that promote prevention. They work with the mass media to publicize effective preventive strategies. They work with researchers to obtain evidence that specific preventive strategies are effective and cost-effective. They convince administrators and public officials to prioritize prevention—and to fund it adequately.

Core Problem 5: Improving Affordability and Access to Social Programs

People often encounter specific or multiple barriers to accessing services. They often find they cannot afford them, endure excessive waits, encounter complex and time-consuming eligibility processes, find services to be geographically distant, or possess health or mental health problems that make travel difficult. Accessibility may be hindered, as well, by a lack of advertising or publicity for specific services so that many people do not know they exist.

People in the United States pay greater out-of-pocket costs for health and human services than people in Europe and Canada, where governments foot a greater share of their costs. Even the ACA will leave about 16 million Americans uninsured in 2020. Many other services and programs require substantial payments from consumers, including most childcare and preschool programs, many medical services, many mental health services, and most postsecondary education programs. The inequities are often glaring: Affluent Americans often gain greater access to services and opportunities because they can afford out-of-pocket costs, unlike many low- and moderate-income individuals, who often refrain from using services or discontinue them prematurely. Out-of-pocket payments take many forms, including deductibles, payment for services excluded from coverage by insurance companies, fees for excluded or noncovered services, and sliding fees that adjust fees upward as personal income increases. These fees can cause hardships for people with low and moderate income, not only impeding their access to services but also decreasing their ability to pay rent, purchase food, or purchase medical and other kinds of care.
Many services require excessive waits, such as emergency rooms in many hospitals, public health and mental health clinics, substance abuse treatment programs, and subsidized housing. People who decide to seek help for substance abuse problems often encounter waits of six months or more. Waits often lead consumers to exit services even when they need them, such as when people prematurely leave emergency rooms.

Health and human services are not distributed equitably across the American landscape but are disproportionately located in relatively affluent areas, because organizations and professionals often seek locations where people are more likely to pay their fees. Individuals who cannot afford cars, cannot afford gasoline, lack public transportation, or cannot easily seek services during working hours find it particularly difficult to access services and programs not located in their communities.

Policy advocates can decrease the cost and increase the accessibility of services and programs. They can propose changes in the fee structures of public programs, such as upward changes in their eligibility levels, inclusion of excluded services, and reduction of deductibles and copayments. They can pressure public agencies to make services more accessible in underserved areas. They can persuade agencies to establish outreach programs or storefront programs for people in underserved areas. They can station services in other agencies, such as in libraries, hospitals, or schools. They can establish outreach programs to homebound individuals. They can downsize their central or largest programs as they move staff and resources to smaller programs. They can publicize their programs by targeting messages to media, churches, libraries, or social media used by specific segments of the population.

Core Problem 6: Increasing the Scope and Effectiveness of Mental Health Programs

Many Americans have serious undetected health and substance abuse problems. These problems may be “hidden” because they are not the presenting problems when people use medical and other agencies. Many people do not volunteer that they have these problems due to the stigma often attached to them. Mental health or substance abuse problems may be caused by other social problems, such as experiencing foreclosure, performing poorly in school, or losing work.

Mental health services are often inadequately provided in settings beyond clinics and institutions that focus on them. Roughly 44% of males and 61% of females in federal prisons possess serious mental problems, but they often receive no, little, or substandard care for them. Primary care physicians provide the largest quantity of mental health services in community settings, but they
often have little mental health training and are not usually supervised by mental health specialists. Publicly subsidized mental health clinics exist, but they often have insufficient resources despite funding from local, state, and federal governments; reimbursements from private insurance; funding from Medicaid and Medicare; and client fees.

Unlike physicians, the dominant providers in the healthcare system, many professionals provide mental health services, including primary care physicians, psychiatrists, psychologists, social workers, marriage and family counselors, and psychiatric nurses. Social workers provide more mental health services than members of any other mental health profession.

Mental health staff are often not present, or only peripherally present, in many settings where people present their mental health problems. Employee Assistance Programs (EAPs) provide mental health services in some corporate settings but reach only a small fraction of American workers. School systems employ relatively few social workers and psychologists despite the sheer number of students with depression, anxiety, autism, attention deficit disorder, and behavioral problems. Many hospitals and clinics employ relatively few social workers and psychologists. Mental health services are chronically underfunded in the United States, both for outpatient care and institutional care that is still needed for suicidal individuals and people who may present a threat to others.

Access to mental health services greatly increased after the enactment of the Mental Health Parity and Addiction Equity Act of 2008, which requires employers offering group health insurance plans to their employees to include coverage for mental health services. The ACA also requires private insurance companies as well as Medicaid and Medicare not to discriminate against mental health services relative to services for physical problems. Many state and federal laws protect the rights of people with mental and substance abuse problems, such as by protecting the confidentiality of patients’ records, requiring legal counsel to represent individuals who are subject to involuntary commitments, and requiring conservatorship for people with serious cognitive deficits.

**Core Problem 7: Making Social Programs More Relevant to Households and Communities**

Assume a person receives care for a mental or physical problem in a clinic or hospital, but her providers are unaware of her home and community environment. Unable to obtain medications and food in her neighborhood because she lacks transportation and is barely ambulatory, she dies from inadequate nutrition—a problem that might have been avoided had professionals enrolled her in services offered by visiting nurses as well as Meals on Wheels.
Several strategies can improve the linkage of services to consumers’ households and communities. Agencies can establish contracts or agreements with community-based agencies that provide specific services, such as from visiting nurses, case managers, transportation services, and many other agencies. Agencies can establish formal collaborations with one another to provide needed services to clients. Innovative electronic systems can be used to monitor and educate home-based individuals with disabilities, chronic diseases, and other conditions.

The ACA is increasingly vesting specific hospitals and clinics with the total care of their clientele in so-called medical homes. These hospitals and clinics are penalized if their discharged patients return to inpatient care or emergency rooms within 30 days after receiving surgeries, providing them with incentives to give patients home-based services.

The ADA requires public housing and other housing agencies to provide accommodations to people with disabilities.

RECOGNIZING THE SEVEN CORE PROBLEMS IN EIGHT POLICY SECTORS

In Chapters 7 through 14, we discuss how these seven core problems manifest themselves in each of the eight policy sectors. In healthcare, for example, specific patients’ ethical rights are sometimes violated when they do not give their “informed consent” to specific medical procedures at the level of an individual or family (Core Problem 1). In the child and family sector, children with specific mental conditions sometimes do not receive evidence-based care at a child or family level, such as when professional staff members do not diagnose clinical depression or anxiety (Core Problem 2). Mental health staff may fail to give specific clients culturally competent care, such as when they do not adapt their services to the cultural needs of Latinos, who often want family members to be present during counseling sessions (Core Problem 3). In the gerontology sector, some elderly people do not receive preventive care from health providers for early-stage chronic diseases such as congestive heart failure (Core Problem 4). Many individuals cannot afford healthcare in the United States due to lack of insurance coverage, a situation that was partially addressed when the Affordable Care Act of 2010 was enacted (Core Problem 5). The mental distress of many prisoners is inadequately addressed in many prisons and correctional facilities (Core Problem 6). People who receive services from agencies in the gerontology sector often receive insular care not connected to their households and communities (Core Problem 7).
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UNDERSTANDING THAT SOCIAL WORK’S CODE OF ETHICS REQUIRES ADVOCACY

Micro policy advocacy, mezzo policy advocacy, and macro policy advocacy are interventions that allow social workers to adhere to the NASW’s Code of Ethics, which requires social workers to engage in “social and political action” (NASW, n.d., Section 6.04):

(a) 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 and to develop fully. Social workers should be aware of the impact of the political arena on practice and should advocate for changes in policy and legislation to improve social conditions in order to meet basic human needs and promote social justice.

(b) Social workers should act to expand choice and opportunity for all people, with special regard for vulnerable, disadvantaged, oppressed, and exploited people and groups.

(c) Social workers should promote conditions that encourage respect for cultural and social diversity within the United States and globally. Social workers should promote policies and practices that demonstrate respect for difference, support the expansion of cultural knowledge and resources, advocate for programs and institutions that demonstrate cultural competence, and promote policies that safeguard the rights of and confirm equity and social justice for all people.

(d) 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, age, marital status, political belief, religion, or mental or physical disability.

Social workers implement this Code of Ethics whenever they engage in micro, mezzo, and macro policy advocacy. They help people obtain rights, services, benefits, and opportunities that they might not otherwise obtain through micro policy advocacy. They advance the well-being of individuals, families, and communities when they engage in mezzo or macro policy advocacy to reform dysfunctional policies through social and political action. Social workers often prioritize the needs of vulnerable populations when they engage in advocacy.
DEFINING “SOCIAL POLICIES”

We define social policies as “collective strategies to prevent and address social problems.” They are “collective” because they are binding on those individuals, populations, communities, companies, and jurisdictions to which they apply. For example, when Congress enacts and the president signs a statute such as the ACA, individuals, health providers, states, and others must adhere to its provisions under penalty of law because statutes are binding laws. They can challenge provisions of a federal law, such as the ACA, through the courts, but must adhere to relevant court rulings. When a state declares the growing and distribution of marijuana to be legal under certain circumstances, it allows growers and distributors to engage in this practice “under certain circumstances,” such as for medical purposes—provided that officials in the federal government, which has its own laws that pertain to marijuana, allow people in a state to grow and distribute this drug.

Many kinds of social policies exist:

- **Constitutions** define the social policy powers of government at the federal and state levels. The failure of the federal Constitution to enumerate social welfare functions for the federal government was originally interpreted to mean that such functions should be left to state and local governments and to the private sector. As a result, the development of social welfare policies in this country was seriously delayed. States, too, possess constitutions that establish important duties of state governments, as well as how they govern themselves.
- Some social welfare strategies involve **public policies**, laws enacted in local, state, or federal legislatures. The Chinese Exclusion Act of 1882, the Social Security Act of 1935, the Adoption Assistance and Child Welfare Act of 1980, the Americans with Disabilities Act of 1991, and the Affordable Care Act of 2010 are examples of public laws, as are the state and local laws that established poorhouses and mental institutions in the 19th century.
- **Court decisions** play an important role in American social policy. By overruling, upholding, and interpreting the federal and state constitutions, statutes of legislatures, ordinances of local government, and practices of public agencies such as mental health, police, and welfare departments, courts establish policies that significantly influence the American response to social needs. For example, in the 1980s, the courts required the Reagan administration to award disability benefits to many disabled individuals even though many administration officials opposed this policy.
- **Budget and spending programs** are also an expression of policy, as are the budget priorities established by the nature of budget allocations and tax policies. For example, Americans chose not to expend a major share of the gross
national product on social programs prior to the 1930s but greatly increased levels of spending in the Great Depression and succeeding decades. Despite the large increases in spending on social programs in the 1960s and the 1970s, for example, the nation chose to devote a significant portion of its federal budget to military spending during the Cold War and also to make successive tax cuts—policies that much reduced the resources available for social programs.

- **International treaties, as well as policies of the United Nations**, govern an array of economic, social, migration, environmental, and national security issues in an era of globalization.

- **Stated or implied objectives** also constitute a form of policy. For example, the preambles and titles of social legislation suggest broad purposes or goals. Thus, as its title suggests, the Personal Responsibility and Work Opportunity and Reconciliation Act that Bill Clinton signed in August 1996 emphasized rules and procedures for getting welfare recipients off welfare rolls rather than providing training, education, or services.

- **Rules, procedures, and regulations** define the ways in which policies are to be implemented. Legislation often prescribes, for example, the rules or procedures to be used by agency staff in determining applicants’ eligibility for specific programs. Courts often prescribe procedures that the staff of social agencies must employ to safeguard the rights of clients, patients, and consumers; the protections afforded to people who are involuntarily committed to mental institutions provide an example here. Government agencies issue administrative regulations to guide the implementation of policies—regulations that have the force of law.

- **Informal policies** as compared to **written or official policies** are subjective views of individuals and groups that influence whether and how they implement specific policies. If we want to know how the poorhouses of the 19th century worked—or how social agencies have implemented the ACA—we have to examine how their staff implemented formal policies that were given to them by legislatures and public officials. Informal and formal policies sometimes work in tandem, such as when the line staff of agencies fully understand and agree with official policies. They sometimes clash, however, when staff do not fully implement official policies because they disagree with them.

Social policy surrounds and envelops social workers, as well as the people and communities that they help, at virtually every point in their professional work. It describes the benefits their clients can receive from many social programs—whether material benefits from programs like SNAP or services from mental health, vocational, or education programs. It describes their clients’ rights through regulations, legislation, and court rulings. It gives opportunities to their clients,
such as educational, preschool, and vocational programs. It provides Americans with tax benefits that help them purchase homes and accumulate savings. It gives civil rights to people of color, women, and disabled individuals. It provides preventive services, such as primary care medical services and nutritional benefits to pregnant women. It helps people survive disasters like floods, hurricanes, and tornadoes. It funds social programs. It determines the purpose or mission of specific social programs and agencies.

Social policy shapes the nature of society itself. It helps to determine, for example, the extent of inequality in a community, state, or nation. If the nation fails to fund education, social programs, and safety-net programs, it decreases the chances that low-income people can improve their lot. If the nation gives affluent individuals tax breaks, it increases the odds that they will retain their dominant economic position. If a state possesses inferior vocational and job-training programs, low-income individuals will find it difficult to improve their economic standing.

Policies are vertically distributed at the federal, state, and local government; community; and agency or organizational levels. The federal government funds myriad entitlements, such as Social Security, Medicare, and Medicaid. It funds many means-tested programs like SNAP (food stamps) and the Supplemental Security Income (SSI) program. It funds the Earned Income Tax Credit (EITC) that gives tax rebates to many families. It funds hundreds of smaller programs through its annual budget, such as health prevention programs, Head Start, and block grant programs that give funds to states for mental health, childcare, and many additional programs. The U.S. Justice Department and the federal Equal Employment and Occupational Commission (EEOC) monitor violations of civil rights and take corrective action. The federal government funds the bulk of the American welfare state because its resources from the federal tax system and other kinds of taxation far exceed the resources of the states.

State governments often share the cost of public education with the federal government, covering only 10% of the cost themselves. They also share the costs of the nation’s huge correctional system, including prisons, parole departments, and local police—save for federal prisons and federal law enforcement through the Federal Bureau of Investigation (FBI) and other federal police functions. States often fund many public health programs. They often inspect health facilities, such as hospitals, clinics, and nursing homes. States have been given many additional roles in overseeing the health system under the ACA. (Considerable variation exists between states regarding which policy functions reside at state versus local levels and the extent to which states and local governments share policy responsibilities and costs.) States provide direction for child welfare, mental health, public health, and other public systems of care. They often are conduits for federal
resources that they supplement with their own funds. They set standards for many public services provided by counties and municipalities. State governments contribute significant resources, as well, to social programs and policies. They cofund such programs as Medicaid and other federal–state programs. They establish and fund many of their own programs, such as public health programs that provide health clinics to low-income areas and inspect food facilities for safety.

Local governments determine how land can be used in their jurisdictions through zoning and tax policies. They determine if specific social agencies, such as halfway homes for people released from state mental health facilities, can locate in specific areas. They provide police and fire services. Cities and counties raise taxes and decide how to use tax revenues, such as for police and fire services, schools, recreation programs, and social service programs. They orchestrate many housing programs. County or municipal agencies distribute welfare benefits to people under the Temporary Assistance for Needy Families (TANF) program and general assistance programs. Many counties and cities administer public systems of healthcare as well as assume important roles in child welfare, mental health, and many other social programs.

Public organizations are largely funded by local, state, and federal governments to implement programs defined by public statutes. They have considerable leeway, however, in making implementation decisions. Not-for-profit agencies, which are exempted from paying taxes by local, state, and federal governments, raise their own resources from public and private sources as well as from fees paid by consumers of their services. They select a mission that shapes what programs they will fund by grants from public agencies, consumer fees, or resources from private donors. They hire staff to implement these resources. For-profit organizations and agencies have owners or shareholders who seek profits in the marketplace. For-profit agencies provide a wide array of social services, such as childcare, nursing home care, job training, education, and other services—and sometimes receive contracts from public authorities to implement welfare, correctional, educational, and other services.

**JOINING THE REFORM TRADITION OF SOCIAL WORK**

Social work has a social reform tradition extending back to the formation of the social work profession. Such founders of social work as Jane Addams militantly supported an array of social reforms in the Progressive Era at the beginning of the 20th century, including housing codes to protect tenants, governmental inspection of food to avert illness, factory regulations to protect workers, and pensions for single mothers with children to avert dire poverty (Jansson, 2014; Wenocur & Reisch, 1989).

In succeeding eras, many social workers joined this reform tradition by working for policy reforms in local, state, and federal jurisdictions. Their work was
bolstered by numerous theorists who developed a systems or environmental perspective on human behavior, arguing that social inequality, blighted neighborhoods, inadequate resources, unemployment, environmental pollution, discrimination, and economic uncertainty cause human suffering and contribute to clinical conditions such as depression and poor health (Germain & Gitterman, 1980; Meyer, 1970).

Honest differences of opinion often exist among social workers. We may disagree about the merits of specific policies. We may support different political candidates. We may draw upon conflicting research findings to support our preferred policies. Yet we are linked by a shared commitment to social justice even as we may differ about how best to advance it.

In this book, you will learn about scores of social policies in the eight policy sectors. You need to know about them because you will often refer clients or patients to them and would be derelict if you were not familiar with them. This book provides an empowerment and advocacy approach to social policy that facilitates your personal involvement on multiple levels. It encourages you to:

- Examine your values and personal perspectives, since they shape how you relate to controversies in American society regarding social policy
- Understand NASW’s Code of Ethics as a foundational statement about ethics developed by and for social workers
- Understand and work to reduce the marginalization of many vulnerable populations in the United States and abroad by engaging in policy advocacy
- View social policy from an empowerment perspective so that you participate in it at multiple levels, including helping specific clients and patients to obtain rights, benefits, services, and opportunities to which they are entitled (micro policy advocacy) and reforming social policies in organizations, communities, and government settings (macro policy advocacy)
- Seek out information on the Internet while remembering that accuracy varies from site to site
- Learn about advocacy groups that work toward creating more just and equitable policies

**LEARNING OUTCOMES**

You are now equipped to:

- Identify eight policy sectors
- Identify similarities and differences between micro policy advocacy, mezzo policy advocacy, and macro policy advocacy
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- Define seven core problems that cut across the eight policy sectors
- Identify provisions of the Code of Ethics of the National Association of Social Workers that require social workers to engage in policy advocacy
- Define and identify a variety of social policies as well as their location in the American welfare state
- Identify the reform tradition of the social work profession

REFERENCES