Policy advocacy is a skilled intervention, whether it takes place at the level of individuals (micro policy advocacy), at the level of organizations and communities (mezzo policy advocacy), or at the level of governments (macro policy advocacy). We discuss each level in this chapter. We discuss each of them in more depth in Chapters 4, 5, and 6, respectively. We illustrate each of them in the eight policy sector chapters.

Using a Multilevel Policy Advocacy Framework

A multilevel policy advocacy framework is presented in Figure 3.1, which portrays micro, mezzo, and macro policy advocacy. Advocates at each of these levels:
• engage in eight challenges, 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 people individually (micro policy advocacy) or collectively (mezzo policy advocacy and macro policy advocacy) surmount the seven core challenges discussed in Chapter 1, including by 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

Figure 3.1 A multilevel policy advocacy framework
Advocates at the micro, mezzo, and macro levels undertake eight tasks, including determining whether to proceed (Challenge 1), determining where to focus (Challenge 2), obtaining recognition that a client has an unresolved problem from other staff in an agency (micro policy advocacy) or securing decision makers’ attention for a policy issue or problem (mezzo or macro policy advocacy; Challenge 3), analyzing or diagnosing why a client has an unresolved problem (micro policy advocacy) or why a dysfunctional policy has developed (mezzo or macro policy advocacy; Challenge 4), developing a strategy to address a client’s unresolved problem (micro policy advocacy) or a proposal to address a policy-related problem (mezzo or macro policy advocacy; Challenge 5), developing support for their strategy to resolve a client’s unresolved problem (micro policy advocacy) or to enact a policy proposal (mezzo or macro policy advocacy; Challenge 6), implementing their strategy (micro policy advocacy) or their enacted proposal (mezzo or macro policy advocacy; Challenge 7), and assessing whether their implemented strategy (micro policy advocacy) or enacted policy has been effective (mezzo or macro policy advocacy; Challenge 8).

Advocates use four kinds of skills as they undertake these challenges—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 individuals to be their own advocates whenever possible, while realizing that some people need some or considerable assistance.

- **Political or influential skills** to surmount the disinclination of specific individuals to agree with specific policy advocacy initiatives at the micro, mezzo, or macro level. Resistance to changes sought by advocates can be mild or intense, as illustrated by the opposition of many conservatives to President Obama’s Affordable Care Act (ACA)—and subsequent attempts by many attorney generals 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 individuals, such as appealing the denial of eligibility to a program by a government official during micro policy advocacy, or developing policy proposals during mezzo and macro policy advocacy.

- **Interactional skills** to communicate effectively to persuade others to take specific actions. Advocates must decipher the motivations of other people so that they can speak to their concerns, decrease their anger, and appeal to their values. They must work in and with task groups often formed during advocacy projects.
Providing Policy Advocacy at Three Levels

Advocacy interventions occur at the micro, mezzo, and macro levels. Let’s discuss each of these levels. Social workers engage in micro policy advocacy when they advocate for specific individuals or families to help them obtain services, rights, opportunities, and benefits that they would (likely) not otherwise receive and that would advance their well-being. 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 on their child, 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 is 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 individuals.
- 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 the woman of her husband’s legal rights and, when no improvement occurs, refers the case to an agency that investigates cases of elder abuse.

We define micro policy advocacy as interventions to help clients obtain services, rights, and benefits that they would (likely) not otherwise receive and that would advance their well-being. We discuss it more fully in Chapter 4.

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 statements 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, so a mezzo policy advocate informs the physician that she is required by federal law to provide translation services.
• Because a health clinic does not use a team approach when helping people 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 brings evidence-based literature to her supervisor, providing data showing that team-based treatment of diabetes is more effective than traditional care delivered by multiple physicians who do not communicate with one another. Her supervisor, in turn, takes that recommendation to higher levels of the health clinic with the goal of obtaining high-level support for the team approach.

Social workers engage in *mezzo policy advocacy at the community level* when they seek to change dysfunctional policies in specific communities. Such policies might include funding, zoning, and land-use planning decisions; the policies of community-based public agencies; and policies that address the allocation and training of first responders in police and other agencies, community social and other services, housing inspections, and repair 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 their disproportionate location in low-income areas. Alarmed about high rates of obesity in these low-income areas, an 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 people is jeopardized by the failure of a specific city to monitor and enforce housing regulations for their apartments. An 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 policy advocacy 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 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 level sufficient to reimburse the full costs of this care (the current level reimburses them for only 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 people with mental health problems in the state.

A state chapter of the National Association of Social Workers (NASW) endorses candidates who endorse the chapter’s policy and budget priorities—and gives them resources to help fund their campaigns.

We discuss macro policy advocacy in more detail in Chapter 6.

IDENTIFYING DIFFERENCES BETWEEN ADVOCACY AND CLINICAL COUNSELING

It is useful to contrast advocacy with clinical or counseling practice in social work. Clinicians do not usually view themselves as advocates because they focus on helping clients improve their mental condition within the counseling relationship by addressing personal emotions, beliefs, and actions. By contrast, advocates help individuals, families, and communities deal with external providers, institutions, laws, and policies. Clinicians often seek internal changes in their clients, such as by helping them resolve conflicts, develop personal strategies, and surmount fears. Advocates, by contrast, focus on ways to persuade, entice, or coerce external entities to give needed amenities to specific individuals, families, or populations. Clinicians do not usually view themselves as representing clients or populations as they deal with service providers or governments, since they often focus on transactions and verbal interchange with clients themselves. Advocates often work for or on behalf of clients or populations. Advocates also often help individuals, families, or populations to obtain skills that enable them to advocate for themselves at the micro, mezzo, or macro levels.

LINKING THREE LEVELS OF ADVOCACY: THE CASE OF PREGNANT TEENS AND TEEN MOTHERS

Social workers sometimes move between 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.
Providing Micro Policy Advocacy for a Pregnant Teenager

According to California Women’s Law Center, California has the second highest rate of teen pregnancy in the nation (www.cwlc.org), and although many school-based programs aimed at addressing teen pregnancy have been successful in reducing early childbearing, schools have often neglected the rights of teens who are pregnant or choose to parent.

My placement of internship is at an urban hospital. A part of my duty as a social work intern at the hospital is to meet with moms who are 17 years old and under to assess their needs and offer them support and resources. When I intervene and assess teen pregnancy, I normally ask the moms questions related to their relationship with the father of the baby, their family background, their support system, their emotional status, their substance abuse history, their education, current resources that they are receiving, and so forth.

Before my internship, I did not have much interest in teen pregnancy and was not aware of the seriousness of the situation. Surprisingly, there are at least three to five teen pregnant patients per week coming to the hospital for labor and delivery. Not all, but a great number of them, are Latinas from low-income family. Many of them and/or their parents are undocumented immigrants, have low education, and work two to three different jobs to support their family.

Even more surprisingly, many teen moms report that they were not aware of their pregnancy until they were four to five months pregnant. Others who have sexually transmitted infections (STIs) report that their schools did not teach them about any risks factors associated with unprotected sexual activities, contraceptive use or methods, or preventive care in general. Not only that, but many teen moms also report that they did not seek help or obtain prenatal care because of their family’s legal status and their own confidentiality needs.

Among many stories of these teen moms, one in particular caught my attention. Annette is a very cute, smart, and dedicated 16-year-old teen mom. During teen pregnancy assessment, she reported to me that she usually gets up at 6:30 every morning and catches two buses to go to a continuation school because of her current situation: her tummy started showing, and her “normal” school not only did not provide her any support, but also suggested that she go to a special school for pregnant teens. Sometimes Annette misses continuation school because it is a burden and tiring for her to wake up early in the morning and catch two buses to go to the school. She went on to say that a girl from her school was also transferred to the continuation school just days before her graduation, apparently to spare the school the embarrassment of having a pregnant girl stroll across the stage in cap and gown

(Continued)
before hundreds of onlookers. This report was very alarming to me. The decision of these teens to leave their old school to attend a special program for pregnant and parenting teens was virtually automatic for them.

When I asked Annette about her education plan after recovery from labor and delivery, she replied as follows: “I’m planning to go back to the continuation school because of my current situation, but I wish I could return to my ‘normal’ school because at a regular high school you learn more.” Even though she believed the parenting classes were good at the continuation school, she worried she was not learning the right things. Annette stated that a lot of the girls at the continuation school were scared about passing the high school exit exam. One of the pregnant teens had taken the test earlier that week, and she did not understand much of what was on it. Annette told me, “They don’t teach you the kind of math they give you on the test. We’re not going to pass that.”

**Identifying a Micro Advocacy Situation**

Even though both federal and state laws guarantee pregnant and parenting teens equal rights and opportunities in all public and private educational institutions (www.cwlc.org), apparently some schools still pressure or force pregnant and parenting teens to leave regular high schools for some kind of continuation school. These teens lose their legal right not only to an equal education but also to the goodies that go with it: college entrance assistance, advanced-placement classes, and the experience of being at a high school with kids who are not pregnant or being punished for school infractions.

Alternative schools, such as the ones most pregnant girls are being sent to, are by law voluntary (www.cwlc.org), but many girls and parents do not seem to know this. Furthermore, Title IX of the federal Education Amendments of 1972 and the California Education Code outlaw all forms of discrimination by public schools on the basis of sex (Findlaw, n.d.), which can be applied to pregnant teens.

I think there is a general lack of respect for pregnant and parenting teens in many schools. They have discriminated against pregnant and parenting teens by not allowing them to have the equal rights and opportunities available to them. They have not given them proper information and options and have failed to provide comprehensive sex education to prevent pregnancy. Even Annette, who appears to be a bright student, reports that she did not know about risk factors, the importance of contraceptive use, and how to access reproductive health care services.

If schools keep discriminating against pregnant and parenting teens, they are sending the message that pregnancy is a bad thing. Some girls may resort to abortion so that they do not embarrass or disappoint their school and family. Others may end up with serious health problems because of the lack of support and preventive care. In
my opinion, a pregnant teen is no worse a role model than the teen who is sexually active and just not getting pregnant. Getting pregnant does not make someone any different from anybody else who is having sex. It is a visual reminder that this can happen to anyone, and it can be a practical lesson to others. It is important to provide all students with equal rights, more support, preventive health care, and, most important of all, comprehensive sex education.

**Interacting With the Patient and Diagnosing Causes**

Even though Annette’s biggest concern was about her education, I found several other problems and barriers in her life. She was the oldest daughter among three siblings and took the responsibility to help her mother with house chores because her mother worked two jobs, even on weekends, to support the family. Her mother was a single mom, an undocumented immigrant from Mexico who spoke very limited English and did not have any other family members or relatives in the United States whom she could rely on. Fortunately, Annette’s two younger siblings were old enough to take care of themselves.

Annette dedicated herself to her schooling and activities because she did not want to become like her mother. Her goal was to study hard, go to a college, get a stable job with benefits, and make a lot of money. However, her goal and dream started fading when she found out she was pregnant. She did not tell anybody at school because she knew that she would be sent to a special school for pregnant teens. She knew about the school “policy” because of her experience with a girl who had been sent to a continuation school days before her graduation. Also, Annette was afraid to ask for federal or community assistance and support to receive prenatal care because of her family’s legal status. She was afraid that her family might get deported to Mexico if she received federal assistance such as Medicaid.

Annette’s luck with hiding her pregnancy did not last long. Her tummy started showing and became noticeable enough for anybody to tell that she was pregnant. A school counselor called her and her mother to have a private conference with them. The counselor suggested that Annette leave the school for a continuation school for teen moms. She told them about benefits Annette could get from the continuation school, but she did not explain to them that it was just an option for her. Annette and her mother thought it was the school’s policy and that they had to follow it.

**Developing a Strategy**

Annette had many barriers in her life, but she also had a big asset that helped her to overcome in her situation. This asset was her intelligence and desire to pursue higher education. My foremost desired outcome for Annette was for her to claim her right

*(Continued)*
to go back to her normal high school to receive regular education. Also, I hoped she could find childcare for her baby through community programs, because she did not have any family members who could assist her with childcare while she went to a normal school. Then, my goal was to encourage her to attend parenting and family planning classes as well as to receive comprehensive sexual education. This way she would be able to get assistance and support while attending normal school and learn to take responsibility for her actions.

As a mandated reporter, my obligation was to include Child Protective Services (CPS) in my advocacy interventions procedure. I discussed Annette’s case with the CPS worker and asked the worker to follow up on her and her baby’s safety and care. The CPS worker stated that she would investigate Annette’s home and school situation, and in the event of any type of abuse or neglect, she would follow up and provide Annette with additional support and resources.

After the report had been made, I educated Annette about the different resources available to her. I reassured her that she and her family would not get deported to Mexico just because she was receiving federal and community assistance and services. After the reassurance, I carefully explained the CPS report as well as the role of CPS and the services they offered. Then, with Annette’s consent, I called a Bridges Program, a community resource program located in the hospital building, to help her and her baby receive Medicaid for medical insurance; the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), which would supply nutritious food for her and her baby; additional formula; diapers; and an infant car seat for the baby. Also, I sent a referral to public health nurse (PHN) services so that they could follow up with Annette on a regular basis regarding baby care, parenting, and health education after hospital discharge.

Furthermore, I encouraged Annette to contact the community Teen Mothers Resource Center, which provides teen moms with case management, financial assistance, teen moms support groups, childcare, parenting classes, and so forth, regardless of one’s legal status. I also provided her with information on the California Women’s Law Center, along with information about her civil rights in a California school. I encouraged her and her mother to advocate for her rights and services in school. I advised to call the Women’s Law Center or visit the Internet sources for additional information about her rights in school.

Implementing the Strategy

Most of the advocacy interventions for Annette were skillfully implemented. CPS responded to my call and confirmed they would investigate and follow up on her case. The Bridges Program and PHN services were put in place to provide her and her baby with support, education, and resources. Also, she and her mother received
information about community services and the California Women’s Law Center, and they were eager to follow my advice.

All the above information and resources assisted Annette with her basic needs and empowered her to fight for her rights. Unfortunately, I was not able to see my foremost desired outcome, which was for her to be able to attend a normal school after recovery, because of my internship setting and protocols. My interventions for her were the work of planting seeds. I just hope that she was able to find her rights in school with the help of CPS and other services.

Policy, Program, and Community Reforms

Studies repeatedly show that insufficient education helps perpetuate the cycle of poverty and teen pregnancy. The “No Time for Complacency” report (Constantine & Nevarez, 2006) released by Berkeley’s Public Health Institute states that teen moms exhibit poorer psychological functioning, lower levels of educational attainment and high school completion, more single parenthood, and less stable employment. Furthermore, a study reports that babies born to teens are more likely to have health troubles, exhibit poor school performance, and become parents themselves when they are teens (National Campaign to Prevent Teen Pregnancy, 2004).

After reading this case example, address the following questions:

• Which of the seven core problems was the social worker addressing in this case advocacy intervention?
• What contextual factors were liabilities that she had to deal with and surmount?
• What contextual factors were assets she could use to facilitate her work?
• Which of the eight challenges in the micro advocacy framework did she undertake?
• Which of the four skills did she use?

POLICY ADVOCACY LEARNING CHALLENGE 3.2

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 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 school have nurses on the premises who distribute condoms? Do schools inform teenagers that they can 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 so that students can obtain information about their options?

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

- Do social workers frequently engage in micro policy advocacy for pregnant adolescents to help them obtain their rights, suggesting systemic defects in organizational policies, such as prejudice by school staff against this population or a 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 in 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 a lack of guidelines from the school district, the state department of education, or the federal department of education to protect the teens’ rights to 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 Caucasian 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 3.3

## Moving Toward Macro Policy

### Advocacy to Help Pregnant High School Students

The United States has the highest rates of teen pregnancies of any industrialized nation, even though the pregnancy rate has markedly declined for teens ages 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 of clear state laws or federal policies. Some of them send them to continuation schools during their pregnancy, where they are separated from their friends, and do not invite them back to their regular school after 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. Various 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 provide 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 giving birth or after they give birth.

Nor is it clear to what extent some states fund special programs for pregnant teens and teen mothers. While 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 provisions.

Nor is it clear what budgetary and policy roles exist for school districts as compared to 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 on this issue in specific states?

These kinds of systemic policy factors can be addressed only 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 between micro policy advocacy, mezzo policy advocacy and macro policy advocacy.
DEVELOPING RED FLAG ALERTS

We now return to the seven core problems that we discussed in Chapter 1 that provide the reason why social workers engage in advocacy at three levels in the first place. We need to move beyond general descriptions of these seven core problems to identify specific manifestations or examples of them so that we can anticipate them.

Let’s illustrate the way social workers can develop Red Flag Alerts by taking an example of a recent research project I conducted with a research team. We wanted to know to what extent social workers, nurses, and medical residents engage in micro policy advocacy, mezzo policy advocacy, and macro policy advocacy in acute care hospitals. We generated a list of 33 specific manifestations of the seven core problems by consulting medical research and by enlisting the help of a panel of healthcare experts that included nurses, social workers, a physician, and a patient (see Table 3.1).

<table>
<thead>
<tr>
<th>Table 3.1</th>
<th>Twenty-Nine Manifestations of the Seven Core Problems in Acute-Care Hospitals</th>
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</table>

CORE PROBLEM 1: ETHICAL RIGHTS
Patients’ ethical rights may be at risk in the following areas:

1. Informed consent for medical intervention
2. Accurate medical information (e.g., risks, diagnosis, prognosis, discussion of treatment planning and timeline)
3. Confidential medical information
4. Advance directives
5. Competence to make medical decisions

CORE PROBLEM 2: QUALITY OF CARE
Patients’ quality of care may be at risk in the following areas:

1. Lack of evidence-based healthcare
2. Medical errors
3. Whether to have specific diagnostic tests
4. Fragmented care
5. Nonbeneficial treatment

CORE PROBLEM 3: CULTURAL CONTENT OF CARE
Cultural content of care may be lacking in the following areas:

1. Information in patients’ preferred language
Once we had identified specific manifestations of the seven core problems, we then asked roughly 100 social workers, 100 nurses, and 100 medical residents in eight acute-care hospitals to indicate the extent to which they had engaged in

| 2. Communication with patients with limited literacy or health knowledge |
| 3. Religious, spiritual, and cultural practices |
| 4. Use of complementary and alternative medicine |

**CORE PROBLEM 4: PREVENTIVE TREATMENT**
Preventive treatment may be lacking in the following areas:

1. Wellness exams
2. At-risk factors not addressed (e.g., smoking, obesity, lifestyle, substance abuse)
3. Chronic disease care
4. Immunizations

**CORE PROBLEM 5: AFFORDABILITY OR ACCESS TO CARE**
Affordability or access to care may be problematic in the following areas:

1. Financing necessary healthcare and medications
2. Use of publicly funded programs
3. Coverage from private insurance companies

**CORE PROBLEM 6: MENTAL HEALTH CONDITIONS**
Care for mental health conditions may be lacking in the following areas:

1. Screening for specific mental health conditions
2. Treatment of mental health conditions while hospitalized
3. Follow-up treatment for mental health conditions after discharge
4. Medications for mental health conditions
5. Mental distress stemming from health conditions
6. Availability of individual counseling and/or group therapy
7. Availability of support groups

**CORE PROBLEM 7: COMMUNITY-BASED HEALTHCARE**
Community-based healthcare may be lacking in the following areas:

1. Discharge planning
2. Transitions between community-based levels of care
3. Referrals to services in communities
4. Reaching out to referral sources on behalf of the patient, such as coordinating services, providing a warm handoff, and monitoring or assessing services
5. Assessment of home, community, and work environments
micro policy advocacy for their patients with respect to those problems during the prior two months. We discovered that many of these health professionals had engaged in micro policy advocacy regarding these specific manifestations of the seven core problems, even though considerable variation existed between them in terms of level of advocacy. We had successfully identified Red Flag Alerts that could help these health professionals anticipate these specific manifestations of the seven core problems in the hospitals where they worked. They could now look for them and, when possible, help patients solve these specific problems.

We also asked these providers to indicate the extent to which they engaged in mezzo policy advocacy and macro policy advocacy. They reported far less of these kinds of policy advocacy as compared to micro policy advocacy, possibly because their work focuses on helping specific patients with the kinds of problems listed in Table 3.1.

POLICY ADVOCACY LEARNING CHALLENGE 3.4

Identifying Red Flag Alerts in Specific Settings

Take any setting that provides human services with which you are familiar, whether your field agency or where you have volunteered or worked. Select any of the seven core problems that we discussed in Chapter 1 and that are listed in Table 3.1. Try to develop a list of one specific manifestation of each of the seven core problems listed in Table 3.1. Then ask a professional who works in the setting you have identified to discuss with you the extent to which these seven manifestations are relatively common in the setting. Also ask this professional to augment your list with several additional problems, and perhaps to delete one or more of the problems that you have identified.

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?
- To what extent did you use research findings, ethical principles, or pragmatic factors to develop these Red Flag Alerts?

DEVELOPING RED FLAG ALERTS AT THREE LEVELS

We have discussed how specific Red Flag Alerts can be developed in specific agencies. 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 documenting that many children are overmedicated for specific mental problems like autism, attention deficit hyperactivity disorder (ADHD), and behavioral problems. You could make this a micro policy Red Flag Alert falling under the sixth core problem (failure to address mental problems of clients): “Children may be overmedicated for behavioral or mental health problems, including autism, attention deficit hyperactivity disorder (ADHD), or behavioral problems.” Were you to work in a mental health or education setting, you would be alert to this issue and might launch a micro policy advocacy intervention to help the child’s parents obtain second opinions to ascertain if their child is overmedicated.

You could transform this micro Red Flag Alert into a mezzo Red Flag Alert or a macro Red Flag Alert by placing it in an organizational, community, or government context. Assume that many children may be overmedicated in a large school system. The micro Red Flag Alert can be changed to a mezzo Red Flag Alert: “Many schoolchildren who have been diagnosed with autism, ADHD, or behavioral problems have been overmedicated with respect to type of medication, number of medications, and dosage.” A social worker could consider launching a mezzo policy advocacy intervention, such as:

- Developing training programs to teach teachers, social workers, school counselors, school speech therapists, and other staff in a school district to recognize signs of overmedication
- Developing guidelines in the state’s board of education regarding overmedication of children

A social worker could contact a children’s advocacy group in Washington, DC, to see if specific regulations by the Food and Drug Administration (FDA) could be developed to regulate the use of medications with children under a specific age—much as the federal government is now attempting to limit prescriptions of pain medications that currently lead to preventable deaths. Of the 22,114 deaths related to pharmaceutical overdose in 2012, 16,007 involved opioid analgesics, also called opioid pain relievers or prescription painkillers (Centers for Disease Control and Prevention, n.d.). This could be a macro Red Flag Alert: “Many schoolchildren are overmedicated for autism, ADHD, or behavioral problems due to lack of federal regulations about the use of medications for these problems in children under a specific age.”
Other manifestations of the seven core problems can be obtained by consulting the Internet, such as by typing problems into online search sites such as Google Search, Google Advanced Search or Google Scholar, or Microsoft’s Bing. Assume, for example, that you wonder if you are likely to encounter malnutrition among schoolchildren in a particular low-income neighborhood. You can find information about malnutrition among low-income children generally or in specific regions. This information may not accurately predict or measure malnutrition in a specific geographic area or a specific school district, so you would need to interview or contact researchers with geographic-specific knowledge about childhood malnutrition.

Take a stab at obtaining information about one of the following problems—and deciding if it should be designated a Red Flag Alert. Identify where social workers might encounter individuals with these problems by sector and geographic area, as well as by the type of agency or hospital where they work.

• The extent to which veterans receive services for brain trauma or for mental problems
• The extent to which homeless people receive affordable housing
• The extent to which sufficient services are given to truants in schools
• The extent to which released prisoners receive assistance with finding employment

We use the term connected policy interventions to describe linked policy interventions. Social workers can begin with micro, mezzo, or macro policy intervention and then consider progressing to other levels. Assume, for example, that a local child welfare department receives many reports from neighbors, school officials, and others that they suspect that specific children have been abused or neglected by their parent or parents. Also assume that a social worker discovers that many of these children, as well as their families, possess serious mental health and substance abuse problems, even though child abuse and neglect are not discovered—and finds that her perceptions are supported by evidence-based research. Yet she finds that these children and their families receive no assistance from child welfare workers once they do not find evidence of abuse or neglect. The social worker may begin with a single child or family and work to get them supportive services from community agencies (a micro policy advocacy intervention), and then decide that the child welfare department should develop a policy to facilitate these referrals for many or all of these children (a mezzo policy advocacy intervention). Or perhaps the social
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worker could inquire whether child welfare regulations at the state level sufficiently mandate the provision of preventive services for children who are referred to child welfare departments, allowing her to determine whether she and others should launch a macro policy advocacy intervention to modify these regulations.

We will refer in this book to:

- Micro policy advocacy interventions
- Mezzo policy advocacy interventions
- Macro policy advocacy interventions
- Connected policy advocacy interventions

LEARNING OUTCOMES

You are now equipped to:

- Provide advocacy at the micro, mezzo, and macro levels
- Identify similarities and differences between these levels of advocacy
- Identify differences between policy advocacy and clinical counseling
- Develop Red Flag Alerts in specific settings
- Develop Red Flag Alerts at the three levels of policy advocacy in specific settings

REFERENCES


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