**Chapter 10: Becoming Policy Advocates in the Mental Health Sector**

***Policy Advocacy Learning Challenges and Exercises***

***Excerpted from the book***

**POLICY ADVOCACY LEARNING CHALLENGE 10.1**

**Connecting Micro, Mezzo, and Macro Policy Advocacy to Protect Patients’ Ethical Rights**

The following case story is quoted directly from Barrio and Yamada (2005).

Josie Mora, a 35 year-old woman, was diagnosed with schizophrenia (disorga­nized type) at the age of 22. Despite large doses of psychotropic medication, Josie exhibited disruptive and bizarre behavior, disorganized speech, inappropri­ate affect, and daily auditory hallucinations. For example, she called out to people using derogatory language, often falsely accusing them of trying to harm her. At home, she required constant limit setting as she would drink continuous pots of coffee and large amounts of soft drinks unless stopped. During the night she would get up several times to pace and clang pots and pans in the kitchen. As a result, she required ongoing supervision and was unable to participate in any psychiatric rehabilitation program activities offered at the mental health center.

The Mora family lived in the same community since they emigrated from Mexico over thirty years ago. The parents preferred to speak in Spanish, although they understood and spoke limited English. Josie preferred English, although Spanish was her first language. Josie lived at home and her parents were her primary caretakers. Several adult siblings and other extended family members lived in the same city and participated in Josie’s care. Mrs. Mora had not worked outside the home since the onset of Josie’s illness. During the day while Mr. Mora was at work, Mrs. Mora relied on a network of family and friends to help her with Josie, particularly whenever Mrs. Mora had her own medical appointments or needed to run certain errands. Eventually, Mr. Mora opted for early retirement from his factory job because he wanted to help his wife with Josie’s care.

Both parents always accompanied Josie to her medication management appointments and monthly meetings with a social worker. The Moras took turns sharing the highlights of the month regarding Josie’s behavioral outbursts, which generally involved family members, friends, and neighbors. Often they shared certain successful outcomes, like going to the park for a family gathering where Josie was able to tolerate being around many people without causing much disrup­tion. Because of her severe impairment and her extensive need for supervision, on several occasions the social worker gently raised the option of a board-and-care facility or other supervised residential care for Josie. The Moras considered the various options presented, but always expressed their willingness to accept their parental responsibility for Josie’s caregiving, and their great “hope” that Josie would get better. The Mora family wanted to raise enough money for a trip to Mexico City. They hoped to take Josie to a special church to receive a holy blessing that would lead to healing and possibly a miracle. Several years later Josie was pre­scribed a new atypical antipsychotic medication, and with additional rehabilitation she made a substantial improvement in her social functioning. The Moras expressed that this progress was more than they had “hoped” Josie would achieve.

**Learning Exercise**

1. How does the social work value of “self-determination” apply to this case example?
2. Does the social worker respect the values of interdependence and the family’s sense of hope?
3. What other advocacy actions could a social worker take to protect the patient’s ethical rights at the micro, mezzo, and macro levels? For example, do the laws of your state allow judges, under specific circumstances and safeguards, to require specific patients to take antipsychotic medications—and would you agree that this is ethical in these specified circumstances?

**POLICY ADVOCACY LEARNING CHALLENGE 10.2**

**Connecting Micro, Mezzo, and Macro Policy Advocacy to Advance Quality of Care**

Adams, LeCroy, and Matto (2009) believe that social workers do not share the medi­cal model philosophy of treatment (focusing on symptoms and diseases) that typi­cally underlies an EBP model because it may not reflect a sufficient focus on the individual and environmental factors that social workers view as essential to quality care. Consider an example of a discouraged and caring family who presents in treat­ment with a family member who has previously been diagnosed and treated for major depressive disorder and despite treatment motivation and adherence is currently so seriously depressed that he or she is unable to work or care for personal daily needs. The potential complexity in the case may not fit neatly into an EBP model.

**Learning Exercise**

Discuss the following questions posed by Adams, LeCroy, and Matto (2009):

1. How would a social work frame of reference—which includes the biopsychosocial model; the developmental stage of the person; cultural, spiritual and community factors; and the ecosystems context—assess and choose an EBP?
2. How might a social work frame of reference impact the assessment and treatment planning for this case?
3. How does the social work emphasis on the alliance or therapeutic relationship get incorporated into the treatment response?
4. What mezzo and macro policy advocacy interventions might social workers consider in these circumstances?

**POLICY ADVOCACY LEARNING CHALLENGE 10.3**

**Connecting Micro, Mezzo, and Macro Policy Advocacy**

Ensuring Culturally Competent Care

An 80-year-old Italian immigrant woman named Maria, who had lived in the United States for 60 years, arrived at an emergency room of a local hospital with her Italian friend and neighbor. She had fallen from her chair as she tried to pick up something that she had dropped, and as a result she cut her eyebrow on the edge of an end table. Her family was called, and when her daughter-in-law and adult granddaughter arrived, the daughter-in-law went with a nurse to fill out some paperwork and the granddaughter stood in the waiting room anxious to find out where her grandmother was and how she was doing. A resident emerged and told the granddaughter in a matter-of-fact tone that he did not have good news.

“Your grandmother has blood collecting in the sinus cavity above her eye, and it will eventually go to her brain and kill her.”

“Isn’t there anything that can be done?”

“Well, she’s very old and likely has a type of dementia, so I’m sure your family will not want to put her through surgery; her quality of life is already poor. What medical conditions does she have? How old is she?”

The granddaughter knew that her grandmother had no medical conditions and that the day before she had planted her garden and had eaten dinner with the family, as was usual for a Sunday, and she had seemed fine. “Demented? How did you assess that?”

The resident went on to say that when the patient was first seen in the hospital, she was unable to answer any questions they asked and wasn’t making sense.

“Did they have someone speak to her in Italian?”

At that moment, the women’s son arrived, and the resident repeated to him that he was sorry that there was nothing to be done for his mother. Hearing what had happened, the son requested that before the resident decide that it was his mother’s time to die, he tell the family what he would do for this type of problem if his mother were 50 years old instead of 80.

“I’d do a CAT scan to see the full extent of the trouble, and then likely surgery to remove the blood and repair the bleed.”

The son suggested he do the CAT scan. He then went to talk to his mother in her dialect and ask how she felt. She spoke to him normally, apologizing for taking him away from his workday. Clearly, as the son suggested later to the resident, his assessment was that his mother’s “mental faculties” were working as usual. The resident was surprised to see the patient was able to respond to her son when he translated questions for her and to laugh when he joked with her about how she looked as if she had been in a brawl (her eye was swollen from the fall, but this was a very petite and mild-mannered woman who hardly ever raised her voice above a whisper). After the CAT scan, the resident returned and reported in astonishment that the woman had no sinus cavity on the right side of her head (where she had sustained the injury), and therefore the black area that had shown up on the x-ray that was thought to be blood was really only the absence of the sinus cavity (a condition that patient had been born with but had not caused any problem). The woman received five stitches over her right eye and left the hospital with her family. She lived happily and independently on her own for another 17 years. This was her first and only trip to a hospital in her entire life. A week after her visit, she removed her own stitches, reporting to her son that she was feeling fine and didn’t need them anymore.

**Learning Exercise**

1. Which of the problems encountered by this patient could benefit from micro, mezzo, and/or macro policy interventions?
2. What assumptions were made by the practitioner? How did those shape the assessment?
3. What advocacy skills do families need when a member of the family is determined to be “incompetent”?

**POLICY ADVOCACY LEARNING CHALLENGE 10.4**

**Connecting Micro, Mezzo, and Macro Policy Advocacy**

Benefits and Risks of Prevention

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) was recently revised. During the revision process, the inclusion of a “category” or disorder that would reflect a prediagnosis risk group was considered, specifically for individuals pre­senting with psychosis-like or attenuated symptoms that might convert and eventually meet the criteria for a DSM disorder. While supporters of the risk category highlighted the fact that “early intervention may help delay or prevent exacerbation into psycho­sis,” others felt that distinguishing between “ill and non-ill persons is difficult,” which would make the likelihood of false positive diagnosis higher (Carpenter, 2009, p. 841).

Given the controversy surrounding screening for psychotic risk and treating indi­viduals before they have a diagnosis, Carpenter (2009) suggested that we consider whether the benefits of early intervention intended to help prevent a psychotic exacerbation outweigh the negative damage of “labeling” individuals with a mental health disorder when it is not certain that it will develop. Further, Carpenter (2009) asked practitioners to consider whether placing a person in a diagnostic risk category could “do more harm than good because of stigma or the unwarranted administration of treatment with a poor benefit/risk ratio” (p. 841). Yet screening for mental health problems is widely practiced in health settings, such as by asking patients to respond to several questions that have proven effective in diagnosing depression.

**Learning Exercise**

1. What are your thoughts about this controversy?
2. As an advocate, what direction would you recommend? Why?
3. Do other efforts to prevent problems associated with mental health serve to edu­cate the public or to reinforce the stigma?
4. How do you think that early detection efforts in schools, hospitals, and other public settings would help to lower risks of suicide and incidence of violence? To be effective, what other changes would be required in the various settings?

**POLICY ADVOCACY LEARNING CHALLENGE 10.5**

**Connecting Micro, Mezzo, and Macro Policy Advocacy**

The ACA Cuts Consumers’ Mental Health Costs

The ACA has greatly decreased disparities between the cost of care for patients of health­care and patients of mental healthcare. For example, a patient who was treated for diabetes and bipolar disorder prior to the ACA’s implementation paid a 20% copay for his diabetes care but a 50% copay for his bipolar disorder. The new healthcare law changes this so that there is parity in copays. Think about some policy implications of this major shift in policy.

**Learning Exercise**

1. Are patients aware that mental health treatment is now much cheaper for them? If not, what kinds of community outreach and education might be considered?
2. Have health providers added sufficient mental health personnel, including social workers, to their rosters to provide the increased levels of mental health services needed by patients who will now receive them?
3. See Silberner (2008) to find how one patient advocate sees this issue.

**POLICY ADVOCACY LEARNING CHALLENGE 10.6**

**Connecting Micro, Mezzo, and Macro Policy Advocacy**

The Impact of Support From Fellow Employees

Without the insistence of her colleagues, who knew that this episode of psychotic symptoms was somehow “different” from previous episodes that they had observed, Elyn Saks, an accomplished law professor at the University of Southern California and recipient of the MacArthur Foundation genius award, might have died of encephalitis. Brought to the emergency room by her colleagues due to worsening psychosis, she was immediately assessed to be psychotic and might have been dismissed by the hospital with additional antipsychotic medications except that her work colleagues strongly requested that doctors check her for something other than psychosis. They knew the symptoms that Dr. Saks usually experienced when her mental illness worsened, and believed that her current behavior was different. Dr. Saks, whose symptoms and mental illness and treatment resulted in hospitalization, forced treatment, isolation, and restraints (Carter et al., 2010), has reported that one of the “pillars” that offered her support was her workplace and doing work that she loved. Saks and other tenured college professors with mental illness, including depression, have spoken openly about their decision to disclose information about their diagnosis due to fear that they might be looked upon as unstable or less competent or be ostracized by peers.

**Learning Exercise**

1. What micro, mezzo, and macro policy actions would you promote in specific employment settings to address employees’ mental health problems, such as help from Employment Assistance Programs? Should social workers be central to EAPs in light of their biopsychosocial orientation?
2. What mezzo and micro policy advocacy initiatives might social workers lead to obtain more responsive care by the VA and other health systems for military personnel and veterans?

**POLICY ADVOCACY LEARNING CHALLENGE 10.7**

**Connecting Micro, Mezzo, and Macro Policy Advocacy**

Fragmented Care

The *Los Angeles Times* (Morocco, 2007) reported on a story that highlights the nega­tive impact created by a fragmented system of care. The story tells of the struggle to find a way to respond to the complex needs of a woman who was homeless, 22 weeks pregnant, and mentally ill, who had been brought to the hospital ER by two good Samaritans who found her mumbling and wandering the street naked. Her physical exam and lab tests were normal except for her mental status. After hours of trying to locate a place for this unnamed person (“Jane Doe”), she was refused admission to the psychiatric unit in the hospital (they didn’t treat women more than eight weeks preg­nant), was deemed to have no medical reason for being admitted to the hospital, and was refused by a county psychiatric center who never called back after reading her faxed record. Even after almost a day of effort on the part of the ER staff and after locating the name of a brother (who would not take responsibility for his sister), the hospital failed to find any possible support for the woman and started the process of re-making every call they had previously made in the hope of eventually being successful.

**Learning Exercise**

1. What failures in the current healthcare system are identified in this case?
2. How would you advocate, and at what level, to assist this woman in getting the help that she needs?
3. Which of her needs would you prioritize? Her medical needs? Her psychiatric needs? Her situational needs?