BEHAVIORAL HEALTH POLICYMAKING

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Abstract: This lecture provides an overview of the processes through which behavioral health policy is made in the United States. It emphasizes the fact that policymaking is more political than rational. Public mental health policy is made at all levels and in all branches of government. It reflects a variety of perspectives, ideologies, and motivations. Although findings of formal and informal research play a role in the development of policy, it is also influenced by diverse moral perspectives and by political alliances, personal interests, the news media, **relationships**, etc. It is also influenced by advocates/lobbyists representing a broad range of interest groups and working in various types of advocacy organizations including trade associations, professional associations, unions, organizations representing different populations, universities, research organizations, cause groups, etc. These groups sometimes work together to pursue common interests, but they also compete to increase their share of available resources.

After discussing the political dimensions of policymaking, I provide an overview of how the legislative, executive, and judicial branches of government make policy. I also provide an overview of how to advocate effectively. I maintain that effective advocacy requires group action. Coalitions are key to effective advocacy, which also requires a threefold process of assessment, planning, and, most of all, **action**. Sound planning, I maintain, is also a threefold process. It requires setting a clear agenda, choosing a realistic strategy, and selecting tactics for action. I also note opportunities to do advocacy on behalf of behavioral health.

It is customary to teach policymaking as if it were a rational process. It does have important rational elements, but **policymaking is fundamentally political**. Policymaking about mental health and drug use (behavioral health) is no exception.

I do not believe that the use of rational processes is largely irrelevant to the development of policy positions. I do not agree with Jonathan Haidt, for example, who argues in *The Righteous Mind,*[1] that reason is used solely to make a case for political views that are formed from other sources, such as group membership, relationships, emotions, etc.[2] The discovery of injustices, damaging consequences, or corruption can have great influence

[1] Haidt, J.
[2] Friedman, M. http://michaelbfriedman.com/mbf/images/stories/Lets_Not_Give_Up_On_Reason.pdf

on policymaking, and there is an important tradition of social research designed to influence policymakers that goes back to the 19th century. The assemblage of data is never definitive, but it is often important to the outcome of political decision-making.

Nevertheless, I maintain that policymaking is more political than rational. By "political", I mean that:

- Making public policy involves **complex formal (and informal) processes** at all levels and in all branches of government.

- At each level and in each branch of government, there are **hierarchies of power and prestige**, and participants in policymaking may be more interested in their position in the hierarchy and their prestige than in the policy being made.

- At each level and in each branch of government, people involved in decision-making have **a variety of perspectives and motivations**. Some are more rational, some less; but even rational people who are primarily seeking the public good rather than personal gain see policy differently from one another and have significant disagreements about goals and about facts.

- People who are elected or appointed to policymaking positions have **diverse ideological views**, have **different political stances** (conservative, liberal, "progressive", etc.), belong to different political parties, and have **different personal and professional interests**.

- Behavioral health **policymakers also must be responsive to a range of concerns** that include, but are not limited to, the needs of people with mental or substance use disorders. These include political ideology, public perception (especially fear and anger), cost/tax increases, gains/losses of jobs, impact on the economy and on local communities, and much more.

- **Policymaking is influenced by advocates and lobbyists**, who represent different interest groups and ideologies. Sometimes these people participate directly in making policy because of their expertise, their connections with people in power, or because they have been chosen to represent their interest group. For behavioral health policy, this includes behavioral health organizations, professions, administrators, educators, researchers, recipients of service, their family members, racial and ethnic groups, child and aging advocates, etc.

- **Policymaking is heavily influenced by professional and personal relationships.** Like everyone else, policymakers rely on the people they trust to develop their positions. In addition, they do favors for friends when they can and expect that their friends will do that for them as well.

Behavioral Health Interest Groups:

In the field of behavioral health, there are **many interest groups competing for resources and influence**. These include:

- **Trade associations** (sometimes called "membership organizations") represent providers, with different associations for general hospitals, private psychiatric hospitals, community mental health organizations, substance use treatment and rehabilitation providers, community health centers, etc. For example, the community mental health agencies in New York City are represented by the Coalition of Behavioral Health Organizations while the general hospitals are represented by the Greater New York Hospital Association.
- There are also trade associations representing industries that do business with behavioral health providers such as drug companies, behavioral managed care, software suppliers, etc. For example, drug companies are represented by Pharmaceutical Research and Manufacturers of America (PhRMA)
- There are also trade associations representing different levels of government, such as local governments seeking policy or funding support from state and federal governments and state governments seeking support from the federal government. For example, there is a National Association Of State Mental Health Directors (NASMHPD) that serves largely as an advocacy group for state departments of mental health.

- **Unions** represent employees working for provider organizations that serve people with cognitive, mental, and/or substance use disorders. There are, for example, unions representing state hospital employees, representing general hospital employees, representing social service employees, etc.

- **Professional associations** represent various professions including psychiatrists, psychologists, nurses, social workers, etc. Examples include the National Association of Social Workers (NASW), the American Psychiatric Association (APA), The American Psychological Association (APA), and more.

- **Academic and research organizations** are often active as advocates and lobbyists seeking greater support for educational programs and research.

- **Public policy think tanks** and **foundations** conduct social studies and also advocate for policy changes. The Commonwealth Fund, The Milbank Memorial Fund, and the Kaiser Family Foundation are just a few of these types of advocacy organizations.

- **Cause groups** advocate for policy changes that advance social causes such as improved mental health, non-discrimination against people with disabilities, and criminal justice reform. Mental Health America (aka The Mental Health Association) and The Bazelon Center, are two such groups.

- **Limited constituency cause groups**, represent children with serious emotional disturbance, older adults with dementia, people of color suffering from health disparities, etc. Examples include Citizens' Committee for Children, The Alzheimer's Association, The Geriatric Mental Health Alliance of New York, and The Veterans' Mental Health Coalition of NYC.

- **Family advocacy groups** advocate on behalf of family members with such conditions as mental illness or developmental disabilities. The National Alliance on Mental Illness, better known as NAMI and formerly the National Alliance for the Mentally Ill is a primary example.

- **Consumer/recipient groups** such as The National Mental Health Self-Help Clearinghouse represent people with histories of mental illness. In NYS people with what they now refer to as "lived experience" are primarily represented by the New York Association of Psychiatric Rehabilitation Services (NYAPRS), which is also the trade association for psychiatric rehabilitation providers.

Given the diversity of advocacy organizations, it is no wonder that **the behavioral health "community" is a community divided against itself**. There are other very powerful tensions among the interest groups, each seeking its own goals and demanding a greater share of the resources.

For example, general hospitals that have inpatient and outpatient psychiatry departments often compete with community mental health organizations by claiming that certain patients need hospital-level care while community housing, rehabilitation, and others claim that many of these people can be well served outside of hospitals.

There are also battles that take place among the professions. Psychiatrists insist that only they are adequately educated to prescribe medications. Psychologists counter that they can do this perfectly well. Psychiatrists also advocate for policies that limit the independent practice of clinical social workers. They in turn maintain that only social workers with a clinical license should be allowed to practice independently and that clinics should not be allowed to use students and new graduates to do clinical work until they have more experience. These are known as "scope of practice" issues.

There have also been battles between researchers and service providers about which deserves greater attention. Researchers have disagreed about

what form of research is most important—biomedical or psychosocial. Families and consumers have fought for perspectives that were (and to some extent still are) alien to providers, academics, and researchers. Etc.

In addition to tensions between different interest groups in the behavioral health community, there is an **ideological divide** between those who continue to advocate for community mental health and the rights of people with mental illness and those who want to roll back policy in the direction of more hospital care and more coercive interventions. There are also ideological divides within the substance use community, particularly with regard to the use of drugs to combat addiction.

Despite the fragmentation of interest groups and infighting within the mental health and substance use communities, behavioral health interest groups have sometimes been able to form coalitions that advocate together.

There also have been some successful coalitions of coalitions. For example, in the early 1990s a number of us got together and formed the Mental Health Action Network of New York, which worked together to push through a "reinvestment" act that moved funds from state hospitals to local service organizations. Similarly, towards the end of the first decade of the 21st century during NYS's effort to reduce the number and sizes of hospitals, I was able to pull together virtually all of the mental health advocacy groups in the state except the unions representing state employees to argue for the preservation of the psychiatric capacity of hospitals. The joint effort resulted in an increase in psychiatric capacity while hospitals were otherwise closed, merged, or cut down in size.

Perhaps the best example of the power of building alliances is the change from institution-based policy to community-based policy in the 50s, 60s, and 70s. This policy shift took place because of a number of clinical and social changes that I have discussed elsewhere[3]. But it also took place because of a largely informal alliance of:

- Advocates, who could not abide the mistreatment of people with serious mental illness in state hospitals or the violation of their fundamental rights

- Professions, which saw the growth of community-based mental health as a great opportunity to expand

- Academics, who saw tremendous opportunities for increased work doing research and providing education and training

- Community providers, who also saw great opportunities for expansion

[3] Friedman, M. (2022). "From Institutions to Community Mental Health".

- Governmental leaders, who believed both that the policy shift would result in better care for people with mental illness and that it would reduce costs to government (especially to state government).

Of course, unions representing state employees fought against the reduction of the size of state hospitals, but they fought in relative isolation. They had considerable influence, especially at the state level, and they may have had a beneficial impact because their advocacy contributed to significant improvements in staff-patient ratios and quality of care in state hospitals. But they were unable to hold back the tide that swept patients out of state hospitals and into the community.

Although unified action has contributed to significant improvements in the mental health system over the past 50 years, schisms within the mental health and substance use communities have fed into the fundamental difficulty of getting politicians and political parties to work together. As a result, improvements in behavioral health policy have been mostly incremental.

It is possible that the pandemic will result in long-term changes in the political perception of the importance of behavioral health, but I frankly doubt that the high level of interest in mental health that exists at the moment will last for a long time, even though President Biden has declared a mental health crisis in America. Hopefully, I'm just an old pessimist.

Policymaking Processes

Mental health policymaking takes place at all levels of government—federal, state, county, and municipal—and in all branches of government—legislative, executive, and judicial.

The Constitution of the United States includes a list of federal responsibilities. All other governmental responsibilities are left to the states—which divide these responsibilities between state and local governments.

Over the course of history, the federal government has taken on some responsibilities not listed in the Constitution. Conservatives and others who are distressed about the expansion of federal responsibility and the consequent diminishment of state power and authority generally use the term **"states' rights"** to advocate for blocking expansion of federal authority.

For example, the civil rights movement led to a conservative outcry about the violation of states' rights. Similar arguments have been made about the expanding role of the federal government in health and behavioral health care. Medicare and Medicaid, which were established shortly after the

passage of The Civil Rights Act, also were resisted on the grounds of states' rights. And the Affordable Care Act (Obamacare) also was hampered by a states' rights argument that led to a Supreme Court decision that the expansion of Medicaid could not be mandated by the federal government.

Thus, the question of which level of government should be responsible for what aspects of behavioral health policy has no easy answers. Behavioral health policymaking takes place at all levels with a good deal of jostling back and forth about which level of government has the authority to make policy and which has responsibility to pay for it.

In addition to the division of labor among levels of government, there is a separation of powers among the three branches of government—legislative, executive, and judicial. Each branch is involved in behavioral health policymaking.

In what follows I provide several key points. For more detail, I suggest that you read Appendices 4 and 5 of my mental health advocacy manual. The material is somewhat out of date, and I am in the process of revising it, but it's still close to accurate.

Policymaking By The Legislative Branch (See attached charts)

The Congress, State Legislatures, and county and municipal legislatures all make laws that can create or influence mental health policy. The legislation that they pass must be approved by the Chief Executive—President, Governor, Mayor, or County Executive—or their veto must be overridden by a super-majority.

So, action by a legislature is not a matter of simple, straightforward democracy, not as simple as majority rules.

Legislatures all have complex processes and a hierarchical structure. They are **divided into committees**; **committees have chairs**; legislation by and large will not be voted on unless it passes through relevant committees formally and gains the approval of the chairs of these committees and of the leadership of the legislative body. Relevant committees include subject-oriented committees, such as The Mental Health Committees of the NYS Assembly and Senate. Because most legislation has economic implications, usually bills must also pass through a finance committee, such as the Ways and Means Committee of the NYS Assembly and the Finance Committee of the NYS Senate. Finally, bills must be approved by a Rules Committee to come to the "floor" for a vote. Rules committees are composed of the leadership of the legislative body and in truth controlled by the legislative leader, who is the real decision-maker about what will get voted on. All of this varies from state to state.

In the United States, federal and state legislatures are bicameral, i.e., they have two houses, both of which must approve legislation before it goes to the President or a Governor for signature or veto. To the best of my knowledge municipal and county legislatures are always a single body.

It is important to know that **there are rules about who can introduce legislation**—a member of the legislature or a chief executive. Neither other government officials nor citizens can introduce legislation; they must persuade a legislator or chief executive to do that.

It is also important to know that **legislatures have a schedule**. For example, in NYS the legislature is convened in January and adjourns at the end of June with occasional special sessions. It is required to pass a budget for the state by April 1 (though often it fails to meet the deadline). There are various other rules about final dates for introducing legislation, etc.

These basic facts have very important implications for advocates. To get legislation passed they must find a legislator to introduce it, hopefully, someone high in the hierarchy. They need to line up co-sponsors, preferably including people high in the hierarchy. They need to line up support from members of relevant committees, and they need to get the support of leadership and ultimately of the chief executive.

And all of this must be done in accordance with the legislative calendar. For example, in NYS it is preferable to get legislation **introduced in both houses** prior to January 1 and on matters with budgetary implications to complete lobbying prior to the passage of the budget on April 1. Etc.

Policymaking By The Executive Branch

The executive branch is composed of a chief executive—President, Governor, Mayor, or County Executive—the staff of the chief executive—a mix of program and budget staff—and administrative departments, which are usually designated in a constitution or a charter. At the federal level, administrative departments are headed by a "secretary". At the state, county, and municipal levels the heads of administrative departments are known as "secretaries", "commissioners", or "directors". Many administrative departments have largely independent and very powerful subdivisions with chiefs who have significant power. For example, The Social Security Department is a part of the Department of Health and Human Services.

In simplistic legal theory, the legislative branch of government makes policy, and the executive branch carries out that policy. But in fact, much public policy that becomes law originates in the executive branch. For example, the Community Mental Health Centers Act was initiated by the Kennedy Administration, the Civil Rights Act and Medicare and Medicaid were initiated

by the Johnson Administration, the Americans with Disabilities Act was initiated by the first Bush Administration, coverage for prescription drugs by Medicare was initiated by the second Bush administration, and the Affordable Care Act was initiated by the Obama administration.

In addition, the executive branch typically is involved in negotiating laws with the legislative branch because, except for relatively infrequent overrides of a veto, there is no law without executive approval.

Laws also usually leave tremendous leeway for the executive branch to fill in the details of a law through the creation of **regulations**, which are not laws, but have the force of law. For example, the law in NYS that calls for the licensing of mental health programs states that this will be done "in accordance with regulations promulgated by the Commissioner of Mental Health".

This gives huge policy-making power to the Commissioner, who determines what kinds of programs will be licensed—inpatient, outpatient, clinics, day treatment, community residences, etc.—and also determines standards for licensure, including service models to be used, staffing requirements, case recording requirements, ambiance, safety, the role of boards of directors, the nature of ownership, etc.

The policy-making power of administrative officials is tempered by a variety of rules about the process of developing regulations. Most importantly, draft regulations must be released for **public comment** except in emergency situations. This is not mere window dressing. It is expected that proposed regulation will be modified after input from the public, and most often it is.

Some proposed regulations are also subject to review and even approval by public bodies that have been created to serve as watchdogs over, and advisors to, administrative officials. For example, hospital and nursing home regulations and Medicaid rates in NYS are subject to review by The NYS Public Health and Health Planning Council. There is a counterpart for behavioral health—The NYS Behavioral Health Services Council—but it does not have as much decision-making authority as the Public Health Council.

Some administrative rules are issued through administrative directives and guidelines of various kinds rather than regulations. These may not have the force of law exactly, but programs disobey them at their peril.

A major source of the power of the executive branch is the federal, state, county, or municipal **budget**. The budget is a law that projects revenue from taxes and other sources and guides spending. It is submitted by the chief executive as a proposal to the legislative branch, which negotiates a budget that is sent on to the chief executive for signature or veto. In many venues, the chief executive has the power to veto lines of the budget

(known as the "line-item veto"); in others, s/he has authority only to accept it or reject it as a whole.

This results in long, hard negotiations until there is finally a budget acceptable to the legislature (often 2 houses) and the executive. (See attached charts).

Once a budget is passed, there is usually considerable leeway allowed to the executive branch to distribute the funds that have been allocated for broad purposes. For example, the NYS budget might include several hundred million dollars for housing for people with mental disorders. Occasionally it stipulates what counties should get this funding, but usually, that is a decision left to the NYS Office of Mental Health. In New York, and many other states, determinations about the specifics of funding get very complicated because the state department responsible for the mental health system—The Office of Mental Health (OMH) in NYS—is not necessarily the state department that sets Medicaid rates—The Department of Health (DoH) in NYS.

Policymaking By the Judicial Branch

In simplistic legal theory, the judicial branch of government does not make policy, it enforces the federal and state constitutions and laws. But in fact, the judicial branch has had huge impact on behavioral health policy in the United States. There have been numerous rulings that support the rights of people with mental illness to live in the community, to refuse treatment, etc. There have been rulings that require the provision of shelter to homeless people. There have been rulings that reject discrimination against people with mental illness. And more.

There are two basic ways in which courts make policy. One is with rulings regarding federal or state constitutionality. The second is with decisions that interpret laws in ways that set legal precedents. This is sometimes done with class action suits and/or with consent decrees.

In effect the courts sometimes make law. This leads to the critical distinction between **statutory law** and **case law**. Statutory law is made by legislatures with approval by chief executives (or veto override). Case law is made via the history of decisions made by courts.

ADVOCACY

There are many sources of policy change both inside and outside government. These include governmental leaders, the media, policy research findings, changes in professional perception and practice, and changes in financial fortune.

Organized advocacy is a major source of change.

First some general observations.

Although it can be a frustratingly slow process that takes great persistence over years, advocacy often works.

Generally speaking, **advocacy only works if it is done in groups**. Occasionally individuals emerge who generate policy change on their own—very occasionally. Most influential individuals form and lead groups that take on the mission that their leaders envision.

As I noted earlier, there are many different types of advocacy groups, each representing different interests and ideologies. They frequently have significant conflicts, but sometimes they can work out compromises that make it possible for them to work together and, in my view, become more effective than when they work alone.

In fact, I believe that **effective advocacy usually requires the development of broad coalitions**. This is often quite difficult to do. In my experience, the major enemies of forming such coalitions in addition to organizational interests are **"egos, empires, and ideology**", all of which are constantly at play when efforts are made to build coalitions. This means that **building an effective coalition must be done in such a way as to satisfy the narcissistic needs of the most influential members of the coalition**. There also **needs to be something in the joint action for every person or organization represented in the coalition.** And it is essential for members of the coalition **to put aside their most passionate beliefs** for the sake of joint action.

Advocacy can be a progressive or a conservative force. Many advocacy groups represent the interests of current "stakeholders". These groups resist change that will give them a reduced role in the system and a reduced share of the resources, even if it is clear to others that it would make the system better. For example, unions representing state hospitals fought for years to retain census and staff in state hospitals and not to close the state hospitals. They generally made arguments that this was better for the patients. And they were sometimes right. Improved staff-patient ratios made a big difference in the quality of care in state hospitals. But in general, they were fighting to preserve the jobs of union members and became defenders of the status quo or of regression rather than of progress.

Whether an advocacy group is seeking self-protection at the cost of progress or not is, of course, in the eye of the beholder and a constant matter of debate.

Elements of Effective Advocacy

What follows is an outline of my view of the elements of effective advocacy. You can find more about this either here or here.

Group development/constituency building: As I noted above, effective advocacy requires groups that work together for change. Democracy responds to constituencies, the bigger (and wealthier?) the better.

Assessment: Effective advocacy also requires knowledge. What's the problem you want to address? What's the history of trying to address it? What's the current status? How much will it cost to fix it? Who are the players who can make a difference? Where is the power to bring about the change? Etc.

Planning: Effective advocacy also usually takes careful planning. This includes:

- Developing a clear **agenda**, i.e., knowing what your goals are.

- Developing a **strategy,** i.e., identifying which of the powers-that-be you will seek to persuade to bring about the change you want, identifying who can influence those with power, and identifying other organizations that would be helpful as partners.

- Selecting **tactics,** i.e., deciding what specifically you will do to influence those with power such as a media campaign, a rally, an e-mail campaign, a study that dramatizes need, etc. (Tactics checklist attached.)

ACTION, ACTION, ACTION: What is absolutely most important is taking action when the time is ripe. You can never have a big enough group, know everything, and have a perfect plan. There's always more to talk about. **But talk is the enemy of action. Action is the essence of advocacy.**

Opportunities for Advocacy

There are many opportunities to be an advocate—as a career, as an adjunct to your career, or as a personal activity.

You can be an advocate for changes in public policy by working from outside government or from inside. Working from outside government to win changes in governmental policy is, of course, the most common image of what an advocate does. But, in fact, the people who work inside government such as elected officials and their staffs or appointed public officials and civil service employees also advocate for improvements in policy.

Working as an advocate can also be either a major activity in your life or something you do in a little spare time. Or it can be no more than making a financial contribution to a cause you support. **Advocacy organizations have a vital need for funding, so providing some is really very important**.

My own history as an advocate illustrates some of the possibilities. My first experiences with advocacy were as a job assignment when I was a program administrator in an organization that was trying to win acceptance of a new location on the West Side of Manhattan. It became my job to win support from the community, including with the local Community Board and other groups that had a say in the location of publicly funded services. I continued my involvement with the community as a resident of the West Side after I changed jobs just because I liked working with the local Community Board and with the group of local mental health advocacy groups I had organized as part of my job assignment. Later I became responsible for government relations as part of my job as an administrator for the large organization I worked for. I continued advocacy as the Executive Director of a mental health organization, which was in part an advocacy organization. Later, when I became a Regional Director (Deputy Commissioner) in the NYS Office of Mental Health, to which I had previously been an outside voice calling for policy changes, I became an inside voice for major changes in child mental health policy. Later I handled government relations for the Department of Psychiatry at a major hospital network. It was only after that that I became a full-time mental health advocate, at a small policy center that I founded working with the Mental Health Associations of New York City and of Westchester. In addition, as a personal matter, I became a contributing member of several mental health advocacy organizations where mostly what I did was to make an annual financial contribution.

So, to say it again, there are many opportunities to be a mental health policy advocate.

<u>From Outside Government</u>

The most important thing you can do is **join and participate in an advocacy group**. Give money, send E-mail when requested, attend a lobbying event, or help with the work of the organization.

If you are a clinician or an administrator working in an organization, you may be able to **become a representative of your organization**.

You can also become active in a **professional association** such as NASW or the Society of Clinical Social Workers, or family therapists. Etc.

There are also a great many advocacy groups that do not represent organizations or particular professions; you can join one of these.

Again, if you do join a group, you can be more or less active. If you would like to become a leader of the group, it's not hard. Volunteer to do the work that needs to be done **and do it**. Most people who volunteer to help never follow through. They "talk the talk" but don't "walk the walk". Leaders emerge from the doers.

There are many opportunities for advocacy activities. For example, you can:

- **Submit comments about legislative and regulatory proposals**. Don't be shy.

- **Communicate with elected and appointed public officials**. Letters, phone calls, faxes, and E-mail can make a difference.

- **Testify at public hearings**. Some hearings are limited to invited "witnesses", but many are open to the public. You just have to sign up, wait your turn, and **be brief**.

- Write **an op-ed or a letter to the editor**. It's very, very tough to get published in the NYTimes, the Washington Post, or other major newspapers or magazines, but in smaller cities, it's easier. Clarity and brevity are very important.

- Try to get appointed to an **advisory group**. This is not easy at the beginning of a career, but over time, with recognition and contacts, it is possible to "be at the table" as public policy decisions are being made.

The kinds of **publications and reports** that you may be taught to write as part of your graduate education **can also make a difference** though not very often. For those of you who are policy students, working with a policy group to conduct a study and produce a report can be a great opportunity to play an advocacy role. But be prepared for your work to be put on a shelf to gather dust or filed in "the cloud", wherever that is. Sometimes, however, studies and reports have tremendous impact. You never know.

That may be too cynical a view. The fact of the matter is that review of data is often part of the process of making a political decision.

There are many other ways to influence government. Take a look at the attached Tactics Checklist or the discussion of tactics in my manual on mental health advocacy.

<u>From Inside Government</u>

As I have already said, in addition to being a voice for change from outside government, you can work for change from inside.

One way to do this is to become an elected official or work for one. Although it is probably most common for politicians to be lawyers by profession, other professionals run for and win elected positions. This includes social workers. Barbara Mikulski, the now-retired Senator from Maryland, immediately comes to mind.

In addition, there are a great many jobs working for elected officials on their political, constituency, or policy staff. The staff of elected officials do not literally have power, but they can have enormous influence and informal power. And working for elected officials is a terrific steppingstone.

Working for a political party whether at turning out the vote or at policy development can also be very influential and a steppingstone.

Working in governmental departments also offers the opportunity for advocacy—sometimes. Some of the lower-level work is, frankly, drudgery in the service of implementing policy made by others; but at higher levels within departments, you can have a formal or informal role in the creation of policy. For example, when I was appointed a Deputy Commissioner of Mental Health in NYS, I was asked by the Commissioner to continue to make the arguments for change that I had been making as an outside advocate inside the department. And I was asked to become the primary voice for child mental health within the department even though there was a person formally responsible for child mental health. For a time, I had more influence than he did with the Commissioner. Then I went too far. A story for another time.

So, to say it for the third time, there are plenty of opportunities to be advocates for improved behavioral health policy. And, very importantly, if you are a social worker, you have a duty to be an advocate for social justice. That, of course, sounds like a lot to take on if you have a direct service job and a personal life. But it doesn't need to be onerous. Not all social workers need to be professional or semi-professional advocates like me. In my view, it can be enough to join a group, make a financial contribution, and follow up on some advocacy activities called for by the group you have joined. But the social work Code of Ethics makes it very clear that you have an obligation to pursue social justice. So I urge you all

BECOME AN ADVOCATE FOR A CAUSE YOU BELIEVE IN!

Attachment 1

TACTICS CHECKLIST

Lobbying

Mail/E-Mail/Phone Calls
Petitions
Meetings
Build Relationships
Hearing Testimony
Written Material
Special Events
Awards
Campaign Contributions

Public Education

Reports
Conferences
Written Material
Web Page
Advertising
News Media
Social Media

Demonstrations

Attendance
Press Coverage

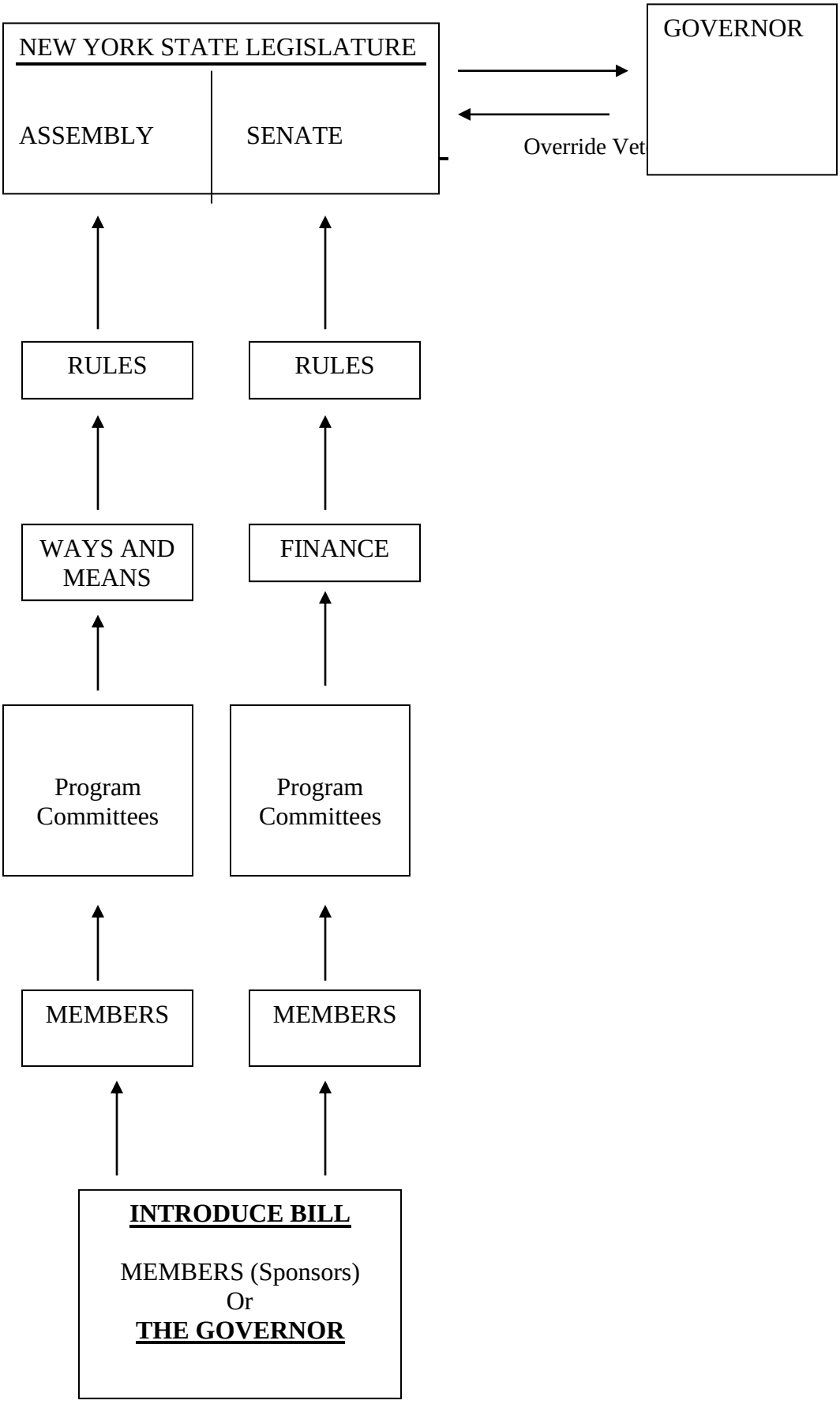
Social Defiance

Boycotts, Strikes, Etc.
Civil Disobedience
Risk Assessment

Advocacy Style

Confront Aggressively
Negotiate
Be At The Table
Provide Expert Advice
Work in Coalitions

MAKING LAWS IN NEW YORK STATE



NEW YORK STATE BUDGET MAKING