Social Justice Advocacy across Contexts: Promoting Advocacy in Mental Health Research and Practice

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Abstract

Regardless of the level of training or area of specialization, mental health professionals are unified in their commitment to a social justice agenda. However, as graduates from such programs have begun working in diverse settings, questions have arisen about how best to apply social justice principles and advocacy to clinical and scholarly work. This article examines advocacy work across contexts where mental health professionals currently work, including while engaged in research, in medical settings, and in schools. For each of the contexts we identify issues mental health professionals typically face when engaging in social justice advocacy work and ways to address those challenges. In doing so, the article aims to equip mental health professionals with the awareness and knowledge necessary to integrate social justice advocacy into their everyday work.

Keywords: Advocacy, social justice, research, schools, health care

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Recently one of the authors shared the following story: I (a psychologist doing primarily clinical work in a hospital setting) have an adolescent patient diagnosed with a significant chronic medical condition and depression. Because the family has limited financial resources, the patient is not able to travel to see me and cannot afford the co-pay for individual therapy. Therefore, I helped the family find a clinician from a community mental health center with a sliding scale fee that can provide weekly therapy. I have also worked with the patient's school psychologist to develop a plan to provide support for the patient during school hours. Beyond this individual-level work, I have an ongoing collaboration with two other psychologists, one at the hospital and one at a local university, to develop annual mental health screenings for adolescents in our clinic. I am also collaborating with professionals in my field on a national level to develop effective interventions to address psychosocial issues for children and teens with this chronic medical diagnosis. While these two latter collaborations may not directly impact my

patient, they do attempt to develop mental health services and resources for youth with his same chronic health condition.

This one story can serve as an example of an integrated, comprehensive treatment approach with a client. The providers involved are a mix of master's, Ph.D., and MD professionals with various specializations who are fusing their expertise to recognize client needs, surround a client with support, and develop necessary interventions and resources. However, even beyond this lesson, the example also speaks to an aspect of mental health treatment that too often is ignored, that being the responsibility of mental health professionals—regardless of degree, training, specialization, or work setting—to advocate for their clients.

Social justice advocacy has a complex history in mental health fields, in part due to the competing demands of imposed objectivity and client needs. Historically, psychologists in particular were taught to prioritize value-free science (Fox, 2003) and professional distance, with Vera and Speight (2003) going so far as to state that, "Traditionally, psychologists have been socialized into seeing themselves as apolitical" (p. 254). However, as the objective empiricism (Putnam, 1962) that dominated the field early on gave way to post-positivist acknowledgements of the importance of subjective experience, attitudes towards advocacy work shifted as well. For example, in several articles published in 2003 authors suggested that mental health professionals should redefine the boundaries we set on our work and do as Arredondo (1999) suggested: working "proactive[ly] on behalf of [our] clients, particularly in institutions that may not have practices that meet the needs of . . . diverse constituencies" (p. 108). In this statement, Arredondo issued an explicit call for mental health professionals to integrate social justice advocacy into the work we do both as clinicians and as scholars. Nevertheless, even now, fifteen years later, we are still discovering the most effective way to meet this goal.

The purpose of this paper is to raise awareness about social justice advocacy as a shared value that unifies the work of mental health professionals across titles and positions, and to illustrate how professionals can collaborate to serve as advocates. To meet this aim, in this article we examine common challenges with social justice advocacy work and strategies to address those challenges in three contexts where mental health professionals currently work: while engaged in research, in medical settings, and in schools. Within these contexts, mental health professionals often practice across disciplines with practitioners and researchers that share similar values around advocacy, but have received differing levels (e.g. master's, doctoral – PhD or PsyD) and types (i.e. social work, marriage and family therapy, school counseling, clinical psychology) of training. By addressing the similarities across these varying contexts, the article aims to equip mental health professionals with the knowledge and awareness necessary to integrate social justice advocacy into their everyday work.

The Challenge

Despite notable improvements, it remains well known that mental health services in the U.S. are not adequately meeting the needs of people who require them. This is especially the case for certain cultural groups, including lower income children and adults of color who are routinely underserved across regions and contexts (c.f., Agency for Healthcare Research and Quality, 2011; President's New Freedom Commission on Mental Health, 2003). For example,

despite widespread and well documented educational disparities between economic and racial groups (Kenny et al., 2007; Orfield, Losen, Wald, & Swanson, 2004), educators and school-based mental health professionals are still struggling to implement culturally responsive practices within schools (e.g., Banks, 1996; Brown, 2004; Keys & Bemak, 1997; Ladson-Billings, 1994; Lee, 2001; Weinstein, Tomlinson-Clarke, & Curran, 2004). Certainly, efforts to create a full range of school-based mental health programs, from prevention to early intervention to more intensive intervention, have gained momentum. However, fully implementing mental health services to children in schools is stalled by a number of barriers, including lack of time for mental health professionals to fully deliver these programs, lack of community support and collaboration, lack of training for school professionals in mental health service delivery, and lack of funding to support such services (Van Acker & Mayer, 2009).

Similarly, in medical settings, numerous studies have noted how the medical system has failed racial/ethnic minority communities. The Center for Disease Control continues to document significant racial/ethnic disparities between Whites and people of color on a number of health related indicators including but not limited to: expected years free of a chronic condition, asthma attacks, diabetes, health related quality of life, pediatric obesity, and infant mortality (CDC, 2013). Additionally, although researchers have not found disparities in the incidence of mental health disorders between Whites and people of color (McGuire & Miranda, 2008), racial/ethnic minorities are noted to receive less access to mental health services than Whites, are less likely to receive needed mental health care, and are more likely to receive poor quality treatment when they do access services (U.S. Dept. of Health and Human Services, Public Health Service, Office of the Surgeon General, 1999).

As noted above, some of these disparities have been attributed to systemic problems with access. The U.S. Department of Health and Human Services (2013) indicated, for example, that for lower income populations of color, accessing mental health services requires the hurdling of multiple barriers including "cost of care, lack of sufficient insurance for mental health services, discrimination and negative attitudes toward mental health problems, fragmented organization of services, and mistrust of providers" (p. 82). In addition, practitioners have also implicated researchers, suggesting that service disparities can be traced back to the limited research available on diverse populations (Carrasco, 2006). Analyses of articles published in psychology journals routinely reveal that the preponderance of articles rely on White, American, undergraduate samples (c.f., Arnett, 2008; Graham, 1992; Peterson 2001; Wintre, North, & Sugar, 2001). So common are American college students used as research participants that Henrich and colleagues (2010) determined that "a randomly selected American undergraduate is more than 4,000 times more likely to be a research participant than is a randomly selected person" (p. 63). Certainly, these explanations are relevant for the current service dilemmas that mental health fields are facing. However, we would also argue that the history of the field of psychology itself has contributed to service disparities because of how that history has constrained the work of mental health professionals.

The Context

During the time that psychology was taking root in the U.S., the positivist movement was in full swing. This movement, which proclaimed the essentialism of objective and measurable

data in order to make claims about the "causal associations among variables" (Hoyt & Bhati, 2007, p. 202), affected both mental health research and mental health treatment. For researchers, the emphasis on objective empiricism meant the prioritization of control over generalizability and the aspiration to eliminate personal values from research. What resulted was the belief that experimental research was the *sine qua non* of scientific and psychological inquiry.

The influence of the positivist movement was not constrained to psychological research; for mental health practitioners, as well, objectivity and measurement prevailed. As a result, behavioral approaches that prioritized the measurement of change and hinted at the possibility of practitioner objectivity gained prominence. Universalist notions of mental health treatment, which assumed that treatments found to be successful for one population (i.e., White, middle class men) should be successful for all, predominated as well. However this "received view," as Putnam (1962) called it, was met with harsh criticism from practitioners in the mid- to late-twentieth century who claimed that traditional psychological methodologies "seem incapable of explaining the everyday social behavior of human beings that is actually experienced by…psychologists in their ongoing interactions with clients" (Polkinghorne, 1984, p. 422).

In partial response to these criticisms, post-positivism emerged as a compelling philosophy of science after World War II. As the twentieth century progressed, mental health fields placed more emphasis on meeting the individual needs of diverse clientele. It was within this post-positivist context that social justice advocacy emerged (Green, McCollum, & Hays, 2008).

Social Justice Advocacy

Defining Social Justice Advocacy

The term social justice advocacy refers to political actions taken by groups or individual people to change existing systems to increase the social power of politically, economically, or socially disadvantaged individuals (Klugman, 2010). For mental health providers and researchers, this can involve raising awareness through training, education, or scholarship in order to "promote the human rights [of clients], reduce stigma and discrimination, […and change] structural or attitudinal barriers" to mental health treatment (World Health Organization, 2003, p. 2). On the surface, the aim of social justice advocacy seems well aligned with the purpose of mental health scholarship and treatment—applying psychological theories, principles, and techniques to improve the psychological functioning and quality of life of clients and patients. As such, mental health practitioners and scholars should have faced few barriers in infusing advocacy into their work. However despite the fact that the mental health advocacy movement has had a marked impact on mental health policies and programming in some countries (World Health Organization, 2001), practitioners and scholars continue facing challenges in their attempts to integrate social justice advocacy into their daily work across contexts.

Problems That Mental Health Professionals Face in Social Justice Advocacy Work

The American Psychological Association (APA), the National Association of Social Workers (NASW), and the American Counseling Association (ACA), though differing in the constituents they serve, have all named advocacy as an essential component of their members'

responsibilities. Despite this, only the ACA has created advocacy competency standards, which were not published until 2003. As a result, one of the problems facing mental health professionals, both in their scholarship and in their practice, is a general misunderstanding about the meaning of social justice advocacy.

Misunderstandings about what social justice advocacy means could be partially attributed to the lack of attention paid to advocacy in many mental health training programs. For example, as Toporek and colleagues note (2009), even students currently being trained in mental health fields may not be receiving formal training in advocacy in part because their professors or supervisors lack training themselves. As a result, though many training programs indoctrinate students about the value of social justice advocacy, they may not leave students with the competencies necessary to make advocacy a part of their scholarship or practice (Lee, Smith, & Henry, 2013).

Even beyond the lack of training that mental health professionals receive about social justice advocacy, misunderstandings about advocacy amongst other professionals may also compromise the abilities of mental health professionals to engage in advocacy work. For example, mental health professionals working in medical settings (often referred to as behavioral health providers, and can include psychologists, psychiatrists, therapists, and mental health clinicians) will likely be working on integrated care teams with medical professionals who have limited understanding of what behavioral health professionals do (e.g., assessment, diagnosis of behavioral health conditions, brief interventions, health behavior-change counseling, consultation, etc.) and what activities are peripheral to their role (e.g., case management and other traditional social work activities, etc.). As such, medical professionals may not be aware that advocacy falls within the purview of behavioral health providers. Similarly, school administrators may not be familiar with the responsibility of school-based mental health practitioners to advocate for their clients. As a result, those same administrators may not provide the support (e.g., funding, time, resources) necessary for practitioners to engage in advocacy activities.

Mental health researchers as well are confronted with misconceptions regarding whether and how advocacy has a place in scholarship. As previously mentioned, the post-positivist movement of the 1940s and 1950s brought with it greater recognition that although overarching research laws or governing principles do exist, knowledge is influenced by the subjective experiences of the individual and should be studied thusly. Within this context, social justice advocacy research seemed to answer the call for contextually informed research that more directly services research participants. However, because advocacy research is intended to inform policy and evoke social change by describing and measuring social phenomena in order to increase public awareness and garner support for change (Marshall, 1998) it has historically been viewed as less scientific than empirical studies because it "cannot be divorced from persuasion" (David, 1972, p. 93). As a result, research methods based on the principles of social justice advocacy (e.g., Participatory Action Research) are still viewed with skepticism by some research audiences that overwhelmingly favor empirical methods.

Because of these misunderstandings, mental health professionals may be faced with biases that call into question the rigor or worth of advocacy in many of the contexts in which

they work. For researchers, many of whom work in academia, this bias may manifest in the messages faculty receive about worthwhile scholarship. Particularly for untenured faculty members, institutional pressure to publish may be accompanied by messages from well-meaning mentors that tenure-track, early career faculty should prioritize projects that will more likely be completed, and therefore published quickly. Social justice advocacy research, which by design requires the participation of constituents, rarely falls into this category. As a result, this more demanding but nonetheless essential type of research is often relegated to "post-tenure" research agendas.

Likewise, the additional time required to practice social justice advocacy affects how this work is viewed in other settings as well. In schools, counselors have increasingly been tasked with an array of responsibilities including planning individual student schedules, interpreting test results, providing individual and group counseling, consulting with teachers on classroom management approaches, and advocating for students at individual educational plan meetings, to name a few (American School Counselors Association, 2015). What is more, with caseloads reaching ratios as high as one counselor per 1000 students (Carrell & Carrell, 2006), it is no wonder advocacy efforts may not necessarily be supported or rewarded. Furthermore, doing so also requires the school counselor to question the roles that have historically defined the profession (Bemak & Chung, 2008; Field & Baker, 2004; Griffin & Steen, 2011). For example, counselors working within schools have traditionally been viewed as individuals who maintain peace and harmony, a challenge that Bemak and Chung (2008) call the "nice counselor syndrome." As a result, practitioners who confront social inequities and take on an advocacy role may face a number of personal and professional challenges, including: a) resistance and negative responses from colleagues and the larger school system; b) "professional paralysis" (i.e., feeling overwhelmed by the task of working towards social justice); and c) potentially uncomfortable dialogues, situations, and personal reflection (Bemak & Chung).

In addition to the aforementioned personal and professional challenges, school counselors must face the lack of empirical support for advocacy work in schools. For example, research on important aspects of advocacy work, including evaluation of proposed competencies and the impact of social justice efforts in school counseling and psychological practice, is lacking (Griffin & Steen, 2011; Ratts, DeKruyf, & Chen-Hayes, 2007). As a result, practitioners working in schools may feel overwhelmed to take on a task that has not been empirically validated to date.

Similar skepticism about the effectiveness and utility of advocacy efforts is often faced by behavioral health providers in medical settings as well. For example, although mental health practitioners have increasingly been included in integrated care teams in hospitals, medical clinics, and other primary care sites, and despite the fact that such teams have been lauded for increasing access to mental health services (Guck, Guck, Brack & Frey, 2007; Pomerantz, Corson, & Detzer, 2009; van Orden, Hoffman, Haffmans, Spinhoven, & Hoencamp, 2009), behavioral health remains a specialty service, historically perceived as ancillary to the functioning of a primary care clinic and peripherally addressed in training programs. Therefore, when mental health professionals are invited to treat patients in medical settings, they are typically entering an environment that can operate very differently than traditional mental health settings. Whereas mental health settings typically espouse a biopsychosocial model of care,

medical settings have historically been grounded in the Medical Model. Practitioners working from this perspective tend to focus on the physical or biological aspects of illness that can be assessed and measured through medical history, physical examination and diagnostic tests, and attend less frequently to psychological, social, and cultural variables. Although biopsychosocial models of care are gradually being utilized, behavioral health providers may face significant barriers in advocating for the necessity of socioculturally informed conceptualizations of patient symptoms and treatments.

Behavioral health providers may also be the only mental health professionals working in an integrated care setting. Although behavioral health providers may be considered a member of the treatment team, they are unlikely to have the advantage of being a part of a collective voice of numerous mental health professionals. As a result, behavioral health providers may find themselves isolated from the larger treatment team, making it even more challenging to advocate for patient needs and rights.

As these particular examples support, challenges remain in the enactment of advocacy efforts across settings due to lack of training and misunderstandings. Such barriers persist despite the fact that the professional organizations that oversee various mental health fields promote social justice advocacy work amongst their members. As a result, mental health professionals are often left without the requisite support or training needed to answer Arredondo's (1999) call for practitioners to engage in advocacy work. Without such support or training, however, practitioners and scholars in mental health fields will likely continue underserving our socially and culturally diverse clientele.

Suggestions for Participation in Social Justice Advocacy Work

Despite the difficulties that mental health professionals face when engaging in social justice advocacy work, the need for such work has arguably never been greater. Thankfully, there are steps that mental health professionals can take to enact the underlying values of our fields and conduct this necessary work, including broadening our definitions of mental health work, increasing training in social justice advocacy, and improving communication about advocacy within and between fields.

Broadening definitions of mental health work

As previously stated, historically many mental health fields encouraged practitioners and scholars to remain apolitical—separate from the value-laden subjectivity that underlies social justice advocacy. However, over the years this orientation has been challenged as workers trained in mental health fields have been confronted with a need to embrace an emic perspective on mental health scholarship and services. To promote social justice advocacy as valued work by mental health practitioners, however, mental health fields must go further in broadening our definitions of mental health work.

To a certain extent, definitions of what falls within the purview of mental health workers have already broadened. Over the last several decades, mental health researchers have become more accepting and appreciative of methodologies designed to capture and prioritize the voice of subjects. By conducting research using methods such as Participatory Action Research, which

aim to empower participants by making use of their own knowledge and lived experiences (Whyte, 1991), many scholars have become what Fine (2007) calls "self-conscious" researchers: scholars who are cognizant of the political powers at play in scholarly discourse and the ways in which these powers shape how we determine our areas of inquiry and position our findings. In medical settings as well, behavioral health providers have helped to redefine what is considered therapeutic space. By providing mental health screening and services in primary care and specialty medical settings while also providing education to medical students, residents, fellows, and medical providers in multicultural competence and other areas of expertise (e.g., behavioral health, health-behavior change), these mental health professionals have expanded their role to include the training of a new generation of medical providers on how to successfully work with diverse clientele. Finally, in schools many counselors have worked to refine policy that allows for the integration of cultural and contextual factors (e.g., social class, race, ethnicity, gender, sexual orientation, immigration status) into the conceptualization of a child's psychosocial well-being, academic performance, and overall development.

However, even more could be done to ensure that social justice advocacy is recognized as a central component of mental health work. One possible place to start is by encouraging all mental health organizations (i.e., APA, NASW) to follow the lead of ACA and develop advocacy competency standards. When such standards are in place, mental health professionals employed in a variety of settings may be more likely to consider advocacy a critical aspect of their identity and an imperative professional activity. Furthermore, advisors and employers would have more guidance in how to evaluate advocacy efforts, which could then lead employers to compensate and even reward social justice advocacy efforts amongst workers.

Increasing training in social justice advocacy

Training programs can also ensure graduates have a solid grounding in social justice advocacy. Certainly, such training would be easier to emphasize if professional organizations developed competency standards, but training programs cannot and should not wait. Rather, trainees in programs across disciplines would be well served by being introduced to the ACA competencies that identify ways mental health workers can act with and on behalf of: clients or students; schools or communities; and in the public arena (ACA, 2003).

In addition, training programs can ensure students are familiarized with advocacy-based research methodologies and the rationale for using such methods. For example, even for trainees who themselves may not aspire to conduct research, trainees should be familiar with how research methods can be used to empower, rather than disempower constituents and be prepared to explain and defend such methods, if necessary (Fine & Barreras, 2001; Rahman, 1993).

Training for mental health practitioners working in various settings should also emphasize the dispositions, awareness, and knowledge that have been found helpful in guiding practitioners in advocacy efforts. Dispositions refer to actively accepting and being cognizant of one's role as an advocate, which includes recognizing the need to empower clients and families, address social inequities, and rely on ethical principles when facing challenging dilemmas (Trusty & Brown, 2005). By accepting one's professional role as an advocate and building awareness about one's own cultural identity and how it may influence one's work, mental health professionals are able to ground their identity as one that is committed to social advocacy efforts.

In addition, acquiring knowledge about the important issues pertinent to particular work settings ensures practitioners are prepared to work on behalf of constituents. In school settings, this could include issues specific to the unique culture of the school and its surrounding community (e.g., school policies, issues relevant to the local and state government, available supportive resources), as well as knowledge of issues that impact social justice advocacy work on a broader scale (e.g., special education laws, barriers to access of resources faced by various cultural groups; Trusty & Brown, 2005). In medical settings, relevant knowledge may pertain to treatment protocols and follow-up services, resources to assist with insurance questions, and even understanding the language and conceptualization differences between medical practitioners and patients. Through such knowledge, behavioral health providers can serve as "boundary crossers," tailoring their presentation of patient information to the medical professionals to aid him/her in understanding how to discuss diagnosis and treatment with the patient and consider appropriate treatments given the patient's worldview.

Improving communication about advocacy within and between fields

Even after mental health professionals have accepted advocacy as central to their work and have been trained in how to perform advocacy work, scholars and practitioners trained in mental health fields must still be prepared to educate others, as co-workers in various work settings may be less familiar with the purpose and necessity of social justice advocacy.

For example, behavioral health providers working in medical settings will need to develop astute navigational and collaborative skills to effectively advocate for their patients and successfully explain and employ empirically supported interventions. Even in clinics where behavioral health providers are integrated into teams, they may need to advocate for themselves within their clinic to establish the power and credibility necessary to effectively advocate for their patients. Working in integrated care can be difficult and behavioral health providers must be willing to assert their point of view for their voice to be heard. In the end, they are going to have a stronger voice and be able to advocate more effectively for their patients when they have developed collaborative working relationships with multiple medical providers. Ultimately, building a network of allies can assist behavioral health professionals in allowing their voice to be heard through a multidisciplinary collective.

Similarly, in school settings counselors should be prepared to explain to others about the necessity of social justice advocacy, which can be challenging given counselors' potential lack of power in the school context that creates difficulty when striving for change (Griffin & Steen, 2011). As a result of this lack of systemic power, school counselors are often faced with the task of having to convince school personnel that advocacy efforts are beneficial for the school and even the school district as a whole. To do so, it is imperative for practitioners to establish positive relationships as a means of "building allies" with colleagues who can support the implementation of advocacy efforts (Griffin & Steen, 2011). Relationship building should occur not only with colleagues, but also with families, who should be actively involved in designing effective interventions for their children. For example, if a child is underperforming in the classroom, the practitioner may facilitate meetings with the student, teachers, and parents to develop behavioral and social-emotional interventions to promote the student's positive development. Collaborative relationships that extend into the larger community, including those

with local business and community agencies, may also be particularly relevant for gaining support to address advocacy efforts.

Making social justice advocacy a central and expected component of mental health work will require more than effort by individuals. People in positions of power must also take a stand in promoting advocacy efforts. Depending on the setting, this could entail ensuring that employees are trained in advocacy, supported in advocacy efforts, and encouraged to conduct advocacy research. By prioritizing advocacy as an essential task of mental health professionals and crafting policies and guidelines that reflect that prioritization, organizational leaders can ensure mental health professionals are supported in their advocacy efforts

Summary

As the field has matured, mental health professionals have begun working across increasingly diverse settings. Currently these professionals can be found in universities as professors, supervisors, and practitioners, in public and private health care settings, in primary and secondary schools, and in a variety of private and government businesses and organizations (CCPTP, n.d.). Though the responsibilities of mental health professionals vary across settings, the orientation of the field and the training provided to its members unifies these professionals as committed to maintaining a social justice agenda. Such an agenda represents a mission that should continue to remain core to our work, and must shape not only our individual values but our actions as well.

Advocacy is not easy—it requires a stalwart commitment to individual rights, a responsive analysis of cultural and organizational dynamics, and an astute ability to represent and communicate the needs of others—but advocacy is vital to the proper care and servicing of our constituencies. It therefore falls on the shoulders of training programs holistically, and mental health professionals individually, to prioritize a social justice orientation and to integrate advocacy into our work, regardless of the setting. Doing so allows the individuals and communities that we serve to be better heard, valued, and empowered.

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