Streams to Ocean: Bridging the Micro/Macro Divide

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Abstract: This personal and professional narrative is a reflection of the emergence of becoming a social worker and embracing both micro and macro practice. The realization is that one flows into the other as a river flows into the ocean. The major implication is the importance of continually addressing human rights and social justice issues in our social work practice as both a micro and macro social worker.

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Introduction

For the last several years I have traveled to mid-coast Maine to my father's home after Christmas to enjoy a few days of respite and tranquility. The landscape includes hues of white, grey, and indigo reflected from the Penobscot Bay and the Blue Hill mountains. It is an ideal setting to reflect upon the year ending and ponder on the year to come. This past year has been a new chapter in my life, full of bittersweet transitions. I have a wonderful husband, father, and three beautiful sons, the oldest of whom left for college last year. However, it was the first year the two most important women in my life were absent from me. My daughter began her first year of college, and my loving mother's long battle with a chronic illness finally ceased when she passed away.

Yesterday I bundled up for one of my favorite activities: running. This is an activity I mostly do individually, alone with my thoughts, reveling in the scenery. I am attuned to how my muscles feel and the clean, crisp air in my lungs, and I absorb all the sights and sounds around me. For more than two decades this has been an essential, almost daily activity that has sustained me as a clinical social worker in healthcare. The six-mile route I always run I named Bluff Run. Part of the run is a mile up a mountain. During the winter months, the dirt road is closed off to cars and not plowed, so the top is icy and snowy underfoot, and I usually have to slow down to stay aware of my footing.

When I reached the top yesterday, I noticed there were numerous deer tracks in the snow, where the deer had traveled the same area I was now enjoying. But what I also saw was evidence they were not running alone. The deer had a companion, a partner, a family, or a community. These creatures were navigating their journey together. According to Riverwoods Preservation Council, doe herds comprise several generations and herd for protection against predators. I was struck immediately with memories of my compassionate mother and of my daughter when she was little and under my protection. I contemplated my years of individual running and my time running with the varsity track team in college. I also thought about my professional work as an individual social work practitioner and as a community organizer and, more recently, as a teacher in a social work graduate school. The fluidity of these arcs, interwoven throughout my family and career, entered my thoughts as I gazed at the multitude of tracks and listened to the snow crunching under my strides.

Personal Experiences

The beginning of my running career was not for self-care purposes—I simply liked to compete! After a strong high school cross-country and track and field career, I was recruited to run for Boston College. As a scholarship long-distance runner I was required to train all year and run at peak performances every season. For four years I lived a disciplined life of daily ten-mile runs, speed drills, proper nutrition, adequate sleep, and weight training. Classes and studying revolved around training and track meets. The workouts were strategic and prepared me to run fast 5-kilometer cross-country races at a 5:30 mile pace. Unknowingly, this individual training enabled me to develop personal goals for my future professional work with clients, families, organizations, and communities.

The summer before my senior year in college, I had one major goal for our team: to make Boston College history and be the first women's cross-country team to qualify for the Division I NCAA championships. I created postcards for the varsity runners and mailed them all summer long. It was simple. One week the postcard would simply read, "THINK," and the following week another postcard would arrive to my teammates reading, "NATIONALS." I was the only scholarship athlete on the team at the time. We would be competing for the spot against college track giants loaded with scholarship athletes, such as Villanova, Georgetown, and Providence College. After months of unending training, sacrifices, and dedication, our team qualified for NCAA nationals in Tucson, Arizona. Since that time in 1991, Boston College has qualified every year and recruited many scholarship athletes.

Retrospectively, my individual running successes do not compare to team successes of which I've been a part. Why is this? Why is it more meaningful for me to lead a team to victory than to cross the finish line first myself? When I consider why this is true for me, I think of my high school coach, who was one of my life's greatest mentors. It was he who taught me the value of teamwork. He created an acronym for TEAM: Together Each Accomplishes More. He cared about the team as much as the individual and believed great results could only be achieved through teamwork. He not only coached more than 20 individual state champions, he also earned several Massachusetts state championship titles. His high value of teamwork influenced me greatly.

My Boston College team achieved something we had only dreamed about. Not surprisingly, all the women who were on that cross-country team are now contributing to society as leaders in their fields of nursing, business, education, and research. The interconnectedness of individual success and team success is similar to micro and macro practice in professional healing. Unbeknownst to me as a young woman, my personal experience of competing was preparing me for a future of social work in healthcare as well as my work with vulnerable women pregnant and parenting amidst poverty.

Social Work Education

After taking Introduction to Social Work during my last semester of undergraduate school, I decided to go to graduate school for social work. What I remember most from that undergrad

course that led me to pursue a professional life in social work was the person-in-environment perspective. This ecological framework resonated with how I understood human behavior. Upon entering graduate school, I was required to make a decision before my studies even began: choose either a micro or macro focus. I remember being confused by this, as I believed, even then, that one part could not impact change without the other. They were interconnected. Each was equally necessary and important. Given that I had a double major in English and Psychology, I resonated with the details of individual and family stories, so my logical choice was micro. At the time, and confronted with that choice, I wanted to work with children and families in healthcare settings, not in community organizing.

Professional Healing

My first position as a clinical social worker was in a large, urban teaching hospital in a pediatric emergency room. Much of the work was crisis intervention, assisting and supporting families who brought their children to the emergency room after a traumatic injury, such as a drowning, falling from second and third story windows, car accidents, and child abuse. After a few months in this position I was asked by a few pediatricians to work with them in a community pediatric health center.

This center was located in one of the poorest communities in the state. Similar to most poor communities, the social determinants of health were prominent. There was a high prevalence of child abuse and neglect, intimate partner violence, and substance abuse. Though we had a great program and offered family-centered integrative care onsite, the problems were not decreasing. In fact, the volume of behavioral and social issues was not feasible for one social worker to address. In order to make long-lasting change, it would take a team approach.

Similar to my efforts to inspire and mobilize individual runners on the track to be the best team, my micro practice needed to connect with macro work. I began to meet with community partners, form professional relationships, and finally organize a large working conference with the local district attorneys, child welfare workers, pediatricians, and local school officials. The goal was to identify vulnerable families in our community and work collaboratively with agencies and families to prevent child abuse and to support families. An interdisciplinary system was put in place to create professional networks so that children and families who needed additional community supports could access services. This accomplishment was by far my most successful, because it was a collaborative effort creating impactful changes that, in turn, positively affected the children and families I worked with on an individual basis.

For the past 21 years, I have worked as a perinatal social worker in a large, urban birthing hospital. This work is primarily clinical and addresses intimate partner violence, sexual assault, substance use, postpartum depression, and perinatal loss. One of my areas of expertise is the prevention and treatment of perinatal substance use. Throughout the past nine years, I have seen pregnant women on a weekly basis who find themselves in a quagmire as a result of their pregnancy and their use of prescription opioids. This creates a profound ethical and professional challenge in respecting the women's self-determination and autonomy when they are required to agree to medication-assisted treatment at the onset of their pregnancy when admitted to heath

care facilities. The internal struggle for many women is their preference not to be on methadone or other medications when pregnant, yet their legal obligation is to do so. The following is a common example of my clinical practice that occurred many years ago and changed my professional life.

Lucia (pseudonym) entered my office reluctantly at the request of her obstetrician. Lucia was resistant to see me because she had experienced a negative response from clinicians she had already interacted with. Many years earlier, she was misusing prescription painkillers and was directed to a methadone maintenance clinic. After the birth of her first baby, she witnessed her infant withdraw from methadone. Lucia was emphatic that she did not want to experience that traumatic event again, declaring, "I don't want to be responsible for my baby withdrawing, and I couldn't live with myself." After many months of self-advocating for medically supervised withdrawal, the physician finally acquiesced.

Lucia explained to me how the clinicians at the local methadone clinic told her she was hurting her unborn baby if she discontinued her methadone, and that the choice made her a bad mother. She was also told that her choice could kill her baby. I listened incredulously to her experience with her health care providers. At the time, I did not have any knowledge about methadone maintenance, effects of methadone on mother and fetus, or the scientific evidence to support the practice.

Sadly, Lucia left our prenatal care clinic because the obstetrician at our center refused to support her choice of tapering off of methadone. She left to deliver in another state. Even though she was no longer our patient, she had asked me to stay in contact with her, so I telephoned her and inquired how her birthing experience was. She reported that she and the baby were doing very well and that her baby had not experienced any withdrawal from methadone exposure because it had been out of Lucia's system long enough. Interestingly, she shared that the nurses who cared for her during her postpartum period in the hospital discovered in her chart that she had been on methadone during her first and second trimester. They had commented to her how awful that she was on methadone during her pregnancy. "I just wish women would not be judged for their choices," Lucia told me. This was when it dawned on me that if Lucia had experienced this judgmental response from health care providers, perhaps there were other women just like her. Even more harrowing than what I watched Lucia encounter is what I see now in my work: Countless early postpartum mothers having their infant removed from their custody as the result of a positive toxicology urine drug screen during their third trimester. The infant is removed directly from the birthing hospital without any chance for the mother to bond or parent. The re-victimization and re-traumatization of these women is incomprehensible. The agonizing cries I have heard echoing through the halls and have witnessed as these mothers left the hospital without their newborns will be with me forever. At various times, this "micro-level" social work left me feeling helpless, discouraged, and experiencing the secondary stress of burnout and hopelessness.

Yet, ultimately, these and other similar experiences compelled me to continue my social work education and earn a Ph.D. The irony was that when applying for doctorate programs, I suddenly realized I was returning to the dilemma forced upon me in the MSW program between micro and

macro focus. However, now I truly understood that a social worker could not really help create positive change for groups without influencing macro policy and practice in organizations. My main goal was to develop and create maternal health policy that addressed perinatal substance use in a collaborative and social-justice based framework.

I often tell this story to my graduate students. If you find yourself frustrated and not impacting meaningful change with your clients, perhaps you need to focus on the current policies that impact the client system and ask yourself how you might impact social and organizational and political change? I was at a crossroads in my clinical social work practice. It was becoming apparent that there were human rights and social justice issues involved with perinatal substance use and that I was a cog in the wheel. Whether I intended that or not was not as important as the reality that I was part of these institutions as a privileged social worker.

As someone who values, both personally and professionally, self-determination and the dignity and worth of the person, I was compelled to conduct a qualitative health study using an interpretative phenomenological analysis to understand the lived experience of pregnant and postpartum women who have an opioid dependence. I wanted to understand who their support was and if they were able to work collaboratively with the healthcare team. I knew from more than two decades of clinical experience that women are highly motivated to care for themselves and their babies when they are pregnant. I also knew as an experienced clinical social worker the transformational power of having someone believe in you as a person, demonstrate respect, and support one's autonomy. I knew that anything was possible with support.

Similar to my perinatal social work practice, two of the major findings of the qualitative health study I conducted were the parallel fear pregnant opioid dependent women had of their infants developing neonatal abstinence syndrome and child protection services' involvement at delivery (Howard, 2015). The research was couched in questions like, "Is it possible to support pregnant and parenting women with substance use disorders?" Is it possible to treat the mother and infant as a dyad rather than polarize the two? This multifaceted and complex issue is an example of the importance of the intersection of micro and macro practice.

Macro Concerns

For me it is important to understand micro level concerns within a macro context. This is a fundamental social work concept of the person-in-environment perspective. From the aspect of policy analysis, how can we address that women who are opioid dependent are fearful of their infants developing neonatal abstinence syndrome and also of child protective services? One starting point is to recognize that current policy tends to limit these women's options. A recent national study of neonates exposed to opioids who received treatment for Neonatal Abstinence Syndrome revealed that the majority (78%) were on public insurance (Patrick et al., 2012). Like the national study, the study population in my research (Howard, 2015) was entirely drawn from a sample of women receiving government insurance benefits as opposed to women with private insurance and access to a broader range of health care alternatives in most states. This major policy limits treatment options for pregnant opioid dependent women depending on the practice guidelines in any given state. For the New England region, methadone maintenance continues to

be the recommended standard of care, with limited opportunities for buprenorphine maintenance or opioid-free recovery. Other states, such as Arizona, Kentucky, and Tennessee, require a pregnant opioid-dependent woman to enter detoxification as soon as she knows she is pregnant. This implies that if a woman is on public insurance, her choices are seriously constrained. Moreover, such constraints constitute a social justice and human rights issue, with painful costs to children, parents, and society that should be acknowledged and evaluated. In my own clinical practice and research, I seek to balance the existing constraints by keeping the mother's protective factors and concern for her infant as paramount.

Several of the participants in the qualitative health study I conducted described having a child protective service worker remove her infant from her care as like watching her child be kidnapped and not having the power to stop it. There have been several recent reviews of state policies focused on the reporting of prenatal drug exposure, as well as variability with how child protective services respond to referrals of substance-exposed newborns (Anthony, Austin, & Cormier, 2010; Goodman & Wolff, 2013; Miller et al., 2014). These reviews recommend early intervention, which can bring lasting benefits to the mother-infant dyad. New maternal health initiatives can encourage engagement with pregnant women in order to reduce substance use and promote healing in their lives. The primary recommendation in these reviews is to institute universal screening using a validated instrument, as opposed to urine drug screening, for early detection and treatment referrals. Helmbrecht and Thiagarajah (2008), for example, recommend creating cooperative teams for better communication between the obstetrician and the substance use treatment provider. The management of this high-risk population needs to be approached using a public health response rather than a punitive response when considering new maternal health policies. These macro level issues impact the mother-infant dyad in profound ways. I came to see in both my clinical work as a perinatal social worker and my research concerning pregnant and parenting women with substance use disorders that there was an acute need for community action.

Community Organizing

Last month, I hosted a conference with the state Department of Health to create collaborative, coordinated, and compassionate care for pregnant women and their substance-exposed newborns. The purpose of the conference was to create strategies to work more effectively across disciplines to decrease stigma and increase accessibility to community resources and treatment for these vulnerable families. There were representatives from Healthy Families America, an evidenced-based program that provides weekly home visits to families and provides concrete and emotional support, maternal fetal nurses, substance use treatment providers, educators, social workers, and child welfare workers. The major feedback we received was that we need to host the conference every year and that professionals appreciated the opportunity to discuss and find solutions to address the opioid epidemic with a collaborative approach. I learned long ago that institutional change occurs only when the conversation is shared, the "problem" becomes human and tangible, and there is a vested interest by stakeholders and policy makers in doing better collectively—like a team.

Conclusion

Although this past year has presented difficult personal and life transitions, I am beginning a new chapter in my social work career in higher education. I look forward to conducting further research that addresses perinatal substance use as well as the opportunity to educate graduate social work students to be both micro and macro social workers in their real-world practice, applying all the principles of good teamwork.

Today, I ran on a wooded trail that led to a waterfall rushing into the Penobscot Bay. The mountain water had melted with the newly fallen snow and was powerfully flowing to the ocean's edge. The snowflakes had turned into a stream that connected with something much vaster. The fresh water and salt water became one intermixed fluid, and, resultantly, a much more formidable natural force. As I ran back to the cozy seaside home where my dad lives now, I felt my mother's presence, her legacy to continue to persevere, and my drive to be an example to my daughter as she pursues her own college education. I thought about my goals to impact maternal health policies that will support the mother-infant dyad as the snow crunched beneath my stride. But what led me to write this article were the haunting voices of those new mothers in the hospital, still echoing.

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