From the Frying Pan into the Fire: Three Advocacy Tales in Child and Adolescent Mental Health Services*

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A persistent criticism of helping professionals in certain disciplines, such as social work and psychology, is that their psychotherapy, counseling, or mental health work with clients occurs at the expense of macro-level efforts to achieve social justice, equality, and changes in the social environment. The authors offer the following narratives as a counterpoint to this view, as they demonstrate integration, rather than polarization, of micro- and macro-level approaches in child and adolescent mental health practice.

Advocacy is an essential skill in contemporary child and adolescent mental health practice which must be developed by a variety of stakeholders—individual clinicians, policy leaders, program administrators, educators—not to mention parents and families. In this narrative, we describe three stories of advocacy interventions undertaken in widely differing practice contexts, identify the strategies and skills we found useful in developing advocacy interventions, and informally assess the effectiveness of these interventions. We hope this article will suggest ways in which readers can help create responsive mental health services for children and youth in their home communities and practice settings.

Conceptual Framework for Advocacy

The two disciplines we represent—social work and psychology—have differing traditions regarding their understanding of advocacy. Psychology—at least as practiced in North America—has traditionally adopted a narrow interpretation of advocacy as actions taken primarily to benefit the well-being and functioning of the individual client system. The major criticism of this approach historically has been that advocacy interventions taken on behalf of the individual often occur at the expense of those directed towards enhancing the welfare of the entire community or society (Prilleltensky, 1991).

Social work, on the other hand, has a greater tradition, at least in certain periods of its history in North America, of emphasizing the role of the social environment as it interacts with the functioning of individuals, families, or groups (Takanishi, 1978). Thus, advocacy in social work has tended to emphasize macro-social interventions—that is, social reform actions leading to structural changes in the social institutions of society to achieve social justice. Historically, the major critique of this approach has been that social workers may get more wrapped up in improving the client's environment and forget to address the individual needs of the client system itself. A secondary criticism has been that the advocate role may foster paternalism—that is, doing *for* clients what ultimately they may be able to do for themselves (Parsons, Jorgensen, & Hernandez, 1994).

Increasingly, however, both of our disciplines are moving toward a conceptualization of advocacy as embracing a continuum of interventions with both

individual persons, on the one hand, and the social environment, on the other. Thus, advocacy can be defined as: "The act of directly representing, defending, intervening, supporting, or recommending a course of action on behalf of one or more individuals, groups, or communities, with the goal of securing or retaining social justice" (Mickelson, 1995, p. 95).

In the stories that follow, we describe advocacy interventions ranging across this continuum. The first story focuses on *individual client advocacy* as an essential part of child psychotherapy and parent counseling done by a clinical psychologist in private practice. The second story focuses on *group advocacy* by a school psychology educator responding to the Columbine High School shootings in Colorado in April 1999. The third story focuses on *advocacy for system change* undertaken by a social work educator in an urban school district. These stories aim to capture the more personal aspects of advocacy work—those times when we as practitioners or educators were faced with doing difficult but essential tasks: going the extra mile to obtain client services, jumping from the frying pan of everyday academic life into the emotional fire and community distress in the aftermath of the worst school shooting in U.S. history, or engaging in an uphill battle against a school district bent on making massive cuts in the school social work staff.

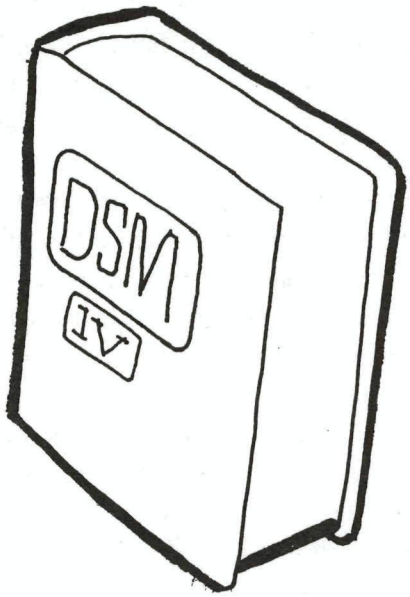
Advocacy Work in Private Practice: Judith's Narrative

I have worked as a clinical psychologist in solo private practice for the past 25 years. Although I see a broad array of clients, my specialty is working with children and families. Like many practitioners, my work with clients also means frequent, often unpleasant, interactions with managed care companies who act as gatekeepers in regulating mental health benefits for employees and their dependents. The aim of these for-profit companies typically is to reduce utilization of the most expensive form of services and to hold down the overall costs of care. My aim as a psychologist is often quite different—to get clients the clinical services and benefits I believe they need. As a result of these opposing aims, I often find myself in an advocate role for and with my clients.

Some time ago, I received an evaluation referral for a five-year-old boy experiencing symptoms suggestive of attention deficit/hyperactivity problems. Needing to "pre-certify" my contacts with the child and family, I called the managed care company to seek approval for my request to do psychological testing in order to sort out the attentional and hyperactivity problems from other possible contributors and conditions. My initial request for testing was denied. When I called the case manager for an explanation, I was shocked to learn that the managed care company's position was that they do not approve *any* psychological testing. The case manager stated that children's attention problems are "learning problems, not psychological problems, which are the school district's responsibility to take care of."

(Memo to the American Psychiatric Association: Please promptly remove the diagnosis of attention deficit/hyperactivity disorder from your *Diagnostic and Statis-*

tical Manual's list of mental disorders. Tell clinicians they can relax. It's a learning problem, ***not*** a mental health problem! Schools around the country will be so pleased!)



Not to be deterred, I pressed the case manager, then the case manager's supervisor, and finally, the CEO of the company to provide a rationale upon which its decision of denial was based. As a result of such persistence, I discovered that the managed care company had no written policy or criteria regarding the psychological evaluation of young children for any presenting problem. Previously, all such requests automatically had been denied.

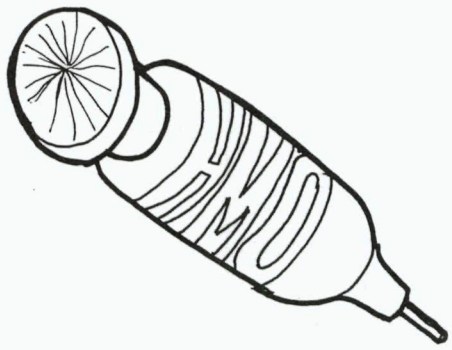
At this point, I developed multiple advocacy strategies. First, I involved the child's mother in appealing the managed care company's decision. I knew that this particular parent was herself a strong and articulate advocate for her child. Together, we worked to make sure her employer (she worked for the state government) knew of this denial. Because managed care contracts are re-bid each year, employee dissatisfaction with the benefits plan or the services provided by a managed care company can be an important factor in determining whether an employer decides to retain the insurance carrier and managed care company. Managed care companies, of course, do not like this type of strategy, and often try to silence providers through intimidation, threats of withdrawal of referrals, or the possibility of being dropped from the panel of approved providers. However, providers hold some power too, since managed care companies cannot drop every professional who complains or raises an issue. They need to have providers available to see clients, particularly in areas such as where I work, where there are few practitioners available to see young children. In this case, however, the more important advocate was the parent who was the consumer paying for services through her monthly health care premiums.

A second strategy was to arrange a meeting with the head of the managed care company and the mother. I took the position that it was important to educate the company about the standards of practice in psychology regarding the assessment of young children. I pointed out the necessity of assessing the level of children's functioning in a variety of areas in order to determine appropriate interventions for their emotional, behavioral, or social difficulties and/or mental health disorders. In effect, I shifted the conflict from being one between me (as an individual mental health provider) and the managed care company's policies to being a conflict between the managed care company and the usual and customary standards of practice in the discipline of psychology regarding appropriate client care. I pointed out that the company's automatic denial of testing, without any written policy or justification, was potentially illegal since it put psychologists in violation of the state's psychology practice act, which requires psychologists to adhere to the standards of practice of their profes-

sion. Those standards clearly pointed to the necessity and appropriateness of systematically assessing children's cognitive abilities when evaluating their emotional and behavioral difficulties. (I pressed the legal angle because of the managed care company's obvious vulnerabilities in this case. In effect, they had been caught with their pants down. Having no policy at all on the assessment of young children could not be defended or justified.)

As a result of this two-pronged advocacy intervention, I worked with the managed care company to draft written guidelines regarding the psychological assessment of young children. The end result was quite favorable. The managed care company not only approved the requested services for this particular child client, but also established a new set of policies and procedures for handling requests for psychological evaluations for both children and adults referred for testing. Thus, what started out as advocacy for one individual child and family turned out to have system-wide implications for many other children whose insurance policy mental health benefits were managed by this particular company.

What I learned from this experience was that taking a pro-active, problem-solving approach, based upon knowledge of the acceptable standards of practice in psychology and the mental health field, can move a managed care system into changing its exclusionary policies. In this case, not only my own client, but also other consumers served by this particular company, had their mental health services enhanced. The ongoing challenge for me as a solo practitioner, whose income depends entirely upon what I earn in my private practice, is to not become worn down by the numerous obstacles and delay tactics that managed care companies continue to cleverly devise. I have to walk the fine line of being able to continue to work with such companies in order to serve my clients, while also not responding to overt or covert pressure they may bring on the individual provider. Often, it seems, I am invited to "give up" on the client, to "give in" to narrow, simplistic treatment protocols, or to "give away" my power and advocate's voice when the company becomes more concerned with profits than patient care. I believe advocacy by mental health providers is essential when clients are not able to effect the desired changes in their environment or themselves because of some *condition*, such as severe and persistent mental illness, *status* such as children or adolescents who lack legal rights, or *power differential* between clients and the various institutional systems of care with which they may be involved.



Group Advocacy in the Aftermath of the Columbine Shootings: Mark's Narrative

The following narrative examines my group advocacy work as a school psychology educator. These events occurred in a school and community experiencing a major emergency mental health crisis resulting from the Columbine High School shootings in April 1999. The details are still shocking. Thirteen students were killed in a calculated assault carried out by two of their teenage classmates, who subsequently committed suicide at the end of the mayhem. The horror of this event sent shock waves

throughout the Colorado suburban school district where it occurred—and indeed to every other school district in the state (and probably the nation). The shootings occurred on a Tuesday, and as a result, the school district canceled classes for the remainder of the week. When students returned to school the following Monday, an atmosphere of shock and crisis continued to permeate many schools, affecting students, parents, and families, as well as teaching and support staff throughout the entire district.

As a school psychology educator, I spend considerable time out in the community, working with individual school psychology interns, their supervisors, and entire schools. In the immediate aftermath of Columbine, I was asked to work with a junior high school (7th and 8th grades) serving 800 students. This specific junior high school was particularly traumatized because it served as a "feeder school" for Columbine. Many of the students were well acquainted with both the two perpetrators of the shootings as well as their victims. In addition, a number of returning students at the junior high school were siblings of those who had been injured, some of whom were still in the hospital in serious condition.

Existing mental health staff in the district (i.e., school psychologists, school social workers, and school counselors) faced an overwhelming volume of requests for mental health services. A team of outside mental health specialists was assembled to assist with the transition back to school in these difficult circumstances. I worked to place as many mental health resources at the school district's disposal as I could. Initially, I arranged with my university administrators to suspend most of my usual duties, except for teaching and advising students, for a period of several weeks in order to participate as a member of the mental health team at the junior high school, aiding the students and teaching staff with transition back to school. I also recruited and coordinated the schedules of other faculty members who had mental health expertise in order to assist the school's effort in coping with the aftermath of Columbine.

My advocacy work directed at the group level was to help establish and participate in a systematic process to facilitate classroom debriefing meetings and consultations during the students' first day back, followed by group and individual counseling sessions for students in need during subsequent days. Working with others in the school and community, I participated in a systematic screening of the student body for acute and long-term mental health concerns. I also disseminated a number of educational handouts for students, parents, and staff on likely reactions to disaster and warning signs of subsequent problems developed by the National Association of School Psychologists and other agencies. Additionally, I participated in debriefing sessions with staff and administrators on a regular basis. As familiarity and trust increased among school administrators, they also asked me to consult on a number of sensitive issues that arose during that first week. At the university, I was able to infuse content on crisis intervention work, advocacy, and school violence into my course lectures and presentations to school psychology students, interns, and other students in the College of Education. In fact, a special meeting of students was convened to address these issues, with a number of students volunteering to provide continuing assistance to the schools in whatever capacity might be appropriate.

Along with the staff and administrators of the junior high, the mental health team helped foster a relatively smooth return to regular school routines. The vast majority of students appeared to regain a sense of

control of their immediate environment during that first week back at school. Students identified with acute reactions to the tragedy were referred to appropriate sources for treatment, both inside and outside of school. Additionally, a number of youth with more chronic or serious mental health problems were identified and also referred for appropriate treatment. The administrators and staff at the school developed a sense of trust and collaboration with several members of the mental health team and their agencies, which was invaluable for further collaborative efforts. (For example, the following academic year, the district began a volunteer clinical consultation program, linking the district's mental health staff with outside mental health practitioners and educators to provide ongoing resources for case consultation and staff development.) Efforts of the mental health team, and those of personnel in other district schools, also were incorporated into a more comprehensive plan for response to future disasters.

My advocacy work in this particular school was but one of many efforts by mental health professionals both in Colorado and throughout the United States in responding to youth violence. Advocating for families, groups, and communities is essential when they are experiencing difficulty accessing services or are in crisis or conflict about the adequacy of services being provided. As a result of this collective response, there has been much greater sustained public attention given to topics of youth mental health needs, school violence, violence prevention programs, gun control, and the management of large public high schools. My hope is that such attention will lead to political action, policy changes, and, perhaps, fundamental societal reforms.

What I learned most from this experience was the vital importance of mental health professionals to be responsive to the needs of their communities and to continue to advocate for needed services in an era of intense competition for resources. Working with so many dedicated professionals from other mental health and community agencies also strengthened my commitment to the notion of interprofessional collaboration and service provision. While our efforts were by no means "perfect" in attempting to respond to the needs of students, parents, administrators, and staff, as well as the community, in this tragic situation, the combined efforts of many professionals and agencies created a synergy that was highly productive. I witnessed many instances of direct benefit to students, staff, administrators, and parents, alike, from the individual and collective efforts of the mental health team. The ongoing challenge, however, is how to sustain such efforts over the long haul, especially in times when crisis conditions do not galvanize the community to the pressing mental health needs of many school-aged children and youth.

I also learned much about the deeply personal nature of helping in the aftermath of tragedy. My contacts with individual students, groups of students, teachers, paraprofessional staff, administrators, and parents affected me in ways I could not have predicted. The mixture of grief and shock, anger and confusion, pain and reconciliation that permeated the school in those first days after the tragedy was palpable. Many of the students who were friends, or at least acquaintances, of the two perpetrators as well as the victims, were agonizingly confused about how they were supposed to feel. On the one hand, they hated what had occurred, but on the other, wanted to confess that they had actually liked the two perpetrators. Understandably, many were fearful and guilty about expressing this view at first, but as the days passed more and more students voiced such feelings. Many were also frightened by what

they perceived to be similarities in their own behaviors with those of the perpetrators. In a group session near the end of the first week back at school, one young man said, "I like a lot of those same video games that Harris and Klebold were always playing. Now everyone says they're bad. Am I going to end up like them?"

My conversations with students consistently led me to appreciate the insight that many had into the conditions surrounding the tragedy. While many media reports seemed to alternate between portrayals of Harris and Klebold as "diabolical killers" and the school as too lax in controlling the influence of negative peer pressure, most of the students I talked with seemed to understand that the truth lay somewhere in between. While acknowledging that Harris and Klebold had committed a heinous act for which they ultimately must be held accountable, most also acknowledged that school was a harsh place for some students. We talked at length about the conditions that seem to create and sustain such an atmosphere, with many students expressing both a desire and a commitment to try to help change the peer climate. It was one of those rare "teachable moments," where a terribly tragic event enabled students to speak candidly about issues and concerns they normally would not share with adults.

Many of the staff were similarly affected. Most had been teachers in the district for a number of years and had had Harris and Klebold, as well as the students killed or injured, in their classes. To help re-establish familiarity and routine for their students, most attempted to get "back to business" in their classrooms, following the initial de-briefing sessions held on the first day. Still, a profound sorrow was evident in their interactions with other staff and with me. It was humbling to see the way this sorrow played itself out in the lives of both students and staff and painful to watch how the effects of the tragedy rippled into other areas of vulnerability. One teacher, for example, who initially declined my offer of assistance in her classroom and wanted nothing but to get back to the business of educating her students, eventually confided in me that she had recently been diagnosed with a heart condition. She needed to maintain a very regular schedule of sleeping and rest, but under the circumstances was finding it difficult to do so. Additionally, she told me she had the primary responsibility of caring for an elderly parent who was in failing health. I found it inspiring to watch her determination in fulfilling what she believed were her responsibilities to her students, and heartbreaking when trying to provide her with some assistance in balancing this with the need to protect her own health.

Finally, I feel I should say a few words about my experience (or rather, lack thereof) with the media during the weeks I volunteered at the junior high. I'm not sure I can communicate this clearly, but I feel that I should try. I had several opportunities to speak with both local and regional media about my experience in responding to school violence and received strong encouragement to do so. I'm sure you are aware of all the arguments for complying with such requests: it will be good for the profession, it will help create needed visibility for mental health in the schools, you should let people know what our profession has to offer, and so on. Valid arguments, all; but I never did.

I'm not a media basher, and I have no animosity toward the press. Certainly, one of the greatest assurances of a free society is a free press; and people have a need to know about events such as Columbine. But under the circumstances, it seemed somehow disrespectful to me to talk about my experience with responding to crisis, even in a general way. Perhaps the issue is timing—

in the midst of such turmoil and shock and grieving, much of which was intensely personal, it seemed somehow inappropriate to talk with others about the tragedy in a detached, impersonal way. Most of the students I was talking with were making it clear that they were unable to cope with the volume and relentless pace of media coverage about the incident. Some staff and parents were as well. So I chose to ignore the urgings of several colleagues, declined the offers I received to speak with the media, and followed my own inclinations. I'm still not entirely certain I did the "right thing" here, but that's the thing I did.

Advocacy at the Institutional/Policy Level: John's Narrative

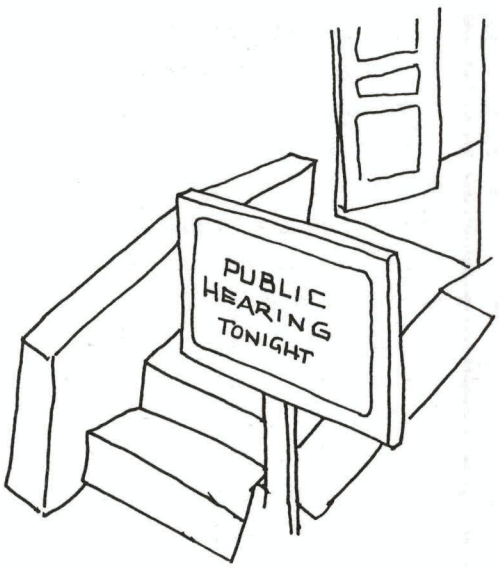
The following narrative concerns events that took place in a large urban, racially diverse public school district in Colorado, in which more than 25% of students are classified as living in poverty. The poverty rate in some individual schools is over 80%. Because of chronic underfunding of elementary and secondary public education by the state government, this local school district had been forced over several years to cut numerous non-teaching positions. As a result, the school social work department had seen its staff positions gradually erode from a high of 55 down to a low of 38. Now, the district was proposing to cut an additional one-third of the remaining school social work staff because of a projected multi-million-dollar budget shortfall. These cuts threatened vital social work services, including special education services, individual counseling, parent outreach and education, suspension and intervention services, and truancy prevention programs. Also problematic was the demoralization of the social work staff who had seen their numbers dwindle along with (not surprisingly) a corresponding increase in the demand for their services.

My role in this advocacy effort began when I was assigned as the social work faculty/field liaison to organize and lead the field seminar training that students placed in this district took over the course of their practicum year. I should add at this point that, by temperament, I am an introvert, and that my practice background comes from clinical social work—not always the best combination for advocacy or activism. Although I have tried to consistently affirm and integrate direct and indirect practice as a unified whole into my thinking, it has been far easier to talk about these ideas, rather than to take action—especially in such a public arena as school district politics. This particular advocacy effort afforded me unusual opportunities and challenges to "put my money where my mouth is." As the story reveals, I had to combine the roles of educator, researcher, activist, and advocate.

My initial advocacy intervention was largely a solo effort and actually was an intuitive "lucky shot" rather than a carefully pre-planned strategy. As field liaison, I had agreed to offer testimony at one of the public hearings the school board was holding in late April and early May on the proposed staff and program cuts in the following year's budget. On this particular rainy night, a very large number of people were in attendance—parents, school personnel, and community members—seated in the auditorium of one of the district's middle schools. Not everyone was there for social work, of course, since a number of other programs were also being threatened by proposed budget cuts. From the outset, I was concerned that there would be too many voices about too many different concerns. It would be all too easy for social work to get lost or overlooked in my being able to make an effective presentation.

The meeting began with the superintendent's opening remarks. His

handout of budget figures clearly showed the budget shortfalls and what the various proposed staff cuts would do to address the problem. Somewhat condescendingly, I thought, he expressed his "regret" about the proposed school social work staff reductions, somewhat in the manner of the country squire fallen on hard times who has decided to let the hired help, long a part of the family, go. So sorry, but what could he do!



A large number of people, about 50 or so, came forward when public testimony was invited, lining up behind two microphones to address the school board, who sat above on the stage. The school board president solemnly advised that each person would have only three minutes to make his or her point. I deliberately chose to be about tenth in line to speak. I wanted enough time to see what points other speakers would make as well as to gauge the school board's receptiveness. I was not very encouraged by what I saw. When a well-respected African-American woman social worker from one of the district's high schools gave a fiery presentation about the devastating effects social work cuts would have on the largely minority community her school serves, the predominately white board sat impassively. When a white social worker spoke of social work as being "the only discipline in the district concerned about 'persons-in-environments,'" their eyes glazed over. What, I wondered, could shake these people? I looked over at the superintendent, sitting on the side with his self-satisfied smile, and got angry. I decided to gamble on a risky strategy, namely, when you don't know anyone powerful, act as if you do.

In my testimony, I chose a deliberately provocative strategy to try to get the school board's attention. I reminded the school board of my university's *investment* in the district. Shamelessly name-dropping, I pointed to the Chancellor's very strong interest in public education and reminded the board that the university and the district already had developed a joint venture elementary charter school serving low-income students. "Another part of the University's investment," I said, "is the 40 or so social work students the School of Social Work places each year throughout the district's schools." I told the board that our student interns provided an important extension of the regular school social work services to pupils and families. "If there are massive cuts to the regular school social work staff, so also would the student intern training program and placements have to be curtailed, since they would have no one to supervise them." This statement indeed got their attention, particularly when I pointed out that in some schools, there were certain days in which the only social worker in the building was one of our students.

In the following week, I heard from the head of the district's school social work department that my testimony was the one thing that had made an impact on the board. In fact, she had been ordered by the superintendent to write a letter to the Dean of the School of Social Work at the University stating that any budget cuts in the

school social work staff would not affect the district's ability to support social work student training. Apparently, the district administration had no qualms about letting go the paid staff, but began to panic when the "free volunteer labor" by students in field placements was threatened. Perhaps the cynics-at-heart would not be surprised to learn that the school district eventually decided against making further cuts in the social work staff (at least for that budget year) because the city agreed to fund some school social work positions, thereby restoring some earlier staff position cuts. My lucky shot apparently had hit at least part of the target, although privately, I also heard that some school board members vowed never again to hold those types of public hearings on staff cuts.

The following September, at the start of the new school year, the head of the school social work department called to ask for further assistance. The district now had decided to appoint "review committees" of experts from the district and community to examine each of the "related services disciplines" (i.e., social work, school psychology, and nursing) regarding their functions and appropriate staffing levels. It seemed to her that these review committees were just another district ploy to cut staff, this time getting committee members to do the dirty work in a far less public fashion.

I had no illusions that another solo "lucky shot" would be successful. What was needed at this point was a much more coordinated and collaborative effort involving people in greater positions of power and authority than I. Fortunately, as the saying goes, timing is everything. At around this time, the Dean of the College of Education (who was favorably disposed to social work because her daughter was an MSW graduate from our program) and the Dean of the Graduate School of Social Work convened an interprofessional task force of University and community leaders to address the problem of social work cuts in the district. This interdisciplinary collaboration was crucial, as it now could not be argued that protests against the budget cuts were merely social workers seeking to protect their own turf or staff positions.

I took the lead in this committee in drafting a report regarding the populations and services currently being provided by the district's school social workers. The interprofessional task force, in turn, drafted a "position paper" based on my original report, which emphasized, among other points, the money currently being generated by the school social work staff as well as the "dollars saved" by the district because of the presence of student social workers. (We chose to emphasize budgetary matters in order to speak to the areas about which the school board was most concerned.) This report, in turn, was circulated to a variety of stakeholders, including the school social work staff, the school board and superintendent, and the media. In addition, the position paper was used by the two Deans in their subsequent meetings with the Chancellor as a way of keeping him abreast of events and as a means of soliciting his support and involvement. Eventually, both Deans were asked to serve on the district review committee for school social work services. Each of them was able to play an influential role on this committee because of their early involvement in establishing the interprofessional task force, and because the position paper had provided them key facts and figures about the services school social work provided. Further cuts in the school social work staff were forestalled once again.

At the end of the academic year, exactly 12 months from my first testimony before the board on the budget cuts, another group of us—three school social work staff who served as field instructors,

two students placed in the district, and I—testified again. Since the board likely was expecting another broadside from the social work community, I advocated for confounding them by "playing nice." We began our testimony by thanking the board for its ongoing support of the school social work student training program. We distributed a detailed report regarding the services performed by students as well as a list of the individual research projects the students had undertaken in the schools.

The board appeared to listen a bit more attentively this time, although their questions after our presentation revealed how little they understood what school social workers actually do. Mainly, they wanted to be reassured that children were not being taken out of their regular academic instruction periods for (much less important) individual or group social work counseling or special education activities. Their sole concern was about advancing student cognitive performance and academic achievement—not addressing students' emotional, social, or family issues. (No doubt this concern was shaped by pressure from the state's "educational accountability mandates" to measure student performance annually through standardized achievement testing.) Fortunately, the school social work staff had a ready answer to this, stating that there already were "life enrichment" periods built into the regular curriculum that they used to conduct their activities. I left the meeting thinking how necessary it would be to repeat such a presentation to the school board on at least an annual basis, since it was clear that their only knowledge of school social work came secondhand from the superintendent and district administration officials.

On another front, a doctoral student and I also undertook a research study on the effectiveness of the school social work student training in the district, and reported results to the school board and administration (Frey & Kayser, in press). In addition, we used the emerging situation to educate the student social workers in their field seminar class about the need to develop advocacy skills. Many of them initially were uncomfortable with advocacy and the possibility of becoming politically active but over the course of the year began to see the larger picture.

The outcome of these individual and collective advocacy interventions was positive. As a result, the district's efforts to cut school social work staff seems to be on hiatus, although for how long is anyone's guess. Remarkably, some grant-supported social work programs, such as the suspension/intervention services and truancy prevention programs, actually have been expanded from selective "at-risk" schools to become a district-wide program.

What I learned most about this experience was that advocacy efforts need many helping hands, and name-dropping about having powerful friends doesn't hurt, either. In fact, there *were* powerful friends involved—the Deans from two academic colleges (and through them, the indirect influence of the Chancellor)—which helped bring the weight, prestige, and self-interest of the university into the school district's consciousness and budgetary decision-making process. Without the involvement of these stakeholders, it is very likely that the outcome would have been less favorable. In effect, the school board was forced to shift its thinking from seeing social work only as an expendable "cost center" to viewing it (even if only temporarily) as an *asset* with a strategic partner.

On a personal level, I also learned that, when necessary, it is possible for me to overcome my own temperamental introversion and undertake advocacy work in a public, political arena. I believe that advocacy at the institutional level is needed to

enable social institutions to become more responsive in providing the required resources to individuals, families, groups, and communities. With some existing organizations, advocacy might result in the creation of innovations - such as prevention and resilience projects in schools, neighborhoods, and community centers, or through collaborative initiatives among helping professionals, parents, government, and community leaders - to remove barriers to existing services. It also might mean advocating for the creation of new services, programs, or organizations. These outcomes occur through political or legal action to strengthen the position of deprived individuals or groups and/or to seek a more equitable redistribution of resources among competing parties in a dispute.

Conclusion

Advocacy means striving for social justice, social responsibility, and social ethics in order to achieve a fundamental shift or radical re-altering in society regarding the distribution of rights, opportunities, and protections available to people within society. In the professional helping literature, advocacy interventions are classified as either *case* or *cause advocacy* (Mickelson, 1995; Parsons, Jorgensen, & Hernandez, 1994). As the above narratives indicate, advocacy at the individual or group level of social interventions can be termed case advocacy because mental health professionals are advocating on behalf of a single entity, a "case" or client system (i.e., individual, family, group, or an entire community). Case advocacy typically focuses on achieving some type of change in the client's immediate situation or circumstance. Advocacy at the institutional or sociopolitical levels, on the other hand, can be termed cause advocacy (also called "class advocacy" or "issue advocacy") because the effort is intended to promote an issue or act on behalf of a population, or class, of individuals. Cause advocacy typically is aimed at achieving social reform or structural change within social institutions.

Both types of advocacy are important and interrelated. As demonstrated in the stories above, advocacy that originally starts at the individual and/or intermediate levels of social interventions often has important ramifications at the social systems/institutional/policy level, and vice versa. We believe that mental health professionals are *ideal conduits* between individuals and groups in need and those in positions of power in determining who gains access to services. Advocacy interventions are an important aspect of mental health practice at whatever level they occur—from lobbying and political organizing of groups, to seeking policy change at the macro-social level, to case management, counseling, and psychotherapy with individual clients. They appear to be particularly important when working with child and family clients and/or the professional groups and institutions serving children and families.

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