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Ecological Framework for Social Justice Advocacy by Behavioral Health Professionals in Public Healthcare

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Abstract

In recent years, behavioral health professionals have expressed increased interest in engaging in social justice advocacy in public health care systems. In this article, we use an ecological framework to explore opportunities for social justice advocacy in such systems and challenges associated with such efforts. We propose that ecological models are well-suited to conceptualize and address the various contexts that affect behavioral health needs, and we emphasize the importance of considering the multitude of increasingly superordinate systems within which behavioral health professionals work when pursuing advocacy initiatives. We outline the central tenets of ecological models, apply them to social justice advocacy, and provide examples of

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advocacy within and across ecological systems. Finally, we reflect on future directions for behavioral health professionals interested in using an ecological framework to guide their own advocacy efforts, with and on behalf of patients and communities, in public health care systems and affiliated institutions.

Keywords

advocacy; ecological; behavioral health; public sector

Social justice advocacy refers to engagement in systematic efforts to ensure a more just distribution of privileges, opportunities, and resources among individuals in society (Mallinckrodt, Miles, & Levy, 2014). In recent years, it has received increased interest from behavioral health professionals and has been identified as a core professional competency (Fouad et al., 2009; Mallinckrodt et al., 2014; Shullman, 2017). This emphasis is because of mounting awareness of the need among diverse communities for accessible, affordable behavioral health services that are historically, socially, economically, and politically responsive (Melton, 2018). Behavioral health professionals may play key advocacy roles in public health care systems because of their understanding of the complex interaction between biological and contextual determinants of behavioral health needs; familiarity with theoretical models of change; appreciation of multiculturalism; rigorous training in data collection and analysis methodologies; knowledge of social relationships, group dynamics, and motivational processes; commitment to ethical practice; experience teaching and mentoring; and positioning within multiple systems wherein advocacy can take place and be fruitful (Golden, McLeroy, Green, Earp, & Lieberman, 2015; Toporek, Lewis, & Crethar, 2009).

Ecological frameworks, which attend to the dynamic interrelations between individuals and their environments at various levels, increasingly are guiding behavioral health advocacy (Mallinckrodt et al., 2014; Toporek et al., 2009). In health service psychology, the advocacy competency involves effective participation in actions that target the impact of social, political, economic, or cultural factors to promote individual, institutional, and system level change (Fouad et al., 2009). As graphically represented by Toporek and colleagues (2009, Figure A1), the American Counseling Association views the advocacy competency along two ecological dimensions: (a) level of intervention, from the immediate environment (microsystem) through increasingly superordinate systems (e.g., mesosystem, macrosystem); and (b) extent of patient or community involvement (advocacy with or on behalf of). These competencies reflect the view that ecologically informed advocacy, paired with self-assessment and lifelong learning, can guide successful social justice advocacy in the public sector. With reflection and experience, individuals may learn what initiatives will be most successful in which systems, how to navigate those systems most effectively, and whether such initiatives should be led by professionals, by people in the communities for which such efforts are intended, or by collaborations between the two.

Little has been written about navigating the advocacy process. To fill this gap, this article offers an ecological framework than can be used to think constructively and practically

about the conceptualization and implementation of social justice advocacy in public health care systems. We begin by reviewing the tenets of ecological models and extending them to social justice advocacy in the public sector. Subsequently, we highlight advocacy opportunities at various system levels and provide examples from our own experiences with advocacy. We conclude with future directions for ecologically informed social justice advocacy by behavioral health professionals in public health care settings.

Ecological Framework

Historical Perspective and Common Factors

In the last 40 years, ecological models have been applied to a range of topics relevant to behavioral health professionals' work in public sectors such as human development, health-related behavior, public health and health promotion, health disparities, social inclusion and disability, and implementation science (Aarons, Hurlburt, & Horwitz, 2011; Bronfenbrenner, 1977; Richard, Gauvin, & Raine, 2011; Sallis, Owen, & Fisher, 2015). Although the terminology has varied (Richard et al., 2011), several tenets are common to approaches that emphasize ecological context: (a) individuals are positioned within relational, institutional, and societal systems; (b) individuals and systems are nested within higher-order systems (e.g., microsystem, mesosystem, exosystem, macrosystem, and chronosystem) with reciprocal effects on one another; and (c) change is best achieved and sustained when intervention occurs at multiple system levels (Bronfenbrenner, 1977; Sallis et al., 2015).

Ecological Framework for Advocacy: Conceptualization

Extending an ecological model to advocacy in the public health care sector involves conceptualizing behavioral health professionals in public health care settings as nested in, affected by, and influencing, a number of increasingly higher-order systems. This means that their motivation, behavior, and success as advocates result from the interaction of their intrapersonal characteristics, the features of a given system, and the nature of the advocacy initiatives. Thus, it is behavioral health professionals in conjunction with systems that generate change (Sallis et al., 2015). According to this perspective, as changes are pursued and achieved in a system, they have a ripple effect on other systems and the individuals nested therein. Therefore, advocacy efforts should be recalibrated continuously to meet the changing needs of individuals and communities to harness their evolving views, strengths, and resources. Below, we apply the three major tenets of ecological models to our framework for social justice advocacy in the public health care system.

Tenet 1: Individuals are positioned within relational, institutional, and societal systems.—Behavioral health professionals exist within multiple systems. Most proximally, they are embedded in professional relationships with their patients and colleagues (e.g., supervisors, supervisees, managers, employees, and administrative staff; Quaye, Shaw, & Hill, 2017). More distally, they are embedded in increasingly superordinate systems including, but not limited to, public health care institutions, professional organizations, local communities, broader geopolitical structures, and social movements (Bronfenbrenner, 1977).

Both intrapersonal qualities of the advocate and environmental conditions of superordinate systems influence advocacy effectiveness. Relevant intrapersonal characteristics include competence in advocacy (i.e., knowledge, skills, and attitudes), willingness to adopt a learner perspective, multicultural identities (i.e., age, disability status, religion, ethnic and racial identity, social class, sexual orientation, sex, gender identity, indigenous background and heritage, national origin, and military/veteran status), and previous experiences (Mallinckrodt et al., 2014). Didactic and experiential learning experiences may bolster behavioral health professionals' awareness of social issues, understanding of inequities, and willingness and capacity to join meaningfully in conversation and action (Goodman, Wilson, Helms, Greenstein, & Medzhitova, 2018). Pertinent relational, institutional, and societal characteristics include systems' advocacy orientations, values, flexibility or rigidity, funding priorities, and multicultural and political composition (Donaldson, 2007).

Tenet 2: Individuals and systems are positioned within higher-order systems, which have reciprocal effects on one another.—Because of the nested nature of behavioral health professionals and the systems in which they reside, person-by-system (e.g., Clinician × Department) and system-by-system (e.g., Department × Hospital) interactions are relevant. As multicultural beings in context themselves, behavioral health professionals' values, passions, biases, choices of, and approaches to, advocacy initiatives are the product of their intrapersonal characteristics and the features of the systems in which they operate (Melton, 2018; Toporek et al., 2009). Person- and system-by-system interactions may affect the progress of advocacy efforts; movement toward change may be impacted by the match or mismatch between the advocacy initiative and public opinion, convergent or conflictual values of nested individuals and systems, and the status of advocates as members or nonmembers of the target group of the advocacy efforts.

The nested nature of behavioral health professionals and their workplaces conveys unique advantages to those professionals who wish to engage in advocacy. These individuals can harness their clinical observations and data collected in their workplaces to inform policy at superordinate system-levels, and following implementation of such policies, they can use data-driven process and impact evaluations 'on-the-ground' in an iterative fashion to refine policy and its implementation (Golden et al., 2015). Accordingly, behavioral health professionals can use their analytical skills to systematically collect and disseminate data, and improve outcome measurement, demonstrating to collaborators and policymakers the objectivity, legitimacy, and value of their proposals (Mattessich & Rausch, 2014).

Tenet 3: Advocacy can be pursued within multiple systems.—Within systems, advocacy can span the continuum of working *with* patients and communities to advocate for themselves to working *on behalf of* patients and communities by pursuing action in various public domains (Mallinckrodt et al., 2014; Toporek et al., 2009). Domains of advocacy with patients and communities can span multiple systems, including empowering patients in the context of direct service provision, collaborating with the community, and providing information to the public. Domains of advocacy on behalf of patients and communities include patient, systems, social, or advocacy (Ratts, Toporek, & Lewis, 2010). These two

forms of advocacy are not mutually exclusive and often are synergistic (Toporek et al., 2009).

Behavioral health care providers can begin their advocacy efforts at the level of the patient-provider dyad, working with their patients to identify unmet needs and empowering them to advocate for themselves. For example, patients and providers might partner to ensure coverage of services by contacting insurance companies and appealing decisions that impede equitable access to quality health care. Alternatively, behavioral health providers can begin by partnering with colleagues in behavioral health settings to address service-related needs. For instance, by leveraging collegial relationships with providers in an outpatient clinic, a provider working in a hospital emergency department may be well-poised to advocate for streamlined referral processes to reduce barriers to follow-up care for patients with few resources.

Behavioral health professionals can subsequently capitalize on their experience within nested systems in a way that increases awareness of, and rectifies, inequities in the public health care system in more superordinate systems. For example, behavioral health professionals can collaborate with other behavioral health professionals as part of state and national professional associations. In such contexts, advocacy efforts might entail submitting position letters to state officials regarding bills relevant to behavioral health and wellbeing, equity, and justice, or offering trainings to agencies to enhance staff knowledge about behavioral health and emotional wellbeing. Behavioral health providers can also engage in social justice advocacy in researcher or consultant roles in cross-sector collaborations (e.g., between community organizations and financial institutions) or as experts in public forums. Finally, they can offer skilled leadership in community-wide prevention or intervention efforts and large-scale initiatives at the municipal, state, or federal level (Golden et al., 2015; Mattessich & Rausch, 2014).

Engaging in Ecologically Informed Social Justice Advocacy

Above, we began to provide examples for engaging in advocacy at various system levels, starting with the patient-provider dyad, and then at increasingly superordinate system levels. Below, we summarize the advocacy career trajectories of two of our authors. The examples illustrate the ways in which these behavioral health professionals integrated their knowledge and experience in the workplace into social justice advocacy activities within their immediate professional environments, as well as in their communities and broader social systems. The descriptions highlight the ways in which these efforts are linked to the specific tenets of our ecological conceptualization. They show how the efforts of one person affect other individuals and influence change in superordinate systems.

It is important to note that each anecdote below represents a career's worth of work. Yet, advocacy need not be the focus of one's career to be a part of it, and advocacy might be done in small ways, not only in large-scale endeavors. Indeed, behavioral health professionals might find that advocacy work on a large scale interferes with other important professional commitments or with their own need for self-care. In Table 1, we have provided additional examples, many of which convey opportunities for advocacy on a smaller scale.

These examples will perhaps be helpful for those individuals making their initial foray into advocacy work or who are limited in their capacity for advocacy work, but nonetheless would like to contribute in some way.

We also wish to note that advocacy need not be pursued alone. Indeed, in the examples below, change was often the result of cooperative group efforts. For behavioral health professionals in public settings, there may be an ample supply of like-minded professionals interested in advocacy, and forming coalitions and interdisciplinary workgroups may help to kickstart advocacy initiatives. Allbaugh et al. (2020) describes the development of an interprofessional advocacy group, and their example might serve as a template for others who wish to do the same.

Career Advocacy

During his work in a university-affiliated community public health training hospital's community mental health center, one author with the requisite advocacy knowledge, skills, and attitudes became concerned that psychiatric and other clinicians were treating a large number of individuals recently and frequently admitted to psychiatric hospital and jail settings (Tenet 1). Conceptualizing individuals as multifaceted in their multicultural identities, he noticed that these individuals were largely unemployed, African American men with limited education, support, and resources. Many had been diagnosed with serious mental illnesses such as schizophrenia and were not taking the antipsychotic medications they received when in those institutions. The author noted the highly disparate use of hospitalizations and jail incarcerations based on individuals' employment, race, gender, socioeconomic status, housing, education, psychiatric diagnosis, criminal and psychiatric incarceration, and medication statuses. Harnessing his training, interest, and clinical observations from his proximal environment (Tenets 1 and 2), the author, over the course of his career, pursued a number of initiatives across various systems within which he was nested. He started at the most proximal level, his own workplace. Leveraging existing relationships in his workplace and his own leadership abilities, he advocated within his institution's clinical training programs across multiple behavioral health professions for diagnostic, assessment, and intervention practices that took into account sociodemographic factors more commensurate with community service practices (Tenet 1). In conjunction with his institution's system (e.g., working with administrators and other faculty), he was able to develop a community psychiatry fellowship in the psychiatry and psychology training programs (Tenet 1). The development of these programs had ripple effects; they educated other faculty and students about relevant practice and community issues, which resulted in an influx of trainees interested in working collaboratively on patient care advocacy (Tenet 2). By providing the necessary education and training experiences, these programs empower trainees of future generations to engage in patient care advocacy, creating, in effect, a shift in the chronosystem (Tenet 2).

The author then pursued advocacy, on behalf of his patients' communities, at superordinate levels—professional and national organizations (Tenet 3). By approaching established organizations like Mental Health America and the National Alliance on Mental Illness, he was able to join a network of like-minded individuals and harness resources available to

superordinate systems that are not often at the disposal of the individual. Specifically, he worked to address macroscopic factors, like mental health stigma in labeling and policing. Again, individual efforts on his part had ripple effects (Tenet 2): discussions he initiated laid the groundwork for statewide antistigma campaigns and the introduction and use of behavioral health sensitive policing approaches when dealing with individuals presenting with mental health conditions (Compton & Kotwicki, 2007). Downstream effects included the development of a Crisis Intervention Team training for police, correction, and security officers in coordination with behavioral health emergency and crisis services throughout the state (Tenet 1). Macroscopic changes in the discourse on behavioral health and policing and shifting priorities later allowed the author to partner with a county judge working with the city's Homeless Task Force. Capitalizing on their partnership (including shared concerns; Tenets 1 and 2) and this existing resource, he was able to create and fund two behavioral health outreach teams. These teams provide a comprehensive array of Assertive Community Treatment services to individuals who are both homeless and have a serious mental illness. Having established relationships with like-minded professionals in the various systems he found himself active within, the author subsequently joined with other community mental and behavioral health service providers in encouraging the State's Department of Behavioral Health to pay for evidence-based psychosocial interventions and services proven effective with individuals found to be "indigent" and diagnosed with a "serious mental illness" (Tenet 1). By pooling expertise and collaborating, this joint effort influenced the revision of the State's payment system to be more inclusive of psychosocial and behavioral services (Tenet 2).

Finally, having developed advocacy competencies and interprofessional connections through the aforementioned efforts (Tenet 1), this author worked on the County's Blue Ribbon Commission to address jail overcrowding and the possible need to build a larger jail. During an initial visit, the author made use of his quantitative background and aided commission members in recognizing that 82% of current inmates were African American males, and over a third of all inmates were on some type of antipsychotic medication. The commission, an interdisciplinary group primarily composed of attorneys and county personnel, recommended the development and implementation of a dedicated behavioral health court focused on "treatment, not incarceration" as a means of reducing the jail population (Tenet 3). The county accepted the proposal, and today, the ripple effects of those efforts on individuals on systems relevant to the work, but generally outside the purview, of behavioral health professionals is substantial: the superior court judge over that court has become a major advocate, heading an organization for the improved treatment of the mentally ill in the state's criminal justice system (Tenets 2 and 3).

Another author used her clinical, administrative, and research abilities to advocate for alternative methods to enroll and retain young adults living with HIV in medical and behavioral health services. Her advocacy began with an immersion in the literature suggesting that HIV positive young adults who are aware of their diagnosis are poorly linked and retained in HIV-related care. Inspired by existing research, this author chose to start at the institution-level and coordinated a number of research endeavors involving colleagues from psychiatry, infectious disease, and public health within a large, university-affiliated public hospital (Tenet 1). Together as a group, the author and her colleagues worked with,

and on behalf of, their target community to determine alternative linkage and enrollment procedures that could minimize barriers to, and facilitate, care continuity that was feasible and acceptable to underserved young adults living with HIV (Tenet 3). To develop youth-informed strategies and provide opportunities for youth self-advocacy, focus groups were conducted with young adult patients and at-risk young adults in the community during the formative stage of the study (Camacho-Gonzalez et al., 2016). Results revealed that newly diagnosed young adults who received alternative linkage and retention strategies had higher linkage to care rates, were linked to care sooner, and had greater appointment adherence and more pronounced improvements in HIV-related biomarkers (Camacho-Gonzalez et al., 2017; Murray et al., 2018). At the administrative level, these results were used to inform improvements to the linkage, enrollment and retention efforts in her clinic (Tenet 2). As a result, the system shifted in such a way that resources were more accessible to a particularly vulnerable group (Tenet 3).

Wishing to address the needs of those living with HIV/AIDS in other ways, the same author looked for opportunities at more superordinate levels, seeking organizations with similar values and aligned funding priorities (Tenet 2). She collaborated with the American Psychological Association's (APA) Office on AIDS/American Psychological Association Ad Hoc Committee on Psychology and AIDS (COPA) and Black Entertainment TV's (BET) RAP-IT-UP campaign, a national antistigma campaign to bring HIV awareness to youth and young adults (Tenet 3). As a member of the APA's consultation team for this collaboration, this author worked on behalf of the patient community, traveling nationally as a panelist on the RAP-IT-UP campaign's panel to address macroscopic factors such as increased HIV awareness and stigma reduction (Tenet 3). This author also worked with the patient community as a committee member for the development of the APA/BET RAP-IT-UP youth advisory board, a board comprised of high school-aged youth that advise APA and BET on sexual health issues impacting youth on a national level (Tenet 3). Lastly, she was an HIV/AIDS Trainer via APA's HIV Office for Psychology Education Program (HOPE), which used this platform to advocate for HIV/AIDS-related training for behavioral health professionals (Tenet 3). As a result, this author conducted trainings to enhance medical and behavioral health professionals' ability to competently and compassionately respond to people infected or affected by HIV/AIDS. Like in the previous example, this effort had important downstream effects in shifting the chronosystem by bestowing upon a new generation of behavioral health professionals the competencies to effectively serve this patient community for years to come (Tenet 2).

Factors Critical to Success in These Examples

In these examples, the authors were able to effect change by bridging their empirical knowledge (e.g., of health disparities, predictors of risk, determinants of change, and efficacy of interventions) with their experience working within, and with consumers of, the public health care system, in conjunction with collaborators outside the pubic health care system. Their positions within public health care systems afforded them the opportunity and visibility to develop colleague partnerships and workgroups that capitalized on different expertise and perspectives. Such collaborative efforts contributed to their success by

increasing accountability among peers, institutions, and communities engaging in social justice advocacy (Melton, 2018).

These efforts were facilitated by interpersonal (e.g., negotiation and persuasion) and research (e.g., familiarity with data collection and analysis methodologies) competencies, advantages conferred to behavioral health professionals by virtue and design of their training experiences. The latter has been highlighted as a competency that is highly valued in cross-sector collaborations. Research suggests that professionals who work with, but exist outside of, the behavioral health professions often value most strongly the data analytic skills of behavioral health professionals; they desire data for improving management of collaborative work and content-relevant data, as well as the development of assessment methodologies to reliably evaluate initiative outcomes and returns on investment (Mattessich & Rausch, 2014). Particularly important to social justice advocacy, and as exemplified in the accounts above, behavioral health professionals are in the position to confirm that data informing policy are valid and relevant to traditionally underserved groups. Further, they can ensure that diverse and underserved populations are included among those who are surveyed in outcome evaluations, and that assessment measures used are free from systematic bias.

As noted before, advocacy need not be pursued alone. In our experience, the social and instrumental support of others is usually crucial to advocacy effectiveness. Anecdotally, in our interprofessional advocacy group (see Allbaugh et al., 2020), we found it useful to open our group to individuals with different training backgrounds at different career stages, even if their level of expertise and total time commitment varied. We met monthly and joined in brainstorming advocacy ideas, sought inspiration through group excursions (e.g., to the National Center for Civil and Human Rights), and invited community leaders to guest lecture. Of course, some behavioral health professionals might not have such built-in networks in their work settings. In those situations, reaching out to others in the proximal professional community, to professional organizations (as exemplified in our career advocacy examples), or to community or other stake-holders, likely will be necessary.

Discussion

In this article, we offered an ecological framework to guide social justice advocacy in public health systems. To advance the literature, we incorporated empirical data pertinent to social justice advocacy in different ecological systems and contexts. We provided hypothetical opportunities and specific examples of our own experiences with social justice advocacy that illustrate the applicability of an ecological framework for such endeavors. Several lessons that can be distilled from our own experiences with advocacy include: the importance of recognizing embedded systems and thinking concretely about how to implement change as part of a superordinate system; the potential for affecting macroscopic factors (e.g., public opinion) by intervening at the level of the patient or community; and the value of behavioral health professionals using their voices when decisions that affect their patients are made by professionals in other fields. We hope our efforts will promote discussion and action in the realm of social justice advocacy.

This article is responsive to rising interests in advocacy among behavioral health professionals. The information provided is intended to, in a theoretically- and empirically-grounded manner, help such professionals overcome personal (e.g., lack of awareness about advocacy opportunities and public polices issue for which to advocate), organizational (e.g., lack of resources), and systemic (e.g., difficulty building collaborative networks) barriers that historically have impeded advocacy engagement and follow-through (Chang, Hays, & Milliken, 2009; Cohen, Lee, & McIlwraith, 2012; Donaldson, 2007; Heinowitz et al., 2012; Lewis, Ratts, Paladino, & Toporek, 2011). Yet, while we hope to help interested professionals engage in scientifically minded social justice advocacy, we recognize that there is an inherent tension between science and policy. Some suggest that social justice advocacy should not fall within the professional scope of behavioral health professionals, as challenges arise when the desire to "do good" conflicts with the need to remain objective in research, or when empirical evidence runs counter to what "seems fair." For these reasons there are ongoing debates regarding dual engagement in research and advocacy, debates that we value. Further, we acknowledge that there are limits upon those behavioral health professionals who do engage in advocacy; for instance, the Hatch Act limits partisan political activity on behalf of federal public employees and state and local employees performing duties financed by federal funds (see Rocha, Poe, & Thomas, 2010). It is important that behavioral health professionals are aware of such boundaries.

We have proposed that an ecological approach to social justice advocacy is informative because it posits that individuals exist in nested systems with reciprocal effects. Yet, it is notable that the systems in which behavioral health professionals operate and pursue advocacy may not fully or at all overlap. For example, a psychologist may be employed by a hospital in one city but run for political office in another. Further, if there is incomplete or non-existent system overlap, it follows that change in one system may not always yield change in another, at least not immediately. Consider the example of advocating on behalf of a transgender patient for changes in one public hospital to meet the needs of transgender persons. How does empowering an individual in one setting change the way that person engages in advocacy in another environment, such as the city or town in which they live? One might wonder about the perception of transgender persons in the community where the person resides, the available community resources, or the policies in the clinic in which they receive follow-up care. If norms, policies and procedures, and regulations vary across systems, then behavioral health professionals must be thoughtful about the implications of advocacy in the specific contexts in which such activities are based and across patients' multiple contexts. It is important that advocates thoroughly contemplate the effects of their actions, including potential adverse consequences of their actions in other contexts; it is important that they consider both "doing good" and "doing no harm." Achieving a balance may involve reviewing literature on diversity and multiculturalism, conducting additional research, and organizing focus groups with patients and communities to elicit their opinions and needs. Seeking training in systems-level interventions, community and public health, and community-based participatory research may be useful as well. Before initiating advocacy endeavors, it also may be helpful for behavioral health professionals to assess systems' readiness for change.

More real-world applications of an ecological approach to advocacy are needed to evaluate this framework's utility in public health care settings. In the event that behavioral health professionals find an ecological approach useful and inclusive, they will need to establish benchmarks for evaluating the utility and success of interventions at different system levels from an ecological perspective. In other words, they will need to develop tools and strategies to assess how change in one system affects conditions in other systems. Defining success in ecological terms might mean quantifying the extent of advocacy initiatives' ripple effects (i.e., to what extent did change successfully made in one system positively or negatively affect change in subordinate, superordinate, or semioverlapping systems). Another benchmark might involve the longitudinal assessment of ripple effects (i.e., how long did it take for an advocacy-related change in one system to affect change in other systems). We recognize that the development of tools and strategies to comprehensively assess ecological approaches to advocacy will be methodologically (e.g., design, statistics) and logistically (e.g., collection of data at multiple levels) challenging given the complex interactions among the various contexts (Sallis et al., 2015). Nevertheless, this focus on evaluating the efficacy of advocacy endeavors is important and consistent with recent calls for activism with scholarship (Lewis et al., 2011). Using an ecological approach, behavioral health professionals have the potential to empower and promote agency among underserved and vulnerable communities, as well as to foster strong alliances that rectify complex and unjust health care disparities.

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Table 1

Ways to Get Started With Advocacy

	Within the workplace	Community, state, or national-level
Learn	Attend lectures on health disparities Review research on traditionally underserved groups Enroll in continuing education workshops focused on culturally responsive care	Take part in community cultural events Complete relevant online trainings or certification courses Visit conferences that address disparities and barriers to care
Gather information	Collect data to validate and revise existing assessments in underserved patient populations Conduct patient needs assessments, focus groups, and program evaluations Research whether colleagues have engaged in advocacy or formed interprofessional groups	Find information on funding priorities of existing advocacy-oriented groups and other agencies Sign up for alerts from professional organizations about new and ongoing advocacy initiatives
Join and engage	Speak with colleagues about your experiences and concerns Brainstorm advocacy ideas with others at your institution or in your professional network Build relationships with administrators to inform clinic policies and practices Meet with government relations officials at your institution	Consult with experts and community leaders in advocacy and reform Serve on professional committees or participate in state or national-level organizations or task forces Design and evaluate assessment tools that can measure impact of policies and initiatives
Organize and educate	Facilitate panels, grand rounds, or roundtable discussions Develop and lead advocacy or patient-care colloquiums Propose or sponsor workshops for trainees and colleagues	Educate others via public forums and social media Present empirical findings on vulnerable groups at conferences Provide data to community leaders, funding agencies, and state legislators