HEALTH ADVOCACY BULLETIN

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Letter from the Interim Director

By Laura Weil

The Health Advocacy Program has enjoyed many successes over the last academic year, and we look forward to continued vitality and growth. We graduated nine students in 2007-2008, and anticipate sending seven more professionals into the field in May. With the support of Graduate Admissions, recruitment has taken significant steps to increase inquiries and applications, attracting a greater percentage of well-qualified younger students to the program. This has given

"It is the alumni who define the field of health advocacy, not the program that trains them."

the entering class of 2008-2009 a healthy mix of traditional full-time students to complement our customary population of part-time career-changers. In addition, the entire faculty has enthusiastically come together for several meetings and a day-long retreat to work on curricular enhancements. We are honing the connections among the courses to support a cohesive curriculum that will better prepare graduates for success in the broad profession that is health advocacy.

Laura Weil,
HAP Interim Director

The very breadth of this profession has posed a challenge for some students in envisioning a professional identity and career trajectory. We have pulled the Program a bit closer to the "professional" aspect of health advocacy, recognizing that our primary responsibility is to provide students with the skills and knowledge needed to be leaders and change agents who can address the inadequacies in our health system. To do that, they need to see themselves in a recognizable professional context — one that they can communicate to potential employers. This was easier when we focused on just a handful of career tracks. As we have widened the advocacy path, the way has become less clear for some.

The Program itself has been tackling professional development: we have worked on a "taxonomy" of advocacy professions to give some structure to the potentially bewildering breadth of possibilities. We're aggressively disseminating employment opportunities to students as well as alumni. It's important for current students to be bombarded with career opportunities, so that they can begin to visualize a goal while still in the Program and prepare themselves to make their chosen goals attainable. We are introducing substantive specializations into the program, enabling students to isolate practice areas and then tailor their studies, fieldwork, and capstone projects to produce a portfolio of learning and work that will demonstrate their expertise to potential employers. We have added career development seminars and more robust fieldwork resources. We feel that this vigorous integration of broad stroke advocacy learning with the applied practice of our profession will give students the experience and authority they need in the career marketplace.

All of the emphasis on jobs and professional development is deliberate, and in the process we need to capitalize on the successes of our graduates, using them as concrete examples who give structure and public identity to the field. It's the alumni who define the field of health advocacy, not the program that trains them.

The purpose of these "Notes from the Field" Health Advocacy Bulletins has been to try to provide some specific examples of the array of advocacy work in which our graduates are currently engaged. We hope that by providing these tangible examples, the range of possibility this degree offers can be seen as irresistible for students — and reinvigorating for alumni.

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Health Advocacy Program
1 Mead Way
Bronxville, NY 10708-5099
Address Service Requested

Letter from the Editor

By Barbara Robb

Editing the Health Advocacy Bulletins has given me a chance to speak with program graduates about their work. All of the contributors have emphasized the importance of internships to their careers. Isela Chavarrria, who has written about her work with the UN Refugee Agency in Sudan, chose internships in which she could serve disenfranchised population groups in the New York area. Helene Lefkow worked for the Mental Health Association of Rockland County while studying at Sarah Lawrence, and was eventually promoted to Quality Assurance and Special Events Coordinator for the organization. Jessica Miller was energized by the challenges and rewards she found in her internship at New York-Presbyterian Hospital and went on to a patient representative position at Memorial Sloan-Kettering Cancer Center. Yvonne Bonkour learned public relations tools for advocacy during her internship and has found a niche working in public relations for non-profit organizations. Jean Anne Cipolla focused on mental health in her internship choices and went on to a post-graduate internship in mental health policy in Washington, D.C.

It is very fitting that this issue of the Bulletin, which emphasizes the importance of internships, also introduces a new field work coordinator. Betty Gilmore will be working with the Health Advocacy Program, beginning in September 2008, to enhance the field work experience for students.

Barbara Robb graduated from the Health Advocacy Program in 2007.

Capstones in the HAP Curriculum: A Growing Feature of the Landscape

By Rachel Grob

HAP students have long had the option of undertaking a "capstone project" before graduating with a degree in Health Advocacy. Capstone will become a required component of the Health Advocacy Program for students who enter the program this year. Beginning in the autumn of 2008, a Capstone Seminar will be offered to support the completion of capstone projects and provide students with an opportunity to continue building their professional identity and knowledge of the health advocacy field as they move towards graduation. The Capstone Seminar 2008-2009 is a collaborative teaching project including Mark Schlesinger, Professor, Division of Health Policy and Administration at Yale University, Rachel Grob, SLC Associate Dean of Graduate Studies and Director of the Child Development Institute, and Laura Weil, Interim Director HAP.

What is a capstone? It can be defined, in paraphrased form, as *"a culminating experience in which students are expected to integrate special studies with the [degree], and extend, critique, and apply knowledge gained in"* the graduate program. It focuses on the *"ways of knowing"* in a specific field, and addresses the types of questions and issues faced by practitioners (Wagenaar, T. C. The capstone course. *Teaching Sociology, 21(3), 209-214).*

Both the **Capstone Project** and the new **Capstone Seminar** are designed to consolidate an understanding of the breadth of the health advocacy field and strengthen students' identity as professional health advocates prior to their entry into the job market. In addition, the seminar will provide students with a strategic perspective on how the field is evolving and with the skills to successfully navigate in a profession that is rapidly changing and in a health care system poised for significant reform. More specifically, the Capstone Seminar is designed to facilitate students' work on their capstone projects by providing them with a group setting in which to explore ideas and refine project parameters; connect the project to broader advocacy concepts and career development opportunities; and get regular feedback (from both the Capstone faculty and from their peers) on works in progress, presentation skills, and broader thinking about the field. In addition, the seminar will explore professional advocacy norms and ethics, current and projected "maps" of the diverse advocacy landscape, and effective long-term advocacy strategies for producing needed change in health and health care.

Rachel Grob is Associate Dean of Graduate Studies and Director of the Child Development Institute at Sarah Lawrence College. She is a graduate of the Health Advocacy Program.

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Interim program Director: Laura Weil
Editor: Barbara Robb
Email: lweil@sarahlawrence.edu

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Notes From the Field

Working with Refugees and Returnees in Sudan

By Isela Chavarria

Working for the United Nations High Commissioner for Refugees (UNHCR, the UN Refugee Agency) is one of the toughest but most rewarding jobs. UNHCR's core mandate is protection — it is the foundation of the way international protection is envisaged in the 1951 Convention and the 1967 Protocol and in UNHCR's mandate. Protection embraces everything UNHCR does, whether it's the delivery of tents, plastic sheeting, the delivery of food, or health care. It improves the environment that people live in. It contributes to their human dignity. It contributes to the realization of their rights and their physical security. Using a worldwide field network, we seek to provide at least a minimum of shelter, food, water, and medical care in the immediate aftermath of any refugee exodus.

Isela (in blue cap) in the field, helping Sudanese returnees

"The complexity of Sudan creates a challenge rarely encountered in other operational contexts."

The UN Refugee Agency's primary purpose is to safeguard the rights and well-being of refugees. It strives to ensure that everyone can exercise the right to seek asylum and find safe refuge in another State, with options to return home voluntarily, integrate locally, or resettle in a third country. The agency has helped an estimated 50 million people restart their lives. Today, a staff of around 6,300 people in more than 110 countries continues to help 32.9 million persons.

On June 20, we celebrated World Refugee Day. This year, events around the world focused on the fundamental need for protection. For some, this means economic security; for others, protection means freedom from violence and persecution. On World Refugee Day, we turn our attention to the millions of refugees who live without material, social, or legal protection. Protection is also about raising awareness. We cannot protect refugees if their plight remains invisible.

As a Community Services Officer for UNHCR in Sudan, I have the opportunity to work directly with the host local, returnee, and refugee communities. The complexity of Sudan creates a challenge rarely encountered in other operational contexts. This complexity is often summarized in the expression, "one country — five operations." For Community Services activities, this goes beyond a geographical and logistical challenge. Sudan presents most of the possible situations and persons of concern for UNHCR. I've been directly involved in major voluntary repatriation operations from neighboring countries (Sudan borders nine countries) to South Sudan. In July 2008 I was redeployed to East Sudan to conduct verification and registration at the refugee camps for the Eritrean, Ethiopian, and Somali refugees.

I have worked in the South of Sudan as a Community Services Officer, helping Sudanese return from neighboring countries — Kenya, Ethiopia, and Uganda. My job involves reintegration of returnees back to the Sudan. I've worked on community harmonization among the returnees and host communities, with most of my activities focused around health and education. Among other projects, I conduct HIV/AIDS awareness and prevention educational sessions for men in the armed forces, as well as UN observers. Cultural, religious, and personal beliefs make this topic very sensitive. It is extremely challenging, particularly when the trainer is female (as in my

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case). A woman in this society is never to address these issues in public or private, or she will be stigmatized and ostracized by both men and women. We see it as a milestone when even one person in uniform shows up at our sessions. As you can see from the photo, we have been successful in attracting both soldiers and UN personnel to the sessions.

Isela Chavarria conducting HIV/AIDS awareness and prevention training session

"We work actively with the refugee communities in defining and seeking solutions to their problems..."

I now work as a Community Services Officer in the East of Sudan. I divide my time between registering arriving refugees in our camps and training national Community Services staff in applying a community development approach in the refugee communities. We work actively with the refugee communities in defining and seeking solutions to their problems, and take particular care to involve women and children in the process. There are regular participatory assessments, using a gender, age, and diversity perspective to understand the refugee population, their protection concerns and priorities, and the resources available to them. We also collaborate with the Protection section in early identification, prevention, response, and follow-up with survivors of sexual gender-based violence. I supervise three Community Service Clerks who collect data during registration, in order to identify individuals and groups with specific needs, such as unaccompanied minor children, children separated from their families, women at risk, and refugees with serious medical conditions.

In simple terms, I work seven days a week. Sometimes I'm in the office writing reports and recommending durable solutions for each individual case referred to the Community Services Unit. Other days I'm out in the field at the refugee camps conducting individual interviews with the refugees. The Community Services Officer is the "human face and touch" of UNHCR. We take the time to talk with each individual as a human being. We assess how to best meet their needs and help them become self-sustaining by finding the best durable solutions. For some refugees, that means returning home; for others, it may mean resettlement in a different country altogether. Most of the returnees have been refugees in other neighboring countries for 20 years or more. The majority are women and children. As this is the first time the children have come to Sudan, it is a very difficult and emotional time for all concerned.

One of my most important activities has been work on Community-Based Rehabilitation Projects (CBRPs). Projects are identified with direct participation from the communities and are mostly oriented towards community-services activities, training in basic public health hygiene, education, environment and water supply, HIV/AIDS awareness and prevention, and prevention and awareness of sexual gender-based violence. CBRPs increase opportunities for dialogue among the various communities, to promote integration. In South Sudan part of my job in Upper Nile State (Sudan consists of 26 states) is to raise awareness in the communities on basic health education, hygiene, and promotion. I've conducted trainings on a wide range of topics: displacement and return, rights

"The Health Advocacy Program gave me the opportunity to continue to map out my own professional plan."

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Mental Health Advocacy

By Helene Lefkow

I began working at the Mental Health Association of Rockland County (MHA) two weeks before I began my official studies in the Health Advocacy Program. What started out as a part-time position "until I got my degree" has turned into a full-time career.

The Mental Health Association of Rockland County is an affiliate of Mental Health America (formerly the National Mental Health Association), the largest non-profit organization in the country dedicated to addressing all aspects of mental health and mental illness. MHA of Rockland was founded in 1951 and opened the first mental health clinic in the county in 1954. Since then, the MHA has grown to include over twenty programs and services.

I was initially hired to be the Executive Assistant to the President — you know, the basic secretarial stuff — scheduling, typing letters, taking minutes, etc. Then, a few months into my employment, the Special Events person resigned and guess who was left to organize and plan all future fundraising, advocacy and educational events? You guessed it — me. And all in a 25 hour work week.

The first event I organized was MHA's first-ever Mental Wellness & Parity Walk in 2005. Besides being a fundraiser, the event's purpose was to raise awareness of the importance of mental health and the need for insurance parity for mental illnesses. (Timothy's Law, the NYS parity law, had not yet been passed.) Since that first year, we have held a walk every year. It has grown to involve not only MHA, but also the National Alliance on Mental Illness, the Rockland County Mental Health Coalition, and the Nathan Kline Institute for Psychiatric Research.

As graduation from Sarah Lawrence loomed, I was approached by the President/CEO of MHA to continue working full-time in a greater capacity. Added to my job description is Coordinator of Quality Assurance for the entire agency, which basically means it's my job to make sure that all MHA programs are in compliance with all federal, state and local laws and regulations, particularly those of the New York State Office of Mental Health and Medicaid. More than that, it means that I must make sure that we are doing right by our clients.

"I bring a unique perspective to my job — that of the 'consumer'."

In the next few months I will be phasing out the Special Events aspect of my position to focus more on quality assurance and special projects, including advocacy. The MHA has been especially active in the area of geriatric mental health. For the past year I have been the agency's representative on the Rockland County Geriatric Mental Health Workgroup, a planning body whose purpose is to identify and assess local needs, availability of services and service gaps and recommend identified goals and priorities to the County of Mental Health. The MHA is also part of the New York State Geriatric Mental Health Alliance, which advocates for changes in mental health practice and policy to improve mental health services for older adults and to develop an adequate response to the mental health needs of the elder boom generation. This past year I had the privilege of being on the Alliance's Annual Conference Planning Committee. The Alliance has also been working closely with the Chair of the Rockland County Legislature on an aging-in-place initiative, with public hearings held for the community to express their concerns about aging in place in Rockland County. A white paper based on hearing results is expected to be published this fall.

I bring a unique perspective to my job — that of the "consumer." Having dealt with my own mental illness for many years, I always look at a situation from the client's point of view. In a public mental health system where patients can often get lost in talk of budgets, liability and turf wars among competing interests, I feel I bring a much needed balance, even if in a small way, to how MHA delivers services. Going through the Health Advocacy Program, with its emphasis on the patient, has only strengthened this stance.

Helene Lefkow graduated from the Health Advocacy Program in 2007.

Front Line Patient Advocacy

By Jessica Miller

When I first began the Masters program in Health Advocacy at Sarah Lawrence, I remember thinking from the beginning, and throughout the course of study, "I am not going to work in a hospital." I came into the program wanting to expand my knowledge of sociology from a public health standpoint to eventually use this knowledge to do policy level research or, even better, to be involved in formation of healthcare policy. Basically, my ideal was to take the micro patient experience and make it into macro level change. Although I have been successful in this pursuit, like many other Health Advocacy students I found myself taking a very different path to that end than I had imagined. As a result of my internship experiences I found myself being drawn towards the direct patient advocacy opportunities available. I realized that through working with patients I could be most effective in empowering individuals to make informed decisions about their health care and in fundamentally helping them become their own advocates in the current confusing health care system. I soon discovered that working in the hospital setting was the most effective way to realize this ideal, which led me to my current position as a Patient Representative at Memorial Sloan-Kettering Cancer Center (MSKCC).

I became aware of the position at MSKCC through my fieldwork advisor and SLC Health Advocacy faculty member, Constance Peterson, while interning in the Emergency Department at New York-Presbyterian Hospital. The challenging experience of working at directly with patients in a multifaceted, dynamic hospital center prepared me for my current position and truly opened many doors for me, both personally and professionally.

MSKCC is a hospital dedicated solely to the prevention and treatment of cancer. Located on the Upper East Side of Manhattan, it serves patients from all areas of the globe and has established itself as an international standard for cutting edge cancer research and treatment. The hospital center consists of an inpatient unit with approximately 20,000 admissions in 2007 and a variety of outpatient facilities located throughout Manhattan, New Jersey, Long Island and Westchester County. Working within a team based approach to care, MSKCC delivers customized cancer treatments to patients through consultation with world-renowned surgeons and oncologists. Research is an integral part of the institution's commitment to cancer care. There are currently approximately 500 active clinical trials, lending many opportunities for patients to be part of state of the art cancer drug development and treatment alternatives. In an effort to ensure patient safety and patients' rights within the hospital system, MSKCC has developed the role of the patient representative into one that is valued and highly respected within the institution. The department consists of eight patient representatives with one department director who reports directly to senior level administration. From this feedback, suggestions are made for improvement and, if warranted, institutional level policy change or formation is recommended.

"...my ideal was to take the micro patient experience and make it into macro level change."

Patients are referred to the Patient Representative in a variety of different ways and for many different reasons. Some patients contact the department directly, or they are referred by medical staff, administration, family members, case managers or social workers, to name just a few. The Patient Representative serves several roles as a mediator between parties, a navigator within the hospital system, and a liaison to different departments within the institution such as the Ethics Committee and Quality Assurance Review Board. When a patient initiates a complaint our department is engaged to mediate and resolve the conflict while keeping the institution informed about its nature and progress of the resolution. Patient Representatives are also involved in advanced care planning, working to ensure that patients have a voice in their health care even after they cannot speak for themselves. As an Advocate I work to create enhanced patient-doctor communication, attend many appointments with patients in the outpatient setting and facilitate "family meetings" in the inpatient unit with the entire interdisciplinary medical team. Additionally, a large portion of my advocacy is devoted to helping patients gain access to the hospital and negotiate insurance issues. All of our patient cases are trended resulting in monthly and annual reports that draw attention to certain areas of the hospital that may need improvement or change.

My job as Patient Representative at MSKCC is a dynamic and diverse one that poses more challenges and rewards than I could have ever imagined as I sat in my graduate classes at Sarah Lawrence. Perhaps the most valuable lesson I have learned is that we continue to grow after our degrees are awarded; we build upon the knowledge we gained as we continue in our careers.

Jessica Miller graduated from the Health Advocacy Program in 2007.

Communicating for a Cause

By Yvonne Bokhour

As advocates — particularly Sarah Lawrence advocates — we are determined to make a difference. We bring passion, dedication and knowledge to our missions. One of the most remarkable aspects of my experience at Sarah Lawrence was absorbing the excitement of my fellow students, who were all incredibly enthusiastic. It was inspiring to see so many ardent, intelligent people firmly committed to health advocacy.

We write a lot at Sarah Lawrence and therefore know from first-hand experience how difficult it can be to express our ideas coherently. Writing an academic paper may be daunting, but presenting your ideas to the public or your colleagues can be equally intimidating. Passion and knowledge are not enough; to be truly effective, you must find a way to engage your audience.

I came to Sarah Lawrence as an established grassroots organizer with some experience writing press releases. I wrote from the heart, which certainly helped me connect with my readers. Nevertheless, I knew I needed more substantive tools to make my case. I had heard that Kovak-Likly Communications, a public relations firm based in my home town of Wilton, Connecticut, specialized in health care, so I approached the principals, Beth and Bruce Likly, with a request. I asked if they would consider helping my nonprofit organization, which raises funds for Lyme disease research. They graciously agreed, knowing Lyme disease is a significant problem in our community. Then I realized I could work and learn at the same time as an intern. They were kind enough to take me on, and I have been with them ever since.

Kovak-Likly has been a potent force in the health care industry for many years, representing a variety of clients from pharmaceutical companies to medical device manufacturers to nonprofit organizations. They have also forged partnerships between these entities, implementing strategies to promote mutual goals. Before I came to work with them, I had vague notions about the importance of a good letter to the editor or an effective press release. Now I know that numerous public relations tools and techniques can play a vital role in improving public health.

"It was inspiring to see so many ardent, intelligent people firmly committed to health advocacy."

Since my graduation, I have been working with the Liklys and my colleagues at KLC to expand our nonprofit portfolio. I feel fortunate to have their enthusiastic support in this effort. There are countless ways pubic relations can assist nonprofits to promote their healthcare missions. For example, pubic relations can help you:

- Craft an effective message. It's crucial to refine your communication goals. Advocates need key message points with substance, focus, clarity and resonance.
- Give an engaging presentation. It's important to convey points clearly and confidently, whether you are persuading policymakers, presenting research or fundraising.
- Attract attention to your cause. Advocates need to know their audience and find the best delivery vehicle to reach that audience. PR professionals specialize in creative strategies to publicize your message to targeted markets. Tools include press releases, press conferences, educational forums, celebrity spokespeople, speech writing, brochures, newsletters, media training, website development and Internet messaging.
- Conduct a successful interview. It's vital to know the ground rules of media relations. Learning interview dos and don'ts, coping methods for difficult situations and memorable phrasing can shape a debate and propel your cause forward.
- Develop mass media campaigns. Television commercials and other mass media vehicles including the Internet have been particularly effective in promoting health — they have had a measureable effect, for example, on people's smoking habits and have become a crucial component in international tobacco control.
- Use media technology to promote health. Did you know you can help patients find care via text messaging? As an example, it's now possible to find an HIV testing center near you simply by texting your zip code to "KNOWIT" (566948). With today's exciting advances in digital media and interactive telecommunications, the possibilities for imaginative health education strategies are endless.

Sarah Lawrence is a remarkable place to learn varied aspects of health advocacy — from physiology to ethics to policy. Communicating this complex knowledge in a practical manner — one that can educate, inspire and move the public and policymakers — would be a meaningful goal for any graduate of the program. Public Relations would be a wonderful career choice for HAP alumni, but whatever path you choose, it is important to recognize that cutting edge communications techniques and technologies play an increasingly vital role in advancing the field of health advocacy.

For more information, please contact Yvonne Bokhour at Kovak-Likly Communications, 23 Hubbard Road, Wilton, CT 06897, ybokhour@klcpr.com or 203 762-8833.

Yvonne Bokhour graduated from the Health Advocacy Program in 2008.

Postgraduate Policy Internship

By Jean Anne Cipolla

Why would a HAP student with three complete field work placements and her credits for graduation neatly lined up seek out a postgraduate summer internship? An unpaid placement in steamy Washington, D.C. instead of a paying job?

My journey to four months as a health policy and research intern at the Bazelon Center for Mental Health Law began in my first semester at Sarah Lawrence in Bruce Berg's Health Care Policy Class. Our first assignment was a paper on an interest group. My interest area was mental health policy and the Bazelon Center kept appearing in my online searches. I became engaged in their mission, to "conduct legal and policy advocacy to protect children and adults with mental disabilities from discrimination and promote their full participation in community life." The paper was a success.

I continued to follow the activities of the Bazelon Center during my two years of classes but a school year internship in Washington, DC was not a possibility. Besides, I quickly became involved with one semester at the Riverdale Center for Mental Health and the Westchester Children's Association, where I spent a full year working on a variety of children's mental health advocacy projects. Still, when March of graduation year came, I checked Bazelon's internship page and saw that they were hiring Policy interns. I sent my resume and cover letter via email and followed up with a phone call to Elaine Alfano, the Deputy Policy Director. Unfortunately, she said their current Policy intern was staying through the summer and there were no policy placements available. "Are you interested in legislative and governmental affairs?" she asked. "I think they are hiring summer interns." I asked her please to pass along my resume. But within a week the Director of Legislative Affairs called to tell me that she had hired someone else.

Crestfallen, I started looking for jobs and other placements. My field work director at Westchester Children's Association connected me with Voices for America's Children, a national children's advocacy organization, located in Washington and looking for a policy intern. I interviewed over the phone and was hired, to begin in late June. Two weeks after I accepted the Voices offer, Ms. Alfano called from Bazelon, saying their summer policy intern had decided not to stay and asked me if I was still interested. Of course! But I had to gracefully release myself from Voices; I told them the truth because I had waited a long time for this opportunity with Bazelon and I wasn't going to pass it up.

Three days before my scheduled departure for Washington, I was hospitalized with a pulmonary embolism. No Bazelon Center for me. The doctors sidelined travel for at least 3 months, if not longer. It was a very long summer.

> *"My journey to four months as a health policy and research intern...began in my first semester at Sarah Lawrence..."*

When my travel restriction was lifted, I called Ms. Alfano and asked if they would consider taking me on again. My timing was perfect. They had a four-month fall policy internship available, PAID this time. Good things come to those who wait.

On September 5, 2007, I started my internship. Being in Washington every day was such a change — the monuments, the number of free cultural things to do every day, the clean metro system. For a New Yorker, it was a treat. I began my internship with attendance at Bazelon's three day Olmstead Conference held each year to keep states up to date on the developments in the Olmstead laws which deinstitutionalized psychiatric hospitals. It was a fascinating conference touching on all aspects of severe and persistent mental illness and how states have responded to deinstitutionalization.

Next, I was sent on my own to represent the Policy Group at a Substance Abuse and Mental Health Services Administration (SAMHSA) conference on primary care for people with severe and persistent mental illness. For the next fifteen weeks, I performed research for a report on how the Deficit Reduction Act of 2006 was affecting each state's ability to manage their Medicaid mental health and substance abuse programs. This report was done for SAMHSA. I also worked on a state-by-state survey of managed care behavioral health providers — their mental health, substance abuse, pharmaceutical services and legal issues related to managed care behavioral health contracts. This survey was done by contract for a managed care behavioral health providers association; Bazelon takes on this type of work from time to time in order to pay the bills of a small non-profit organization.

Many days I attended congressional hearings on mental health parity bills, Medicare or Medicaid legislation, or homelessness issues, collected hearing testimony, and then wrote notes for the Policy Director and the Director of Legislative Affairs. I was also sent as a stand-in for the Director of Legislative Affairs to attend policy briefings by members of Senator Kennedy's staff, meetings on adolescent transition from foster care at Children's Defense Fund, and general positioning meetings of the Mental Health Legislative Group.

My four months passed quickly and it was a fun, challenging and exciting time for me. I feel that I learned quite a bit about how a small, albeit powerful, legal and policy firm works. And I truly enjoyed spending that time in Washington, seeing the cradle of power up close. But what's most important is this — if there's someplace you feel you need to have a field work placement, find a way to make it work. The Bazelon Center was not on the HAP program's radar, only mine, and I made it work for me.

Jean Anne Cipolla is a 2007 graduate of the HAP program, with interests in child and adolescent mental health policy and advocacy, juvenile justice, and school-based mental health. She is currently looking for a great job!

Student Paper
Changing How We Eat

By Megan Donovan

The relationship today's Americans have with food is, as we all know, very complicated. The relationship our food has with the economy, the environment, the health of our nation, and our ties with the rest of the world presents even further complications. Our nation's diet symbolizes some of the worst characteristics of the US — excess, consumption, and disregard for others, for starters. As if that weren't negative enough, these same characteristics cost the health care system $90 billion[1] a year and congest it with millions of chronic conditions that could have been prevented — or at least more easily managed — with more responsible diets.

> *"Americans were eating poorer quality food, and more of it."*

However, today we are on the cusp of a hopeful future, a time when Americans are beginning to consciously consume what is best for themselves, the environment, and the other 6.75 billion people out there in the world we all share. The recent enlightenment of America's diet — the emergence of more mindful eating choices, such as the organic and local food movements — presents a rare opportunity for consumers to dictate the "how and where" of our food intake, stealing the reins from the government and powerful food industry. These two leaders in determining the American diet, though manipulative from time to time, could not have been so successful in setting the national standard for what and how we ate over the past 200 years if it weren't for a highly complacent (and hungry!) public. But again, opportunity is knocking to change the tide and return to local, wholesome, and natural diets. To make the most of this opportunity, we must be open to the lessons available. And as with most lessons, all we need to do is look back a few decades into our nation's history.

Allow me to paint a picture of the food-related climate in the fifteen or so years between "the cholesterol scare" of the early 1960s and the release of Senate Dietary Goals of 1977, an era steeped with relevant lessons for today's Americans, especially considering the many parallels with today's food climate:

- Literature such as Rachel Carson's *Silent Spring* was raising public awareness of the environmental and individual effects of the chemicals introduced without regulation into the national food supply. (Today, Michael Pollan has become the messiah of the mindful eating movement);
- Americans were feeling dissatisfied with, and dismayed by, their health care system. (The US health care system is now ranked 37th in the world by WHO);
- At the same time, international reports with images of starving individuals fighting against rising food prices made Americans aware of their position as a wealthy, well fed nation. (In 2008, we still have people starving to death. That's unforgivable);
- This indication of overabundance came at a time of insecurity regarding America's consumption habits, as the oil crisis and subsequent rising costs highlighted the nation's addiction to oil. (Does that ring a bell?);
- An increasingly incompetent government, paired with a highly unpopular war, had decreased the nation's confidence in national leaders and increased activism nationwide. (Subject to your own opinion);
- Americans were eating poorer quality food, and more of it. Obesity was on the rise, despite "the cholesterol scare" that had challenged long-standing Amrican beliefs about milk and meat products. The resulted was an insecure population compensating for their uncertainties about their diets with rampant use of vitamins. (Today's equivalent can be seen in the popularity of highly fortified food products.) Moreover, infectious diseases, which had been the leading cause of death, had all but been eliminated through advances in the medical field, so it was logical to change the focus to other sources of health problems.

These forces came together to threaten the food industry. In addition to public outcry, at this time the federal government was redefining its responsibilities for the health of the nation and took the opportunity to clarify some issues relating to American food consumption.

> *"...the federal government was redefining its responsibilities for the health of the nation..."*

The federal government initiated a review of scientific research related to obesity and its causes and effects. The process resulted in the release of the controversial "Dietary Goals" of 1977 by the Senate Select Committee on Nutrition and Human Needs, led by South Dakota Senator McGovern. The goals set standards of expectations for the American diet. They were the first suggestions that, instead of eating more of healthy foods, Americans should be eating less of a number of

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Changing How We Eat

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particular foods. The language proposed by Senator McGovern noted the link between red meat and dairy consumption and heart disease, and called for Americans to decrease meat consumption. The food industry, particularly the meat sector, did not appreciate being singled out. Powerful industry lobbyists persuaded the committee to change the language to "choose meats, poultry, and fish that will reduce saturated fat intake."[2] They also succeeded in booting Senator McGovern from his seat in the Senate in the next election. If that isn't a message to politicians to stay away from food industry profit, nothing is.

This instance of federal involvement set into motion something much more influential on the American diet — the emphasis on the *nutrient* rather than the *food*. Changing the language from "decrease meat" to "choose meats…that will reduce saturated fat intake" sparked the practice that Gyorgy Scrinis coined "nutritionism," the idea that the US as a culture focuses not on the food as a whole, but on its "nutritional and chemical constituents and requirements."[3]

We now see nutritionism in action every day. We can't pick up a tomato at the grocery store without being reminded of its lycopene content by the fingernail-sized advertisement on its skin. Junk foods — for example, those heavily processed, sugary cereals that taste so good — boast of their (artificially-added) vitamin content. Being conscious of the nutritional makeup of one's food is not a bad thing, but it distracts us from what food could be — a source of enjoyment, even love, a means of connection with our environment and ourselves.

The recent embrace of this connection — food, ourselves, and our surroundings — is hopeful and has the potential to change how Americans eat forever. In order for that to happen, however, the moment must be seized while it is still ours, without the overbearing involvement of industry and government regulation. We would be wise to help ourselves before they serve us something we aren't hungry for.

1 Center for Disease Control, 2008. ww.cdc.gov.
2 United States Congress Senate Select Committee on Nutrition and Human Needs, *Dietary Goals for the United States* (Washington: US Government Printing Office, 1977) 43.
3 Gyorgy Scrinis, "Sorry Marge." (*Meanjin* 2002) 108.

Megan Donovan is a student in the Health Advocacy Program. This article is extracted from her paper about the history of nutrition for the History of Health Care class.

Working With Refugees and Returnees in Sudan

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of children and women, disabilities due to land mines and unexploded ordinances, HIV/AIDS awareness and prevention, and the prevention of sexual abuse and exploitation.

I was a Peace Corps Volunteer in Hungary and then worked with the UN Refugee Agency in Bosnia. These positions allowed me, at a young age, to directly help vulnerable communities in an international setting. I returned to the United States to contribute to our New York City communities and obtain my Masters degree in order to enhance my outreach capacity in domestic and international areas. During my two years at Sarah Lawrence, I always maintained my commitment to the disenfranchised by ensuring that my internships contributed to communities through public health outreach in bilingual settings. I worked in the New York City Department of Health with youth from the Bronx, with Medicare recipients to help them navigate the system, and through the March of Dimes Birth Defects Foundation with pregnant women on maternal-child health. Working with specific populations such as women, children and the elderly, both at home and abroad, gave me the opportunity to help them meet their needs. Whether I'm working in a refugee setting or back in New York, these three groups of people have always motivated me to go beyond my job descriptions.

The Health Advocacy Program gave me the opportunity to continue to map out my own professional plan. I rejoined UNHCR through their competitive examination program, the International Professional Roster. I left New York for the Sudan in May 2006. To date, I continue to be a Community Services Officer in Sudan. The eclectic diversity I have seen here in Sudan has led me to dub it the "New York of Africa." It is most humbling to be able to work for the UN Refugee Agency. The refugees, returnees, and other people of concern have touched my professional and personal lives in a most humbling way. They are some of the most resilient and brave people, particularly the chidlren.

If you would like to read more on the Sudan operations of UNHCR, please visit our website: www.UNHCR.org

Isela Chavarria graduated from the Health Advocacy Program in 2002.

Faculty Profile: Betty Gilmore

Betty Gilmore, HAP Field Work Coordinator

Betty Gilmore will be the new Field Work Coordinator for the Health Advocacy Program, as of September 2008. She brings to the assignment over 35 years of experience in health care. She has worked in three VA Hospitals in the New York metropolitan area in a wide variety of clinical, administrative and managerial positions. A Social Worker by profession, she is accustomed to advocating for clients, staff and programs in order to maximize access to quality health care services. Betty's background includes an MSW from Columbia University and an MS in health care management from NYU's Wagner School of Public Service. She is currently serving as an Adjunct Professor at NYU's Silver School of Social Work, teaching Practice I & II at the school's division on the Sarah Lawrence campus.

Having supervised social work and health care management interns, she has a good understanding of the opportunities and challenges for both students and the organizations in which they are placed. She believes that field work experiences are critical to helping students integrate and apply the theoretical knowledge they acquire in the classroom. Betty is excited about working with the students and faculty in the Program and is looking forward to helping students have a positive field work experience.

Faculty Profile: Rebecca Johnson

Rebecca Johnson, HAP Faculty

Suddenly in this election year my career of over three decades is in the spotlight and inexplicably controversial (it's as if those who I learned the work from hadn't brought us the civil rights movement). So let me begin by saying, my name is Rebecca Johnson and I am a community organizer. Usually in introducing myself I say writer and activist and occasionally I cite my academic credentials, but community organizer is more to the point in my role as Health Advocacy Program faculty teaching History of Health Care in America and facilitator of a biweekly writing group open to all HAP students.

Every organizer knows that to be effective we must understand how the problem we and our community are working to solve came to be. Understanding, communicating, and explicating history is essential in accomplishing our goal and the goals of the community. In my work these goals have included ending housing displacement, fighting discrimination for newcomers to this country, and guaranteeing food security for all.

In the HAP history class we do, at a graduate school level, what a multi-generational, linguistically diverse group of low-income immigrant women of color do in organizing meetings. We ask questions. "How did health care come to America? Who decided some bodies are worthy of care and others aren't? Who decided which diseases get treatment and which do not? How did doctors come to have power? When did they begin to lose power? Did patients/consumers ever have power?" Inevitably, whether in the classroom or at the proverbial community organizing kitchen table, we discover things aren't always what they appear to be. And then we must figure out how to communicate our learning. That is where the second part of my responsibilities comes in.

For example, in writing about social dispossession and focusing on the lives of African-American men born in the early 20th century, I recently learned that railroad trackliners of the late 19th century were mostly black men. Their work was physically demanding and painful. Beginning in the 1880s they were given a new painkiller "discovered" by Sigmund Freud — cocaine. This marked the introduction of coke into the black community, north and south. So drug addiction, like everything else, has a history but maybe not what we expect. Appreciating it makes community problem-solving more effective. Of course, the same is true in health advocacy.

Rebecca O. Johnson, MSCED, MFA Non-Fiction, lives and works in Dorchester Massachusetts, a neighborhood of Boston. She is an alumna of the Sarah Lawrence Graduate Writing Program.