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advocacy

Challenges and Inconsistencies in Providing Effective Advocacy for People with Disabilities in Today's Health Services Environment: Exploratory-Descriptive Findings

Richard L. Beaulaurier, MSW, PhD and Samuel H. Taylor, DSW

ABSTRACT

he purpose of this study was to explore the extent to which hospital-based social workers were aware of, and actively involved in, *client* and *system* advocacy on behalf of people with disabilities. A review of the literature revealed that, although disability interest groups rank increased advocacy as an important need, there has been little or no empirical research in this area of practice.

A sample of 286 social workers employed in 57 different hospital and rehabilitation settings participated in a survey that focused on advocacy and related topics. A questionnaire explored participants' perspectives and the levels and kinds of practice activities they engaged in relation to the needs of people with disabilities.

Most respondents indicated that client advocacy was part of their professional responsibility and that clients with disabilities needed such assistance. However, their own reports of their actual advocacy activities consistently fell below their recognition of need, particularly with regard to system advocacy.

Although advocacy is viewed as one of the core activities of health services social workers, it is still relatively rare to find studies that focus primarily on these advocacy activities. Of the few studies that have focused on the role of social workers performing as advocates, only one has focused specifically on the professional activities of health services social workers (Herbert & Levin, 1996). When advocacy is discussed in the health practice literature, it is usually as an addendum at the end of an article or chapter (Black & Weiss, 1990; Bracht, 1979; Nielson, 1987; Spring, 1981). Since the 1960s and 1970s, advocacy has, in fact, only rarely been addressed as a central theme (McGowan, 1987).

No studies at all were located that focused on social workers' advocacy practice with individuals with disabilities. However, recent developments in the area of disability rights and independent living movements suggest the need for an examination of advocacy practice with this population. People with disabilities, like many other health care consumer groups, have become increasingly assertive about their

needs and their right to determine the course of their own treatment (DeJong, 1981; Zola, 1983). Advocacy is a social worker's traditional response when clients indicate that their benefits or rights are being unfairly curtailed or restricted. The relative dearth of literature raises questions about the extent to which health care social workers are actually engaging in such practice. Indeed, the general dearth of literature in this area raises questions about whether social workers in health settings are knowledgeable about, or interested in, advocacy practice. There have been suggestions that modern health services organizations, principally hospitals and hospital systems, may be restricting such activity. Cost reduction and managed care orientations may have created a climate in which advocacy is discouraged or where workers are made to feel that it is professionally risky (Herbert & Levin, 1996; Sosin & Caulum, 1983; Sunley, 1997).

CLIENTS WITH DISABILITIES AND THE NEED FOR ADVOCACY IN HEALTH SETTINGS

Over the years, many people with disabilities have come to see their interests as being quite different from those of mainstream health and social service organizations (Kailes, 1988; Mackelprang & Salsgiver, 1996; Renz-Beaulaurier, 1994). Zola (1983) and other authors associated with the disability rights movement have tended to see rehabilitation and medical professionals as being overly concerned with issues of physical mobility and functioning, while displaying little or no concern for the social sequelae of these interventions (DeJong, 1981; Hahn, 1991; Kailes, 1988). These authors contend that the goal of maximizing physical functioning can actually have deleterious effects on the *social functioning* of some persons with disabilities. By way of illustration, Zola (1983) notes that he used crutches for many years until discovering that a wheelchair made him far less tired as he went about his daily activities. He noted that, although he often complained that the fatigue he experienced using crutches was interfering with his professional and social activities, none of the health care professionals he encountered ever suggested that he use a wheelchair. In fact, the use of a wheelchair might well have been considered a step backward rather than forward in the rehabilitation process, since the use of crutches more closely approximates "normal" functioning (DeJong, 1981; Renz-Beaulaurier, 1994).

The different orientations of disability rights groups and health professionals can result in tension (DeJong, 1981). Zola (1983) speaks for many in the movement when he asserts that no gain, or physical "normalization," is worth a loss of social integration.

Increasingly, the desires of people with disabilities for social integration and self-determination lead them to challenge medical and rehabilitation practices. These tensions could be exacerbated even more as managed care practices come to predominate in the health care field. Managers in hospitals and other health organizations are increasingly concerned with cost control, profits, market share, and competition. Such concerns could well compete with or overshadow attention to patient satisfaction and well being (Haglund & Dowling, 1988; LoGerfo & Brook, 1988). In such an environment, managers and administrators can be expected to be reluctant to move away from standard practices that have known and predictable costs, especially when the alternative is new practices where costs are not predictable and outcomes may differ from traditional medical norms (Perrow, 1961). Persons with disabilities emerging consciousness of their social needs, and a desire for greater autonomy and community integration, can manifest itself as a need for advocacy in order to gain more innovative assistance, particularly when needed resources are blocked or restricted by reluctant bureaucracies and policies.

In addition, health services managers may at times view social workers as monitors or "gatekeepers" whose principal function is to make sure that patients comply with treatment regimes and stay within approved and financially acceptable service guidelines (Sunley, 1997). In such situations, there may be an expectation that social workers will function more as agents of social control than social change.

Clients increasingly call on social workers to intercede in order to help them secure services that are either unavailable, or are restricted due to financial concerns and increased bureaucratic gatekeeping. In so doing, clients may find themselves and their social workers on a collision course with some health services organizations and systems.

ADVOCACY IN HEALTH SERVICES SOCIAL WORK

There is no commonly agreed-upon definition of advocacy, even though there is general agreement that it has been a central activity of social workers since the

inception of the profession (Hepworth, Rooney, & Larson, 1997; Mickelson, 1995). Advocacy is most often characterized as partisan activity taken on behalf of, or in partnership with, the clients to ameliorate or eliminate the effects of injustice or unmet need (Herbert & Levin, 1996; Reisch, 1986; Rothman, 1991; Sunley, 1997). Moreover, advocacy serves either to protect or promote the interests of vulnerable clients who have been "neglected, stigmatized, or otherwise denied access to opportunities" (Patti, 1985). Ezell (1994) adds that advocacy may also be used proactively to prevent "bad" decisions from being made.

Part of what makes advocacy a somewhat slippery concept is that it is not restricted to a single type or level of intervention. Advocacy has been discussed at the level of: legislative and national activity (Ezell, 1993; Mizrahi, 1992); at the level of the community (Black & Weiss, 1990; Reisch, 1986; Weiss, 1993); at the level of the direct services workers (Epstein, 1981; Herbert & Levin, 1996; Rothman, 1991; Sunley, 1997); and as characterizing the activity of entire social service agencies (Patti, 1985; Reisch, 1986; Reisch, 1990). Another difficulty in limiting the definition of advocacy is that its targets vary. At times, federal, state, or local laws or policies may be in need of change; at other times, the target will be rigid or recalcitrant bureaucracies. In some empowerment-oriented approaches, clients or client groups may be the direct focus of change (e.g., by giving them knowledge, motivation, or training) in order to make them more capable of solving their own problems (Mickelson, 1995). In such approaches, changing policies and removing restrictions on benefits may be the indirect object of advocacy practice efforts.

Most definitions draw a distinction between client and class advocacy. *Client advocacy* (also called "case" or "benefits" advocacy) involves working on behalf of individual clients to obtain specific resources or secure entitlements that they have been unable to obtain on their own. *Class advocacy,* (also called "cause" or "systems" advocacy) seeks to obtain changes in conditions, laws, or policies in order to create or gain entitlements or benefits for an entire group or category of persons (Epstein, 1981; McGowan, 1987). Mizrahi (1992) notes that these concepts can be further delineated in terms of whether change is being sought inside (internal advocacy) or outside (external advocacy) the worker's own organization.

The partisan nature of advocacy could become a delicate and professionally risky proposition if it were seen as pitting social workers and their clients against the hospitals and health or social service systems of which they are a part (Reisch, 1986; Sosin & Caulum, 1983). In fact, some prominent disability rights and social work authors have expressed skepticism about the likelihood of this type of practice, noting that this is tantamount to biting the hand that feeds (Haggstrom, 1995; Kailes, 1988; Sosin & Caulum, 1983). This is particularly likely when the concept of advocacy is defined as campaign and social action activities (McGowan, 1987; Reisch, 1986; Sunley, 1997).

Adversarial tactics are indeed one element of advocacy (Reisch, 1986; Rothman, 1991). However, some authors have pointed out that advocacy efforts need not always involve or escalate to the use of adversarial and social action tactics. In addition to coercive tactics, social workers may employ "discussion, persuasion, and prodding" (Rothman, 1991).

Even when tactics are not adversarial, social workers may feel that there is some risk in even suggesting service innovations during the times of cutback and cost containment that have tended to characterize managed care. In cases of internal advocacy, workers may find that the role of advocacy within their organizations increases their risk of marginalization or even termination (Berg, 1981; Sunley, 1997). Workers may feel torn between the interests of clients, their employer, and even the interdisciplinary teams of which they are members (McGowan, 1987). As a consequence, workers may feel subtle pressure to avoid advocacy activities.

Social workers may feel that there is no need to engage in what could be a potentially risky activity, though there is a general public perception of an increased need for advocacy in health services settings (Herbert & Levin, 1996; Sosin & Caulum, 1983; Sunley, 1997). Herbert and Levin (1996) assert that there are "many clients who are marginalized, vulnerable, and unable to get their needs met in large, complex systems." By the same token, in most settings, advocacy will only be needed by *some* clients *some* of the time. For this reason, Rothman (1991) refers to advocacy as an "intermittent" service, to be provided on an as-needed basis. It stands to reason that in organizational environments where service innovation is discouraged, social workers may not engage in advocacy activities unless they believe their clients have clear and serious unmet needs. While one can speculate, at present no studies have reported on

whether social workers feel many of their clients with disabilities are in need of advocacy services.

It is important to note that advocacy activities can be professionally and personally rewarding. Black and Weiss (1990) note that the involvement in advocacy activities can aid the worker in professional development activities and lead to increased involvement in organizational and community task forces, conferences, and other projects. This can be beneficial to their organizations by improving visibility and contacts with the community at large (Jansson & Simmons, 1986) and even contribute to a worker's career enhancement.

ADVOCACY ACTIVITIES OF HEALTH SOCIAL WORKERS WITH PERSONS WITH DISABILITIES

Numerous social work authors have called for increased advocacy efforts to aid people with disabilities as they attempt to gain their civil rights and other benefits, but Mackelprang and Salsgiver (1996) contend that social work professionals have done little in relation to their causes. They suggest that "…relatively few social workers work with people with disabilities." However, social workers employed in hospitals and rehabilitation settings may be the exception, since under the definition of "disabled," used by the *Americans with Disabilities Act of 1990*, most chronically ill, physically or mentally impaired persons would be considered "disabled." Increasingly, these are the populations that are being treated by health care systems, especially the *acute* care systems (Bracht, 1990; Harper, 1986).

This study posed a number of questions about the motivations, philosophical commitments and activities of social workers in health settings with regard to advocacy activities, particularly with clients who have a disability:

➤ Do health services social workers feel that advocacy is one of their core responsibilities?
➤ Do they feel that people with disabilities in their caseloads have problems that require advocacy?
➤ Do they feel philosophically committed to advocacy?
➤ Do they feel that they have the knowledge base to be successful advocates?
➤ Are they are actually engaging in advocacy activities?

The purpose of this study was to explore these questions by inquiring about both the perceptions and self-reported activities of health and rehabilitation social workers in relation to the nature of their practice with clients with disabilities and their families.

METHODS AND DESCRIPTION OF THE STUDY PARTICIPANTS

A questionnaire was developed by the authors as part of a study of health social workers' practice with people with disabilities. A series of questions focused on advocacy. Upon completion of a pilot study, the final version of the questionnaire was administered to a sample of 286 social workers employed in 57 different hospitals and rehabilitation settings. Convenience sampling and snowball sampling were used to obtain participants. A list of all members was obtained from the Southern California Chapter of the Society for Social Work Administrators in Health Care. Directors of social service departments in the Los Angeles area were asked if they would allow their part- or full-time MSW social workers to participate in the study. The directors were also asked to recommend other social work directors who also might be willing to allow their staffs to participate. To broaden the sample, a private and a government hospital in a medium-sized city were also included, as were two private hospitals and one government hospital in a rural community.

Six hundred and eighty-nine social workers received a copy of the questionnaire, with a return rate of 43% (N=286), which is consistent with the norm for a study of this type (Kerlinger, 1986). At least some surveys were returned from 89% of the departments that were asked to participate.

Two thirds of respondents reported that they were professionally involved with at least three people with disabilities per month. Half saw at least 10 (the median). The average number of people with disabilities seen by respondents was 20.

FINDINGS

The Need for Advocacy

Disability rights authors contend that, all too often, medical and rehabilitation professionals view an individual's physical impairment as the primary problem, whereas members of the independent living and the disability rights movements tend to believe that their problems are more closely related to the *disabling environments* that are typical in mainstream communities (DeJong, 1981). When physical impairment is viewed as

the primary problem by professionals in health care systems, advocacy may be considered unnecessary or of secondary importance, since it does not directly relate to clients' physical condition. However, when the environment is considered a primary source of problems, advocacy attains greater importance in helping clients to deal with prejudicial attitudes, unfair restrictions, and limitations on benefits.

There is a long tradition in social work of viewing problems as potentially societal in origin. As part of their education, social workers are made aware of structural factors such as oppression, limited opportunities and biased social policies that may create serious problems for clients. Indeed, social workers are often the only professionals in hospitals with this sort of professional orientation. An item on the questionnaire asked respondents whether they tended to view problems of clients with disabilities as being more linked to environmental factors or to physical limitations.

Table 1. Societal basis for disablement. (Note. In some tables percentages may total slightly more or less than 100% due to the effects of rounding.)

	Mostly True	Some- what True	Some- what False	Mostly False
1a. What is disabling to people with physical impairments is the fact that society has not accommodated to these impairments rather than the impairments themselves.	n=100 (37%)	n=134 (49%)	N=34 (13%)	n=5 (2%)

Interestingly, the overwhelming majority of respondents concurred with the position held by disability activists (Table 1). This finding might surprise many disability rights authors whose writings often suggest that they expect just the opposite response from social workers (Berrol, 1979; DeJong, 1981; Hahn, 1984; Hahn, 1991; Zola, 1979).

It seems clear that many of these social workers held perspectives about the nature of disability that are congruent with the disability rights and independent living movements. This suggests a strong congruence between the way that disability rights authors and health and rehabilitation social workers view the problems of

people with disabilities.

Respondents' Opinions About the Importance of Advocacy
The traditional medical perspective emphasizes a focus on the physical impairment as the principal cause of client problems and seeks to surmount problems by directly treating the impairment (DeJong, 1981; Renz-Beaulaurier, 1994). However, if clients' primary problems are conceived of as relating to barriers and limitations and other societal factors, a logical inference would be that those clients will also need advocacy as an essential component of their treatment plans (Berrol, 1979; DeJong, 1981; Mackelprang & Salsgiver, 1996; Quinn, 1995; Renz-Beaulaurier, 1994).

Table 2. Need for Advocacy

	Mostly True	Some- what True	Some- what False	Mostly False
2a. People with disabilities are in need of client advocacy efforts in order to obtain needed benefits or resources.	n=144 (51%)	n=130 (46%)	n=5 (2%)	n=2 (1%)
2b. People with disabilities are in need of group and/or class advocacy in order to obtain needed changes in policies, regulations, and laws.	N=133 (47%)	n=130 (46%)	N=17 (6%)	n=4 (1%)

Participants in this study seemed to agree (Table 2). Ninety-seven percent indicated that they believed people with disabilities needed one or more kinds of advocacy assistance. Nearly as many (93%) believed that advocacy was necessary in order to bring about important changes in the social environment.

These findings taken together strongly suggest that respondents made a connection between persons with disabilities problems originating in the social environment and the need for advocacy services. Moreover, most respondents reported that they saw a need for both client (Table 2, Question 2a) and class (Table 2, Question 2b) advocacy.

Is Advocacy a Social Work Responsibility?
It does not necessarily follow that, because social workers believe that advocacy is necessary, they will also believe

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that *they* should provide such services. A separate set of questions (Table 3) queried respondents about what they believed social workers "should" be doing with, and on behalf of, their clients with disabilities. Their responses were very consistent with their beliefs about the needs of people with disabilities for such services. More than half of all respondents suggested that it was "mostly true" that client advocacy should be a part of their professional activity and responsibilities (Table 3, Questions 3a and 3b). However, they seemed as a group less convinced that class advocacy should be a part of their professional duties (Table 3, Questions 3a and 3b). Only 21% of respondents selected the "mostly true" response category when asked whether social workers should be engaged in class advocacy (Table 3, Question 3c). This shift in the pattern of responses seems to be a subtle difference that does not appear to diminish the basic strength of the findings that indicate their conviction that both kinds of advocacy were important.

Most respondents also reported that they agreed in principle that advocacy was a part of the social work role and function (Table 3, Questions 3d and 3e). However, again it should be noted that more respondents were inclined to report that client advocacy rather than class advocacy was a part of their organizational and professional roles. Even so, 83% of respondents indicated that it was at least "somewhat true" that class advocacy

was a central social work activity (Question 3e).

How Involved are Social Workers in Advocacy Activities?
As noted, most of the social workers that participated in this study clearly indicated that they believed advocacy practice should be a part of their professional role (Table 3). This is interesting in light of responses to another series of questions that focused more specifically on the kinds of advocacy activities these social workers were actually involved with in their practice (Questions 4a through 4e, Table 4).

Most respondents reported that social workers in their organizations advocated on behalf of clients, and this included efforts to influence other professionals on their behalf (Question 4a). A majority also reported that their practice efforts were focused on helping other people accommodate to clients' physical disabilities (Table 4, Question 4b). However, they seemed far less likely to be actually engaged in forms of advocacy that would help clients find living accommodations suitable for their impairments, in lobbying, or in changing policies or laws (Questions 4c and 4d, respectively). These are activities usually associated with class advocacy. The vast majority of respondents indicated a rather pronounced disinclination to engage in such forms of advocacy practice. Moreover, they reported that social workers in their respective organizations did not work

Table 3. Advocacy General Perspectives

	Mostly True	Some- what True	Some- what False	Mostly False
3a. One of the primary functions of social workers should be to advocate for the empowerment of individual clients with disabilities.	n=193 (68%)	n=75 (27%)	n=11 (4%)	n=3 (1%)
3b. Social workers should help clients achieve their own goals concerning their care and treatment, even when different treatment plans are suggested by other professionals.	n=142 (50%)	n=123 (44%)	n=14 (5%)	n=3 (1%)
3c. Social workers in this organization should collaborate more with clients to change policies or procedures in this organization.	n=57 (21%)	n=155 (56%)	n=45 (16%)	n=19 (7%)
3d. One of the primary functions of social workers is to advocate for the empowerment of individual clients with disabilities.	n=166 (58%)	n=96 (34%)	n=18 (6%)	n=5 (2%)
3e. One of the primary functions of social workers in health settings is to advocate for the rights of all people with disabilities.	n=102 (36%)	n=133 (47%)	n=36 (13%)	n=14 (5%)

Table 4. Advocacy Activities

	Mostly True	Some-what True	Some-what False	Mostly False
4a. In this organization, social workers actively advocate on behalf of patients including trying to influence the decisions of other professionals.	n=121 (43%)	n=126 (44%)	n=22 (8%)	n=15 (5%)
4b. Much of my practice related to people with disabilities focuses on helping others to accommodate to their physical limitations and impairments.	n=55 (19%)	n=120 (42%)	n=76 (27%)	n=34 (12%)
4c. My work often focuses on improving the lack of suitable accommodations for the limitations and impairments of my clients with disabilities.	n=22 (8%)	n=69 (24%)	n=96 (34%)	n=97 (34%)
4d. I have participated in lobbying or advocating to change laws, regulations or policies which I know are a concern to my clients with disabilities.[a]	n=17 (6%)	n=60 (21%)	n=56 (20%)	n=150 (53%)
4e. The social workers in this organization often collaborate with clients to change policies or procedures in this organization.[b]	n=17 (6%)	n=86 (30%)	n=103 (36%)	n=78 (27%)
4f. My organization has participated in advocacy efforts on behalf of people with disabilities.	n=35 (12%)	n=108 (38%)	n=69 (24%)	n=72 (25%)

[a] One respondent marked a point in between "mostly false" and "somewhat false."

[b] One respondent marked a point in between "somewhat true" and "somewhat false."

with clients in order to change policies and procedures. This raises an interesting issue. We do not know whether they believed that there were no needs or problems that called for such advocacy activity within their organizations, or if this is evidence of their simply not engaging in such type of practice, for whatever reasons.

The data strongly suggest that, for most respondents, advocacy practice tended to be focused on the needs of their own clients at the case level. This seems reasonable, since case advocacy fits within and complements the traditional roles performed by social workers in hospitals. For example, the responses to item 4a strongly suggest that a primary arena for advocacy practice is within the social workers' immediate team or work group. This is consistent with the more traditional role of health services social workers in hospital and rehabilitation settings who are often called upon to identify and communicate knowledge about the social needs of patients to other medical professionals.

Although there are small differences in the patterns of responses to questions about the overall need for client and class advocacy with individuals with disabilities, larger differences in the data emerge between respondents' *philosophy* and their *actions*. Respondents, for the most part, seemed very favorably inclined toward the idea of both client and class advocacy and embraced them as a part of their role and function in health settings. However, when asked about more specific class and client activities that they engaged in, their responses were less clear and appear to suggest that they were *not* as active in *their* performance of specific advocacy roles.

**Observed Inconsistencies: The Advocacy Indexes**

The patterns of the responses to questions about specific advocacy activities (Table 4) contrast rather sharply with the findings related to respondents' general orientation toward the need for advocacy (Tables 2 and 3). In Tables 2 and 3, the data suggest that many respondents had a very favorable ideological and philosophical perspective and were generally disposed toward the need for advocacy. The data in Table 4, by contrast, suggest some important limits with regard to the extent that they

actually engage in a particular advocacy. For example, even within their own organizations, they did not seem inclined to advocate with clients to bring about policy changes. They also did not seem highly inclined to engage in "outside" activities such as lobbying or working to help clients obtain suitable housing accommodations that would improve their basic living conditions in the community.

To highlight the differences between these two patterns of responses, indices were created from the items in Tables 2, 3, and 4. These indices serve to spotlight the differences between respondents' general philosophical orientations and their involvement in particular advocacy activities on behalf of clients. Items in Tables 2 and 3 were used to create an "Advocacy Philosophy Index" (Figure 1) because the questions in these tables seem to establish respondents' general orientation and beliefs about advocacy. Items in Table 4 focus more on specific advocacy practice activities and were aggregated to form an "Advocacy Activities Index."

Figure 1. Advocacy Philosophy
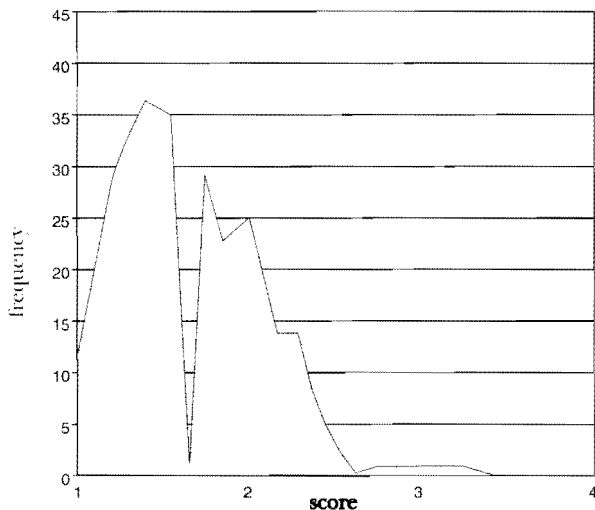
Cronbach alpha: 0.6922; Mean: 1.65; Standard Deviation: 0.41; Skewness: 0.660

Both indices are summated rating scales that were created by adding the responses to the items forming the index. This procedure is outlined and discussed separately by Kerlinger (1986) and Spector (1992). The sum obtained for each respondent was then multiplied by a constant. This mathematical adjustment makes the indices easier to compare and interpret, but does not affect the scale intervals. [Note. There are various examples of adding a constant to make an index scale more readable. See, for example, Antonak & Livneh (1988). A somewhat similar procedure can be found in

Cronbach (1970.)] The lowest possible score on the scale for both indices is "1." A score approaching 1 indicates that the respondent was very positively oriented toward an advocacy practice perspective or philosophy (Figure 1), or toward advocacy practice activities (Figure 2). The highest possible score for both indexes is "4." A score approaching 4 indicates little or no interest in, or orientation toward, advocacy (Figure 1) or advocacy practice activities (Figure 2).

Figure 2. Advocacy Activity
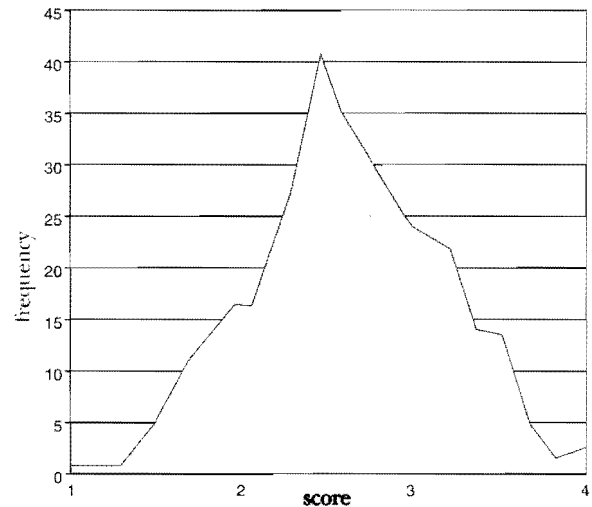
Cronbach alpha: 0.6507; Mean: 2.62; Standard Deviation: 0.56; Skewness: -0.044

On the more general philosophy index, 98% of all respondents received a score between 1 and 2.5 (Figure 1). In fact, 41% of all respondents obtained a score between 1 and 1.5 on this index. This is to say that almost all respondents indicated that, on balance, they believed that advocacy was important and that it was a very important element of social work practice in the health settings where they worked.

The scores on the advocacy activities index (Figure 2) were considerably more modulated, as might be expected given their responses reported in Table 4. The mean score on the "activities" index (2.616) is close to the midpoint of the scale (2.5). In Figure 2, most scores are clustered around the mean, which suggests that comparatively more respondents reported that they were only moderately active in terms of the various advocacy activities described in Table 4.

Not surprisingly, a t-test indicated that the observed difference between the indices was highly significant (t = 29.68, p < 0.001). The contrast may be observed even more sharply by comparing the responses on the "favorable" end of the indices: while 41% of all

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respondents obtained a score between 1 and 1.5 on the philosophy index, only 2.8% of respondents received a similar score (between 1 and 1.5) on the activity index.

Knowledge Related to Advocacy

One item on the questionnaire asked whether respondents felt knowledgeable enough to engage in those advocacy activities that are considered to be of particular importance to people with disabilities. Responses are presented in Table 5.

Table 5. Need for Education in Advocacy

	Mostly True	Some- what True	Some- what False	Mostly False
5a. I know what needs to be done to help my clients with disabilities surmount most of the barriers they face in obtaining benefits such as housing, employment, legal assistance, etc.	n=50 (18%)	n=130 (46%)	n=77 (27%)	n=28 (10%)

Thirty-seven percent felt that their knowledge was not adequate. This suggests that many of the respondents might benefit from closer contacts and collaboration with independent living centers and local disability interest groups that tend to be more familiar with issues, resources and special needs that affect people with disabilities who are living in mainstream communities. Responses indicate that training in this area might also be helpful, at least to the 46% of respondents who indicated that they were only somewhat knowledgeable, as well as to the 37% who reported that their knowledge was not up to par.

Limitations of the Study

The findings suggest that these health and rehabilitation services workers were quite positively oriented toward advocacy practice, and were of the opinion that it is or should be an important component of practice. The findings must be interpreted carefully, however, since respondents were not drawn from a random sample. There may also have been some bias in the sample itself, since social workers who did not feel that their orientation toward advocacy was positive may have elected not to fill out or return the survey form. In addition, some items on these indices may have been somewhat prone to response bias, since some social workers may have believed that a positive stance on advocacy was socially desirable. Participants were all informed that their responses would be anonymous and could not be linked to them personally or to their institutions. The authors hoped that this would limit socially desirable response bias. However, the potential for such bias is one of the inherent limitations of doing survey research with this population. Other research efforts may want to consider alternative methods for achieving a greater level of specificity in their findings, and to further guard against bias.

However, even taking into account positive response bias, index scores (Figures 1 and 2) indicate that self-reported advocacy activities were substantially less than what would be expected in light of the generally positive philosophical orientation. Although the measures developed for this study were not specific enough to pick up the nuances of social workers' advocacy activities, serious questions remain concerning the amount and types of advocacy that they actually engage in as part of their professional practice. It is possible that respondents were engaged in kinds of advocacy that this study did not inquire about. However, it is unclear what these activities might be. Future studies may need to explore which activities health services social workers define as advocacy practice, as well as more in-depth inquiry regarding the apparent gap between their philosophical orientations and their actions.

NON-SIGNIFICANT FINDINGS

The degree of homogeneity in the findings was rather striking. It seemed reasonable that social workers who reported seeing more people with disabilities in their caseloads might be more inclined to engage in advocacy. However, this was not evident. Neither scores on the philosophy, nor the activity index, were higher for social workers who reported having more people with disabilities in their caseloads.

It also seemed reasonable to speculate that "identification" with people with disabilities might be related to advocacy attitudes or activities. Respondents who reported that they themselves had a disability were compared to the rest, as were respondents who reported being a member of a racial minority. Women respondents were also compared to men. Surprisingly, none of these characteristics were significant predictors of more positive advocacy attitudes or involvements.

Several authors have commented on the need for practitioners to have knowledge about organizations and how they function in order to engage in successful advocacy efforts (Black & Weiss, 1990; Rothman, 1991; Sosin & Caulum, 1983; Sunley, 1997). However, respondents who reported having studied community organizing or administration in their MSW programs did not have more positive advocacy activity or philosophy scores than other respondents. Respondents who reported having some administrative duties did have slightly more positive "philosophy" scores. However, their self-reported activity levels were not significantly higher or lower. Moreover, there is little to be made of this finding since, while significant ($p=0.024$), the mean difference in scores was very small: just 0.14 difference on a scale from 1 to 4.

Herbert and Levine (1996) report anecdotal findings suggesting that social workers at the beginning of their careers may be somewhat more "idealistic," and therefore more likely to engage in advocacy. This was not confirmed in the current study. No relationship was found either to respondents' time in health services settings, or to time since acquiring an MSW, on either index.

Professional setting also did not seem to make very much difference. Even those respondents indicating that they worked in health maintenance organizations (HMOs)—which would seem to be the most restrictive environments with respect to social work autonomy—did not differ from respondents in other settings. Social workers in private hospital settings reported significantly more advocacy activity ($p=0.003$). The difference between the groups, however, was actually quite small (a mean difference of 0.20 on a scale ranging from 1 to 4). This may suggest either that the advocacy practices of private and public sector health services social workers were actually more similar to each other than different, or that this scale was not sensitive enough to pick up greater differences that may have existed between the two groups.

DISCUSSION

Sunley (1997) suggests a dilemma in modern health settings. He suggests that managed care policies may be restricting the range of advocacy activities of social workers while at the same time engendering greater needs for these services than ever. Taken at face value, these findings suggest that social workers in the health services may be feeling this dilemma acutely. Clearly, their self-reported activities did not seem to keep pace with their attitudes.

It is possible that respondents simply do not know enough about advocacy to engage in it effectively. Other studies have found that many social workers lacked confidence about their level of knowledge about advocacy (Herbert & Levin, 1996; Herbert & Mould, 1992). This may be as true for social workers, who received coursework in administration and community organizing. For others, there was no difference in the way they responded to the questionnaire.

Hospitals and related settings may also have some unique features that make advocacy difficult. For example, other duties may not leave much time for advocacy in health settings, particularly if such activities are not seen as important by management. Moreover, executives and supervisors in social service departments may be understandably concerned about how to justify time and budget allocations for advocacy to third party payers and efficiency-oriented managers. This has prompted some authors to conclude that it may be "irresponsible" to suggest that social workers should be doing *more* advocacy (Ezell, 1994).

If we are going to promote and expect advocacy from health social workers, we need to be clearer about how they can do this without damaging their own interests. One of the few articles that documents advocacy efforts on behalf of clients with disabilities concludes by noting that the social worker was dismissed, presumably for insubordination (Berg, 1981). However laudable the actions, ultimately social workers must find ways of engaging in advocacy practice that does not damage their careers.

Although advocacy is generally thought of as a partisan activity, it is the rare organization that will tolerate employees who work at cross-purposes to the organizations that employ them. It is important, therefore, that social workers be skillful at collaboration, negotiation, and persuasion. Moreover, these tactics should precede more confrontational approaches by a considerable margin. Netting, Kettner, and McMurtry (1995) suggest that, in many cases, collaborative approaches can be used to get service systems to cooperate with client groups and implement change without developing hostility. They also suggest trying educational and persuasion tactics if cooperation is not forthcoming.

Such approaches also build on a traditional strength of social work departments in linking communities with institutions. Such linkages offer opportunities for social workers to intercede and to negotiate viable solutions if conflicts do emerge, and can add considerably to the credibility of social workers and their departments (Jansson & Simmons, 1986).

This suggests another important feature of successful advocacy efforts. Sunley (1997) points out that contracts circumscribing the activities of professionals are often negotiated between health systems and employers. The former, Sunley contends, are increasingly concerned with profit margins, while the latter are concerned with keeping health care expenses low. He observed that neither health care systems nor employers may be primarily interested in protecting the interests of clients. It stands to reason that social workers will need to help their clients formulate alternative approaches to treatment in terms that managers in these systems can appreciate and accept. This includes an emphasis on cost effectiveness. Many of the interventions that disability rights groups seek are not inherently more expensive than the standard interventions (Kailes, 1988). Social workers need to be skilled at presenting such information and perspectives. Social workers may also be able to offer an early identification of situations that can lead to costly confrontations with activist, articulate, and increasingly well-organized, client groups. In some cases, social workers, by virtue of their ability to form liaisons with client groups, may identify new markets and market share for their organizations. Presented in these terms, social workers with advocacy skills may well be perceived as a valued resource in their organizations.

Black and Weiss (1990) also note that social workers will need excellent skills in group processes and in training. Group process skills can help to avert communication problems and to facilitate recognition among clients, health systems, and organizations of shared goals and commitments. Social workers can also use educational skills to help client groups to develop the skills they need to advocate on their own behalves as well as to educate members of their interdisciplinary teams, organizations and systems regarding sensitivity to newly-emerging needs and desires of clients with disabilities. Such activities can lead to other involvements with client groups that are both personally and professionally rewarding, such as involvement in speaking and training engagements, conferences, membership in community task forces, and other advocacy projects (Black & Weiss, 1990).

FUTURE RESEARCH EFFORTS

This study is a preliminary look at the advocacy attitudes and activities of social workers with people with disabilities. Clearly, the respondents in this study felt that advocacy was important, that it was an important aspect of their jobs and responsibilities and that their clients were in need of advocacy. Considerable gaps in our knowledge remain, however, about why these respondents reported that they were not more actively engaged in advocacy efforts.

It is possible that organizational factors may have constrained the social workers in this study from engaging in advocacy practice at levels more commensurate with the interest and importance they reported. Are other activities and responsibilities taking priority over advocacy? Are their employers imposing overt or subtle pressure to avoid such activities? Future studies will be needed to answer these questions.

One possibility is that health services social workers are in fact engaged in more advocacy-related activity than the instrumentation in this study was sensitive enough to record. Subsequent research efforts may benefit by focusing more on qualitative, open-ended interview techniques in order to explore more about how health services social workers view their advocacy practice, and how they characterize their activities. Such an approach might result in more specificity about the types of advocacy health services social workers actually engage in. This would benefit future quantitative efforts by providing a basis for developing questionnaire items that are empirically grounded in practice as well as in the literature.

One of the more startling findings in this study is that no personal, professional and setting-related characteristics could be identified that related to high (or low) levels of advocacy activities. A more open-ended, interview approach might yield interesting information about those individuals who are more successful in their advocacy efforts.

There is also a relative dearth of research about social work involvement with people with disabilities and

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the disability rights movement. Health services social workers probably have more contact with people with disabilities than any other members of the profession. Moreover, health services social workers engage people with disabilities in those settings that have traditionally made them feel most vulnerable (Kailes, 1988). As a profession, we need to know more about how to work with this population and how best to meet their needs. This is, in part, consistent with the traditional social work mission of seeking out and aiding oppressed and neglected groups. The disability rights movement and its constituents have become increasingly assertive throughout the 1980s and 1990s. Social work research needs to reflect and to keep pace with these developments by establishing research agendas that are consistent with the emerging interests and campaigns of disability rights groups. In great measure, these agendas revolve around shifting from traditional health care approaches to community based alternatives (Hahn, 1991; Kailes, 1988; Mackelprang & Salsgiver, 1996). More research on health-services-related advocacy with, and on behalf of, this population is clearly warranted.

CONCLUSION

In spite of any intentional, or even unintentional, efforts to control or to limit the advocacy activities of social workers, it is important not to lose sight of the importance of advocacy to clients. Sunley (1997) observes that the current health care environment places serious constraints on consumers who all too often encounter distant decision-makers, service fragmentation, and a lack of coordination. This contention is fortified by recent accounts in the popular press that have highlighted the degree to which the interests of patients, physicians, and health care organizations can be at odds with each other (Brink, 1996; Church, 1997; Larson, 1996). Sunley suggests that clients have an especially great need for readily available advocacy services. Moreover, Renz-Beaulaurier observes that social workers are uniquely positioned in health services organizations to aid people with disabilities in becoming "...active, informed consumer(s) of services" (Renz-Beaulaurier, 1998).

Addressing the needs of clients for advocacy services in the current health care environment may require concerted efforts and action on the part of the entire social work profession at the legislative and policy levels. Social workers also need to join with others in efforts to create or change laws in order to protect the advocacy

function. *Time* magazine reported that 35 states have already passed laws regulating the practices of HMOs in an effort to limit abuses and protect consumers (Allis, Dickerson, Booth, & McDowell, 1997). Social workers need to establish links and partnerships with consumers and other groups to assure that such laws include support and legitimization for advocacy services.

Disability rights organizations such as local independent living centers already employ advocates, although not necessarily social workers. In some cases disability rights organizations have also hired consultants to provide training in community organizing so that they can undertake more effective social action (Varela, 1983). Organizations such as the International Ladies' Garment Workers' Union have also employed social workers to help their members gain and maintain both public and private benefits and entitlements. Such efforts need to be expanded.

Although there may be limits on the types of advocacy practice that can be expected of health social workers, this should not be construed to suggest that an advocacy role is not viable. In the current study, a small but non-negligible portion of the respondents reported having engaged in various forms of advocacy. Moreover, the majority indicated high levels of commitment to advocacy, at least in principle. Continuing research is necessary to determine which advocacy strategies and tactics are most effectively utilized in response to various situations. Such studies may offer important insights about what works best in today's highly complex health care environment.

It seems reasonable to assume that successful advocacy in complex hospital and health services environments requires appropriate levels of knowledge and understanding of the functioning of bureaucratic organizations. Moreover, a clear understanding of such processes would enable social workers to offer their clients with and without disabilities, alike, a fuller array of options and speedier approaches to the resolution of problems and barriers encountered when trying to cope with complex health care systems.

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