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This paper presents an innovative advocacy model designed to assist people coping with psychiatric disabilities to fulfill their basic living needs. The model emphasizes the importance of clients defining their own needs for advocacy and then, with the support and assistance of an advocate, taking direct action to fulfill these needs. The model is elaborated in terms of its basic attributes, the interlocking roles of both clients and advocates, the importance of the advocacy relationship, and seven core processes of advocacy. The authors conclude with a discussion of possible effects of introducing the model into social work practice in mental health settings.

Many social workers agree on the importance of client advocacy as a critical function of mental health practice whether in case work, in case management, or in family work (Gerhart, 1990; Moxley, 1989; Rapp & Hansen, 1988). However, much of the emphasis placed on the importance of advocacy by the profession is rhetorical. It encourages social workers who otherwise identify themselves as clinicians and therapists to address environmental and institutional factors that prevent the fulfillment of clients' basic living needs. Yet we know that many social workers in the mental health field are more comfortable with office-based practice that places them in the roles of clinicians (Johnson & Rubin, 1983; Mowbray & Freddolino, 1986). These workers may view advocacy and related environmental

modification activities to be superficial extras in addressing the "real" needs and problems of people with psychiatric disabilities which the workers define more in terms of psychological and psychodynamic processes than in terms of environmental and structural factors (Johnson & Rubin, 1983).

Alternatively, social workers may view advocacy as more of a paraprofessional function, easily done by workers without professional training. Social work clinicians may be reluctant to embrace roles that thrust them into conflictual arenas within community settings where they may not be able to use effectively the skills of collaboration and consensus-building which are so fundamental to our profession's traditional approach to problem-solving.

The relative inattention paid to advocacy by social workers practicing in mental health may be compounded by the failure to achieve consensus within the profession on what constitutes this intervention (McGowan, 1987). Does advocacy mean assisting clients in gaining access to services or entitlements, with the functions of brokering and linkage being the most important (Moxley, 1989)? Does it mean protecting the substantive rights of clients, thereby requiring the social worker to invoke legal processes (Raider, 1982)? Does it mean working in the client's "best interests" despite the possibility that the client may not agree with the aims of the social worker (Gerhart, 1990)? Or does it involve a partisan perspective in which the social worker only acts on those goals or issues that clients want to achieve for themselves (McGowan, 1987; Moxley & Freddolino, 1990)? Each of these definitions suggests a different type of advocacy activity.

Given this extensive diversity in the definition of advocacy as used in mental health contexts, the concept and related interventions can mean different things to different practitioners. It is not surprising, therefore, that the profession does not have clear and compelling *practice models* that guide our provision of client advocacy. This paper is based on the authors' empirical research on advocacy which identified a high prevalence of unmet basic living needs among consumers of mental health services (Freddolino, Moxley, & Fleishman, 1988; Moxley & Freddolino, 1991). This research also evaluated the impact of

an advocacy intervention in fulfilling these unmet needs using a consumer empowerment strategy. In the paper we articulate a basic model of advocacy practice that was actually field tested (Freddolino, Moxley, & Fleishman, 1989) and assess the relevance and practicality of this model for social work practice in mental health settings. The model is based on the fundamental view that advocacy must be grounded in the self-defined needs and desires of consumers, resulting in a client-driven approach to the provision of social work services.

The Relevance of an Advocacy Perspective

In the context of social work practice in mental health, is advocacy relevant to serving people coping with psychiatric disability? Indeed, several conditions underscore the importance of advocacy in the mental health arena (Moxley & Freddolino, 1990).

People labeled mentally ill constitute a vulnerable population, nowhere more visible than in the areas of housing, employment, and income maintenance (Moxley & Freddolino, 1991). People with severe mental impairment are at risk of homelessness (Torrey, 1989). Anywhere from one-third to two-fifths of homeless individuals may be coping with significant mental impairment (Lamb, 1984). Because they do not control many housing placements, mental health agencies have not been able to respond to this explosion in the need for housing, and they have also found it difficult to coordinate their services with public housing authorities reluctant or even hostile to serving people with psychiatric disabilities (Mechanic, 1987). In the face of this, advocacy strategies may offer an alternative to front-line social workers that is much more consistent with the values of the profession—such as promoting self- determination (Moxley & Freddolino, 1990; Freddolino & Moxley, 1992)–than oppressive alternatives that reduce client autonomy (Belcher, 1988).

Many people coping with psychiatric disabilities experience considerable difficulty in obtaining gainful employment due to discrimination by employers, employment that pays an inadequate wage, and a reluctance by vocational rehabilitation agencies to serve people with psychiatric disabilities (Gallagher, 1987). An advocacy approach which emphasizes assisting clients

in addressing their self-defined needs may provide a concrete method for dealing with these situations instead of accepting the only currently-available alternatives such as a sheltered workshop designed for people coping with different disabilities (Malamud & McCrory, 1988).

In the area of income maintenance, the actions to strip many people with psychiatric disabilities of their social security disability benefits by the Reagan administration during the early 1980s illustrate the vulnerability of this population not only to the elimination of public income supports but also to the broader danger of bureaucratic manipulation (Goldman & Gattozzi, 1988). Through a narrow interpretation of administrative rules, the Reagan administration eliminated many people with mental disabilities from federal income supports and forced them onto public assistance or onto their own, often inadequate, means (Burt & Pittman, 1985). Both individual advocacy (dealing with specific people) and systemic advocacy (dealing with groups or classes of people and broad system-wide conditions) are certainly relevant strategies for addressing the relative lack of access to basic living resources experienced by many people coping with psychiatric disabilities. People labeled mentally ill are certainly not insulated from future administrative ploys to decrease or eliminate vital social benefits in the name of budget balancing or retrenchment.

Being labeled mentally ill can have negative social consequences, resulting in stigmatization leading to rejection, mislabeling by the media, and lack of motivation to provide essential services even by health care professionals (Gallagher, 1987). Advocacy in this context may need to address social and interpersonal processes that lead to gross misperceptions of people with psychiatric disabilities which in turn can prevent their integration into our communities.

The effects of stigmatization can be worsened by learned helplessness, involving a loss of motivation and reduced feelings of self-efficacy and resulting from important decisions, opportunities to make choices, and critical tasks of daily living being usurped by significant others or by mental health workers (Taylor, 1979). The resulting dependency may mean that individuals coping with psychiatric disabilities will be unwilling

to take autonomous action. Again, advocacy—in the form of assisting clients to address their self-defined needs—may be quite relevant.

Finally, some people coping with psychiatric disabilities may not see clinical services as having much utility for them. They may see relevant services as ones that assist them in obtaining housing, employment, income and other necessities of daily living-services that address basic resources and not the psyche. Rather than mental health services or in addition to clinical care these consumers may desire more pragmatic social supports that address their basic living needs and that assist them in achieving the goals that they themselves identify as most important (Anthony, Cohen, Farkas, & Cohen, 1988; Cohen & Anthony, 1988; Freddolino, Moxley, & Fleishman, 1988).

The Client Support and Representation Model

Five Attributes of Client-Driven Advocacy

The Client Support and Representation (CSR) model views individual (client specific) advocacy as a means of improving the well-being of people with psychiatric disabilities through a process of skill development and support leading ideally to empowerment (Rose and Black, 1985). At the core of this empowerment process are five attributes that give the model a client-driven character by emphasizing the values of self-determination and client control (Moxley & Freddolino, 1990).

First, this model of advocacy recognizes the legitimacy of clients defining their own wants and desires. Needs are not defined by the social worker or by others but by clients themselves. The role of the social worker, ideally, is to facilitate the identification and definition of the problem from the client's perspective. This process of self-definition is fundamental to the problem solving process that is used by CSR. Second, advocacy is not defined as a passive activity in which the advocate identifies systemic and environmental barriers and then takes action on behalf of clients. Alternatively, the clients', own problem-solving skills and resources are strengthened in relationship to attaining self-defined wants and desires, and in dealing effectively with barriers and constraints that prevent the fulfillment

of daily living needs. A third attribute is the importance of on-going social support and the role of the advocate as a strong source of support to clients. Advocates assist clients in defining problems, in establishing goals, and by providing on-going encouragement in the resolution of needs and desires. A fourth attribute is the need for clients to acquire knowledge about the broad range of community resources that exist within many of our communities. Knowledge is seen as a critical precursor to empowerment since clients need to know what exists (and what does not exist) in relationship to their own individualized wants and desires. The final attribute is the legitimization of clients', disputes and disagreements, including support for the right to express these disagreements and to seek either formal or informal hearings in order to resolve them.

The Client Support and Representation framework is based on a humanistic view of people coping with psychiatric disabilities. CSR advocacy assists clients in developing and strengthening their abilities to acquire knowledge, assertiveness, and problem-solving skills. Advocacy also is designed to assist clients in overcoming personal and environmental challenges that can stand as barriers to their obtaining what they want for themselves (Rapp & Wintersteen, 1989). Advocacy in this context becomes a form of personal self-assistance, based on self-identified needs, that unfolds within the context of a very supportive interpersonal relationship with an advocate. This approach is seen as appropriate for clients diagnosed with a broad range of psychiatric disabilities, similar to the target groups for case management services. It has been field-tested with clients labeled with schizophrenia, major affective disorders, and schizoaffective disorders (Freddolino, et al., 1989). But perhaps what is most important is the identification of those individuals who prefer an approach in which they struggle to make their own decisions and to select their own courses of action (Moxley & Freddolino, 1990).

Two core values are fundamental to all five of these CSR model attributes. The value of self-determination (Moxley & Freddolino, 1990) means that clients must understand their needs and define what action they want to take to fulfill them. The value of client control means that the advocacy process

involves direct action by clients to resolve their problems or to fulfill their desires. The value of client control, therefore, is a recognition that the purpose, aims, activities, and evaluation of advocacy must be formulated and implemented according to the perspectives of clients themselves (Moxley & Freddolino, 1990; Freddolino & Moxley, 1992).

The Roles of Clients in CSR

The values of self-determination and client control are further operationalized through the roles available to CSR clients. Four roles, all based on the idea that clients must take responsibility for operationalizing the process of advocacy through their own actions, are fundamental components of the field-tested model. These four roles are: initiator, implementer, evaluator, and educator.

As initiators, clients take responsibility for initiating the advocacy process by agreeing to become involved, by defining their own needs through a needs assessment process, and by determining the actual advocacy activities that will be employed to address these self-identified needs. As implementers, the CSR advocacy process requires clients first to implement action on their own behalf before any higher order level of intervention is undertaken-especially by the advocate. Within the CSR model emphasis is placed on self-help and direct action by clients while the advocate provides on-going technical assistance, support, and encouragement. As a result, clients are actors rather than passive recipients of services provided by the advocate.

Throughout the process of CSR, clients are involved as active evaluators of the process and outcome of advocacy. Clients are involved in monitoring which advocacy activities should continue, whether they are satisfied with the outcome of these activities, and whether advocacy activities should continue, be modified, or stop. Consequently, emphasis is placed on clients taking the role of active decision-makers.

Finally, clients are seen as educators of CSR advocates and others about their preferences, what they want to achieve for themselves, how they want to go about achieving what they have identified as important for themselves, and what they are willing to accept from mental health and other social welfare

systems. In this role, clients are seen as active agents who are increasing the understanding of advocates and others.

The Roles of Advocates in CSR

The CSR model identifies four roles of advocates that complement client roles: mentor, coach, supporter, and representative. The CSR advocacy model does not assume that clients will have all of the requisite skills to engage in proactive problem-solving. It is up to the advocate to be available to clients to mentor them through the learning of these skills and their application to specific situations. By modeling effective problem-solving, by teaching clients the essential skills involved in dealing with institutions and bureaucracies, and by suggesting to clients how to network and with whom to network, the advocate can promote problem-solving on the part of clients.

The role of coach is connected with that of mentor and is useful to teaching problem-solving skills directly. Here the advocate is much more explicit about teaching specific skills. This may involve task analysis, the provision of special knowledge concerning regulations, and the use of rehearsal to give clients opportunities to practice skills.

In operationalizing the role of supporter the advocate provides a range of supports including emotional, instrumental, and informational resources (Gottlieb, 1981). Attentive listening, empathic responding, and allowing the expression of anger and frustration are some of the ways that the CSR advocate provides ongoing support. In addition, support is provided even though the advocate may disagree with the course of action that clients have chosen. As a supporter, the advocate is available to assist clients in making these decisions and perhaps to reconcile any difficulties that may arise as a result of the choices made by clients. There is an inherent dignity in making choices about a course of action even though these choices can result in failure (Wolfensberger, 1972). CSR advocacy is consistent with psychiatric rehabilitation principles which emphasize that clients need opportunities for both success and failure since these opportunities are so fundamental to learning in real life situations (Farkas & Anthony, 1989). Finally, the CSR advocate is always prepared to serve as a representative of client wishes

and desires within institutional, bureaucratic, and community situations. CSR advocates do not fulfill this role based on their own assessment of the situation but take this role when advocates and clients agree that this is the preferred course of action. As representatives, advocates may attempt to resolve disputes through mediation and negotiation, or through more assertive actions such as administrative hearings or formal legal action.

The Importance of the CSR Advocacy Relationship

As with most effective human service technologies that use interpersonal techniques, CSR requires the development of an effective relationship between advocate and clients in order to integrate the roles of the two parties (Egan, 1985). Undergirding this relationship is mutual trust. This trust can be developed between advocate and clients when the advocate accepts the legitimacy of client perspectives and desires and, in turn, when clients are forthright in identifying what they want to gain from the advocacy effort. The only a priori limits on the types of clients for whom this approach may not be optimal are those with organic brain conditions and clients whose primary diagnosis is substance abuse.

Trust also is developed when clients articulate the actions they want advocates to engage in, and advocates take these actions and do not pursue their own agenda. In addition, the advocate sustains trust by asking, on a consistent basis, what clients want the advocate to undertake and then pursuing these activities. Again, the advocate avoids unilateral action or "action in the best interests of the client," leaving that approach to the other professionals in the mental health system. Fourth, clients and advocate sustain trust by "touching base" with one another, preferably on a regular basis, in order to inquire into how things are going, to identify new needs, and to evaluate whether agreed-upon actions should be continued.

Last, trust is sustained by advocates when they recognize that clients may want to drop in and out of involvement in CSR advocacy. This is recognized by both parties as legitimate action, and the advocate has faith in the ability of clients to recognize for themselves when they want to be involved and when they do not want such involvement. By addressing this

and all of the other aspects of relationship both the advocate and the client will be able to build and sustain a productive collaboration.

The Process of CSR Advocacy

CSR makes use of seven core processes which are based on casework and rehabilitation practices of demonstrated effectiveness including the use of tangible objectives, the task analysis of activities, contracting, homework, the development of client problem-solving skills, and the monitoring and evaluation of the implementation and effectiveness of advocacy activities (Anthony, 1979; Brown & Hughson, 1987).

The seven advocacy processes are:

1. Engagement. CSR services are offered to an identified group of clients or to all clients within an identified geographic service area. Advocates explain the services, and inquire into whether clients want to participate. These outreach and engagement activities are implemented to assure that clients who might otherwise not have the skills or resources to obtain the assistance on their own initiative if they want it will not be deprived of the opportunity to participate. For those clients who do not have any self-defined needs, the routine and unconditional offer of advocacy services increases their awareness of the service and offers the possibility of linkage with the program sometime in the future if they so desire.

2. The Assessment of Advocacy Needs. To assess the needs from the perspectives of clients themselves, an open-ended needs assessment instrument is employed that allows clients maximum opportunity to identify their self-perceived needs without the formal structure of either the program or the advocate being imposed upon them.

In order to give some focus to the interview process, the needs assessment instrument is structured so that nine daily living needs areas are covered. These areas are: housing; employment and training; income and benefits; health, mental health, and dental care; transportation; medication; legal problems; social, personal, and family issues; and conservatorship; An additional question is included to allow clients to identify needs that do not fall within these categories.

The practically of the need areas within the instrument attests to CSR's concern for identifying issues pertaining to clients' self-perceived quality of life within the community rather than with the quality of their mental health care. The needs assessment process reinforces the client role as the initiator of advocacy activity. In addition, the process is designed so that clients can engage in the role of educators who teach the advocate what they need or desire.

3. Setting Objectives and Identifying Tasks. Following the identification of needs, clients and advocate work together in the formulation of client driven plans. The advocacy plan consists of mutually-agreed upon objectives for the issues clients defined based on their self-identified needs, problems, and barriers. Objectives are concrete statements of what clients want to achieve in order to reconcile their identified needs and problems. These objectives are then prioritized so that clients and advocates can address the issues that are most pressing from the perspectives of clients themselves.

Clients and advocates then collaboratively identify tasks that must be accomplished if the objectives are to be achieved. By the time tasks are specified both clients and advocate understand the responsibilities each must undertake in order to achieve a successful and desirable outcome.

A major bias of the CSR model revealed here is the emphasis on encouraging and supporting clients to take on as many specific tasks as they can handle in their own behalf. Except for emergency situations, the general advocacy principle guiding staff is not to do for clients what they can do for themselves even if it may take more time or demand more effort. The emphasis placed on self-initiation reinforces the client role of implementer, thus working toward overcoming learned helplessness. This emphasis also means that advocates are more likely to engage in coaching and mentoring rather than in direct action on behalf of clients.

4. Maintaining Relationships Across Space and Time. A fundamental principle of the CSR model is that weekly contact with clients is to be attempted no matter where the client is located. For the purpose of the CSR research demonstration, the contact area was defined as that space within a 50 mile radius

of the project office. Tracking the client so that there can be an on-going offer of CSR advocacy services means that advocates follow clients if they are committed to psychiatric facilities, move from one residential program to another, or if they are sentenced to jail. Client movement, therefore, does not mean that clients need to break with the advocacy services. Although clients can choose to stop receiving CSR services, advocates bear the responsibility for maintaining contact, offering assistance, and following-up with clients no matter what system–mental health, criminal justice, or medical–the client enters. By following the client, advocates seek to maintain continuity of the advocacy effort.

CSR calls for maintaining the offer of assistance across time. The intervention is seen as an on-going one during which clients can drop in and out of service based on their preferences. Treatment compliance is not incorporated into the model since continuing with the advocacy service is a choice made by clients.

5. Problem-Solving and On-Going Needs Assessment. Implementation of the advocacy plan typically begins with the advocate providing technical assistance and information on how to resolve each specific need or problem before any higher level of intervention is undertaken by either party. At the time of each weekly contact client and advocate discuss progress made toward the fulfillment of objectives. If technical assistance does not appear to be sufficiently effective for a specific need, the advocate can become more involved if the client requests such involvement. Advocates, for example, may represent clients at administrative hearings, at face-to-face negotiations with landlords, or in meetings with employers if clients request such action.

At this stage of the CSR process a short needs assessment is completed during each weekly contact. The advocate inquires into how things are going in specific areas of potential need, determines whether the client wants to address any other needs, and the two then update the advocacy plan accordingly. Frequent repetition of the brief needs assessment process allows the timely identification of newly emerging needs and reinforces for clients that an on-going source of support and representation is available to them.

6. Monitoring of Problem Resolution. Maintaining frequent communication between clients and advocates is an important aspect of the intervention process. Clients and advocates contract for both face-to-face and telephone contact with the purpose of discussing how things are going. Monitoring is not designed to assess whether the client is complying with the agreed-upon plan under threat of some punitive action for failing to do so. The purpose of monitoring is to determine if milestone tasks are relevant, if they are being achieved, and if adjustments in strategies need to be considered by the two parties. In addition, the monitoring contacts permit friendly visiting between the client and advocate, an activity that reinforces the on-going supportive nature of CSR services.

7. Evaluation of Outcome. The extent to which clients are satisfied with the resolution of their needs or problems is an important criterion used to evaluate the effectiveness of the CSR advocacy effort. Although this may seem rather simplistic, the use of client satisfaction is consistent with the "client driven" character of the CSR model. This approach to evaluation prioritizes the perceptions of the participants. It respects their status as independent decision-makers who have the capacity to determine when they have resolved a situation to their own liking, and it reinforces the importance of participant reflection on the attainment of their own preferences and desires.

Practice Implications

The Client Support and Representation model of advocacy is an interpersonal practice approach that can expand the repertoire of social workers practicing in mental health. In the past, social work practice in mental health has emphasized the casework role of the social worker who worked with client and family coping with the onset of psychiatric illness and then in helping both client and family to adjust to the milieu of the institution. Practice has evolved into more of a case management approach in which the social worker practices at the boundary of the mental health program and the community. The social worker helps clients to identify the services that are necessary to meeting their needs in community-settings and then links them to these services. Advocacy in this context typically involves getting clients access to services.

The CSR model can complement this case management approach to mental health service delivery by expanding the advocacy function. The model promotes the values of self-determination and client control over intervention activities. Despite the fact that the profession espouses these values, it has been difficult to operationalize them in situations where social workers must represent the interests of the system or of agencies over those of the clients. Thus, social workers may find themselves in "people processing roles" rather than in roles that enable them to represent the desires and goals of clients (Cohen & Anthony, 1988). The adoption of CSR principles can assist social workers in working collaboratively with their clients in defining and acting on what they want to achieve for themselves. Perhaps social workers adopting this approach to practice will find themselves working on mental health issues under non-traditional auspices such as public interest law firms, consumer-operated services, and self-help alternatives.

Another implication for social work involves the practical focus of the CSR model, which addresses the basic needs and resources of clients from the perspectives of clients themselves. The focus of CSR is on whether clients, from their perspectives, are coping with major problems or issues that can prevent them from achieving the lifestyle that they wish for themselves. Clients' desires concerning housing, employment, legal issues, and medical care, for example, are much more important to the model than their diagnostic profile or their psychiatric histories. The latter are seen as potential barriers because of the way other people–mental health professionals and community residents alike–use these profiles and histories to make a priori decisions about clients' competencies and capabilities. By focusing on the needs that clients define as important the social worker is more of a generalist practitioner than a psychiatric professional. Perhaps this will mean that social workers practicing in mental health will take into consideration what the community as a whole has to offer clients and will not confine their attention only to those services that are readily available through the mental health service system.

Many approaches to interpersonal practice emphasize the importance of mobilizing the action of clients in resolving their

own problems and needs (Epstein, 1988; Germain & Gitterman, 1980). The CSR model operationalizes this principle of effective social work practice by emphasizing the need to formulate advocacy plans that identify the action taken by the client to address each prioritized need or issue and how the client and worker will collaborate in resolving the identified need or issue. Rather than indicating that clients are left to their own devices to help themselves, this means that the worker takes responsibility to assure that clients have every opportunity to exercise their own skills–or to develop new ones–so they can make a positive impact on their environment, a condition that is so essential to the realization of personal mastery and effectiveness (Wine, 1981).

An emphasis placed on mobilizing client action may also be useful in offsetting some of the motivational deficits induced by psychiatric disability. By identifying their own skills, by exercising these skills, by learning new skills, and by receiving support to use these skills, people coping with psychiatric disabilities may learn to sustain their motivation and to resolve other problems effectively in the future with less dependence on professionals.

Despite its focus on individual action, the CSR model also recognizes the role of environmental factors in preventing people from realizing their goals and desires. The model emphasized the importance of identifying any legal, institutional, societal, and bureaucratic processes that can prevent clients from meeting their needs. The advocacy process emphasizes the importance of resolving these environmental issues, which means that the social worker may have to represent clients in different forums. Thus, this model of advocacy requires the social worker to work with clients directly in augmenting their problem-solving skills, to work with the client collaboratively in addressing environmental issues, or to take action independently of the client when this is mutually agreed upon.

Finally, a fundamental aspect of the CSR model is the need for on-going support provided by the social worker during the course of advocacy. On-going support–whether it involves emotional sustenance, active listening, the provision of information, or simple encouragement–may be very important to clients who

have experienced considerable discouragement, frustrations, or oppression when trying to achieve their goals. The consistent provision of support may be a major tactic for propping up the motivation, problem solving, and autonomous action of clients.

Client Support and Representation encapsulates much of what the profession defines as good social work practice. The model complements and operationalizes the profession's historic commitment to meeting the basic needs of vulnerable client groups and to involving clients directly in the process of social work service delivery (Towle, 1987). CSR also is a practice model that is consistent with the profession's person-in-environment framework. Perhaps the incorporation of CSR into the repertoire of social workers practicing in mental health will further strengthen the leadership role of the profession in enhancing the lives of people coping with psychiatric disabilities (Wintersteen, 1986).

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