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Richard L. Beaulaurier  
*Florida International University*

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# Health Services Social Workers' Activities with People with Disabilities: Predictors of Community Practice

RICHARD L. BEAULAURIER

Florida International University  
College of Health and Urban Affairs  
School of Social Work

*The purpose of this study was to explore the extent to which hospital based social workers were actively involved in community practice on behalf of disabled people. The study attempted to identify what variables influence social workers in health settings to engage in community 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 community practice was part of their professional responsibility and that disabled clients needed such assistance. Regression analyses showed that self-reports of community practice activities were nevertheless highly related to self-reported advocacy activities. However, their reports of their actual advocacy activities consistently fell below their recognition of need.*

A major tenet of the *Americans with Disabilities Act* (ADA) is that people with disabilities frequently encounter institutional, social and physical barriers as they try to establish and maintain lives in mainstream communities. This view is held by a great many disability rights advocates and authors who suggest that many of the problems encountered by disabled people are neither psychological nor medical (Mackelprang & Salsgiver, 1999; Tower, 1994). Rather, they contend that disabled people encounter problems in their contacts and interactions with communities, organizations and mainstream health and rehabilitation

organizations that for one reason or another limit full participation by people with disabilities (Beaulaurier & Taylor, 2001b; Hahn, 1984; Kailes, 1988; Roberts, 1989).

Although people with disabilities are becoming more militant about demanding new types of services, there is reason to believe that the health organizations that serve them may actually be working to limit their options. As managed care becomes more prevalent in health services, administrators can be expected to seek to limit the discretion and flexibility of practitioners, particularly when it comes to prescribing more costly services and options whose costs are unknown or not supported by third-party payers (Herbert & Levin, 1996; Sunley, 1997, pp. 88–89). Grass roots advocates in the disability rights movement, however, increasingly favor programs and services that support “independent living” approaches that maximize the clients’ ability to live and work in mainstream communities (Crewe & Zola, 1983; Herbert & Levin, 1996; Kailes, 1988; Mackelprang & Salsgiver, 1996; Sunley, 1997; Tower, 1994). This may create a situation in which administrative pressures may conflict with increasingly articulate and well-organized disability rights groups, not to mention other consumer and patient movements. What people with disabilities increasingly say they need are alternatives to the services provided by mainstream rehabilitation and health organizations (Beaulaurier & Taylor, 2001a; Tower, 1994).

The notion that people with disabilities need assistance and services that lie outside the traditional framework of mainstream health and rehabilitation organizations is well established in the disability rights community (Kailes & Weil, 1985; Mackelprang & Salsgiver, 1996; Renz-Beaulaurier, 1998; Tower, 1994). For a substantial number of disabled people, however, there is also a need for services and other forms of assistance, in order to facilitate community-based living (Mackelprang & Salsgiver, 1999; Mathews, 1990; McAweeney, Forchheimer, & Tate, 1996). In order to obtain both rights and services, many disability activists have had to organize and mobilize their constituencies (Varela, 1983).

In an environment where organizational and environmental priorities appear to be at odds, social workers in health care settings increasingly feel the need for better community practice

skills in addition to more familiar direct-practice skills. However questions arise as to whether social workers in health and rehabilitation settings believe community practice is part of their function at a time when modern health organizations may not consider these activities to be "billable services." Are social workers making corresponding adjustments in their practice? Do social workers in health settings perceive the needs of clients with disabilities as legitimate, deliverable services? If so, do social workers perceive that community practice is the method for adjusting existing conditions to better satisfy these needs? To what extent do they indicate that they are engaged in community practice? This study investigated the self-reports of social workers in health organizations (primarily hospitals) about their engagement in community practice activities.

It has not been established empirically whether social workers agree with the need for community practice activities, particularly those social workers in traditional health service organizations. By their nature, community practice activities would involve a departure from more traditional clinical activities. Since the inception of health social work, practitioner activities have primarily focused on direct service activities with families and clients (Bartlett, 1957, p. 87; Cannon, 1930, pp. 90–96; 1952, p. 205; Pfouts & McDaniel, 1990). Some authors have also speculated that managed care policies imposed by health care organizations may be restricting what social workers in such settings are able to do with clients (Cornelius, 1994; Tower, 1994, p. 191). At times, however, direct practice social workers have also been active in forming linkages and collaborative arrangements with community groups (Taylor, 1985, pp. 204–207). A central question is whether social workers in health settings see the importance of community practice, and of creating linkages with the disability community as one of *their* responsibilities? If so, are there any restrictions on their autonomy, particularly at the organizational level, that would prevent them from engaging in such practices?

Weil and Gamble (1995, p. 577) have noted that there are five objectives of community practice:

- develop organizing skills and abilities of citizens and citizen groups

- make social planning more accessible and inclusive in a community
- connect social and economic investments to grassroots community groups
- advocate for broad coalitions in solving community problems
- infuse the social planning process with a concern for social justice

The *sine qua non* of these activities for health social workers is *contact* with individuals and groups within the disability community. In fact, many of the services available to help people with disabilities live independently in their communities of choice are operated by other people with disabilities (Racino, 1999, chaps. 8 and 9; Tower, 1994). "Independent living centers," for example, stress the importance of self-help and peer support from other people with disabilities who can serve as role models. Such centers and related services are themselves part of networks and associations of people with disabilities and can be found in most major metropolitan areas, as well as many rural areas (the most comprehensive list available is at <http://www.ilru.org/jump1.htm>).

This article reports on exploratory-descriptive findings related to health social workers' self reports of community practice in their professional activities with people with disabilities. The principal research questions related to (a) whether social workers in health settings felt committed to community practice with and on behalf of people with disabilities, (b) to what extent were they in contact with the disability community and (c) the degree to which other factors influenced their ability to engage in community practice with this population.

## Methods

### *Sample*

A questionnaire was administered to a sample of 286 social workers employed in 57 different hospitals and rehabilitation settings. Convenience 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 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 and one government hospitals 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). This is consistent with the norm for a study of this type (Kerlinger, 1986, p. 380). At least some surveys were returned from 89% of the departments that were asked to participate. Eighty percent of respondents were women. Seventy-six percent were white; 9% of respondents reported being African American, and an equal number reported being Latino. The remainder reported being of Asian, Pacific Islander or Native American decent. Most respondents were either licensed clinicians (64%) or "clinical associates" in the process of earning their clinical license (5%), although 20% reported that they had at least some administrative responsibilities. Most respondents indicated that they had regular professional contact with people with disabilities. Two thirds of respondents reported that they were professionally involved with at least three disabled people per month. Half saw at least 10 (the median). The average number of disabled people seen by respondents was 20 per month.

### *Measures*

The questionnaire used in this study was developed by the author as part of a larger study of health social workers' practice with people with disabilities. A series of questions focused on whether respondents felt that community practice activities were (a) important and (b) one of *their* practice responsibilities. These items were used to develop two short measures, one to measure the degree of their philosophical commitment to community practice on behalf of people with disabilities ("Community Practice Philosophy"), and the other to measure whether respondents were in regular contact with members of the disability community ("Community Contact"). These measures were created by combining several individual items on the questionnaire using

the summing procedure suggested by Spector (1992) in order to create a summated rating scale. Since these measures have not been used in prior studies no validity statistics are currently available. Cronbach alpha scores were calculated for both measures as a partial indication of reliability.

Alpha scores and summary information were also calculated for the Advocacy Activities Index, a summated rating scale that was developed in conjunction with the questionnaire for this study. This index included items about activities including lobbying, advocating for change within their organization, seeking to change laws and policies, seeking reasonable accommodations, etc. Findings related to this scale, as well as more extensive information on its development, were previously reported in Beaulaurier and Taylor (2000)

In addition to these scales, several individual items from the questionnaire were also analyzed and reported on below. These items related to (a) administrative restrictions placed on practitioners and (b) clinical activities. Since the questionnaire was developed *de novo* for this study, measurement characteristics for the instrument as a whole or for these individual items are not known. However, a pilot study was conducted using the entire questionnaire. Several changes and clarifications based on the pilot were incorporated into the final version of the instrument.

### *Analysis*

Responses to individual items have been summarized in Table 1. Bivariate statistics were calculated using a combination of t-tests, Spearman *r*, and Pearson *r* statistics. Hierarchical multiple regression (Pedhazur, 1982, pp. 164–167) was used to develop a statistical model of variables that might influence health services social workers' motivation and ability to engage in contact with the disability community, although a simple regression procedure ultimately appeared almost as effective. All analyses were conducted using version 10 of SPSS for Windows.

## Results

### *Administrative Restrictions*

Most respondents believed that they had considerable autonomy in their work with people with disabilities. The responses in

Table 1, (administrative restrictions section), indicated that they did not feel there were many administrative restrictions placed by the organization on their practice. Most felt rather free to innovate in their practice with people with disabilities.

### *Community Practice Philosophy*

Most respondents also indicated that they recognized the need for organizing and taking action. Moreover, they indicated that they believed social workers had a role in this process (see Table 1, Section 2). Interestingly, respondents tended to believe that helping the client to achieve independence in the community was a primary function of the social worker (Questions 2a and 2b). There was almost unanimous recognition that community practice activities were important (Question 2a) and that such skills help social workers accomplish one of their major practice functions, namely: assisting people with disabilities to achieve independence (Question 2b).

Questions 2c and 2d (Table 1) suggest that respondents believed their co-workers were involved in organizing activities on behalf of people with disabilities and their families. Eighty-four percent of respondents believed that social workers helped families organize on behalf of disabled family members, and an even greater percentage (96%) indicated that social workers helped families to organize on behalf of themselves.

A scale was created by summing the responses to questions in Table 1, Section 2. This procedure is outlined and discussed separately by Kerlinger (1986, pp. 453–455) and Spector (1992). The sum obtained for each respondent was then multiplied by a constant to render a scale with values between 1 and 4 and a midpoint of 2.5. Low scores indicate a high orientation toward a community practice perspective or “philosophy”; High scores indicate a lack of interest in community practice. An alpha score of .61 indicated an acceptable level of internal consistency in the scale. The obtained mean was 1.4 indicating that respondents tended to be highly committed in their attitudes toward community practice.

### *Community Contact*

The four questions in Table 1, Section 2, were focused on the general orientation and perspectives of respondents with regard

Table 1

*Questionnaire Items*

	<i>Mostly True</i>	<i>Somewhat True</i>	<i>Somewhat False</i>	<i>Mostly False</i>
<b>Section 1. Administrative Restrictions</b>				
1a. I am limited in terms of what I can do with/for people with disabilities because of administrative practices in my organization. <sup>a</sup>	4.6%	26.4%	35.4%	33.2%
1b. I would be reprimanded by administration for using non-standard treatment options with disabled people.	6.2%	20.1%	40.1%	33.6%
1c. I regularly develop new/innovative treatment options for disabled patients.	5.6%	32.5%	33.6%	28.3%
<b>Section 2. Community Practice Philosophy</b>				
2a. Apart from other skills social workers should have good community, networking and organizational skills in order to be of help to the families of people with disabilities.	81%	19%	0% <sup>b</sup>	0%
2b. A primary function of the social worker who works with disabled people is to assist them in obtaining the services and assistance they need to live independently in the community.	77%	23%	1%	0%
2c. Social workers often help families organize in order to obtain support services for themselves (i.e. respite care, etc.).	68%	28%	3%	1%
2d. Social workers often help families organize to take action in support of people with disabilities.	40%	44%	12%	5%
<b>Section 3. Community Contact</b>				
3a. I am frequently in contact with people with disabilities who are not currently patients.	15%	21%	27%	37%

	Mostly True	Somewhat True	Somewhat False	Mostly False
3b. I am frequently in contact with local organizations and associations of disabled people.	11%	29%	26%	34%
3c. I initiate follow-up contacts with people with disabilities who have been discharged.	18%	33%	22%	28%
3d. Social workers introduce people with disabilities to successful role models in the community in my organization.	11%	33%	29%	27%
Section 4. Clinical Activities				
4a. Most of my practice with newly disabled persons is devoted to therapy and grief work.	20%	48%	21% <sup>c</sup>	11%
4b. Much of my practice with the families of newly disabled persons is devoted to therapy and grief work.	26%	51%	19%	4%

<sup>a</sup> One respondent marked a point in between "somewhat true" and "somewhat false."

<sup>b</sup> There was actually one response in this category, (0.3%) which rounded to 0.

<sup>c</sup> This includes one case in which the respondent circled both "mostly false" and "somewhat false."

to community practice; their *philosophy* of community practice. However, of primary importance to people with disabilities are practitioners' activities. Another series of items (see Table 1, Section 3) addressed more specific questions about the extent to which respondents and their social work colleagues were engaging in community practice activities in the form of actual community contacts. While it would be impossible to capture all of these activities in a short instrument, the questions in Table 1, Section 3, gave an indication of whether social workers in the study were in regular contact with people with disabilities in something other than their clinical roles.

Only about half of the respondents indicated that they initiated follow-up contacts with disabled people who had been

clients (Question 3c, Table 1). Even fewer indicated that they had *any* other contact with people with disabilities (36%, Question 3a, Table 1), with local organizations or associations composed of disabled people (40%, Question 3b, Table 1).

Exactly the same method was used to create a community contact scale from the questions in Table 1, (community contact section), as was used to create the community practice philosophy scale. The obtained mean obtained was 2.76, with a Cronbach alpha score of .71.

Most responses on the “philosophy” scale indicated a highly favorable orientation toward the concept and value of community practice. In fact, 56% of all respondents obtained scores of 1.25 (the median) or lower. By contrast, frequencies in the “contact” index clustered toward the high end of the scale indicating a rather low rate of actually engaging in concrete, specific community practice tasks. Over half of the respondents (51%) obtained a score significantly above the midpoint of the scale (2.5), as indicated by a t-test ( $t = 30.26, p \leq .001$ ). This indicates that overall most respondents claimed that they were not in regular contact with members of the disability community.

### *Accounting for Differences*

#### *Non-significant findings*

Bivariate analyses showed that demographic differences between respondents tended to be non-significant with regard to community contact. Moreover, several variables that seemed like good candidates for predicting an inclination toward community practice were also found to be non-significant predictors of contact with the disability community. For example, macro practice education—one aspect of which is community practice—did not seem to be a factor. A reported engagement in another aspect of macro-practice, namely administration, did not make a significant difference in the amount of reported community contact activities. Neither the social workers indicating that they had macro-practice majors ( $n = 25$ ) nor those indicating that they were using macro-practice skills in administrative positions ( $n = 53$ ) were significantly more likely to report regular community contacts.

It has been suggested that managed care practices may create a somewhat more restrictive environment for social worker

autonomy (Cornelius, 1994). Thus, social workers employed by Health Management Organizations, the settings with the longest and deepest commitment to managed care processes, might be expected to experience more restrictions on their practice imposed by their employers. Whether or not this proves to be the case for their autonomy in general, social workers in HMOs ( $n = 39$ ) were determined to be no less likely to engage in community practice than other respondents.

#### *Competing activities*

It seemed possible that social workers who were somewhat more engaged in other activities, such as clinical work with disabled people or their families, might be less likely to have much contact with people with disabilities who were not patients.

Two variables in the study seemed particularly closely related to clinical work with disabled people and their families (clinical activities' section). Direct practice with families had a weak, negative correlation with clinical practice activities ( $r = -.14$ ,  $p \leq .01$ ), however the same activities performed directly with people with disabilities was not significantly related.

#### *Advocacy practice with people with disabilities*

The variable found to be most closely related to community contact was *advocacy*, as indicated by self-reports on the Advocacy Activities Index (AAI). Cronbach alpha scores were acceptable (.67). Scores on the AAI were distributed, between the scale's high point (1) and its low point (4), with most responses clustering around the mean 2.65 ( $sd = 0.56$ ) which was near the midpoint of the scale (2.5).

There was a relatively high degree of correlation between self-reported advocacy and community practice activities ( $r = .60$ ,  $p \leq .001$ ). In some ways this is not surprising since both are forms of macro-practice activities that have a primarily extra-organizational focus.

#### *Exploring multivariate relationships*

While only two variables correlated with community contact (a weak negative correlation with family therapy and a strong positive correlation with advocacy), it seemed possible that there might be a more complex multivariate relationship. These

relationships were explored in the hierarchical regression procedure in the SPSS statistical package.

Variables were entered in three blocks. Block 1 controlled for the effects of theoretically interesting, but non-significantly correlated variables (education, macro-practice major in M.S.W., HMO setting). The two variables related to clinical practice were entered in a second block. AAI scores were added to the model in the final block. The resulting model was highly significant ( $p \leq 0.001$ ) and accounted for 39% of the variance. Although this was the arguably the best model, it represents only a slight improvement over a simple regression model, since AAI alone accounted for 36% of the variance.

### *Discussion*

Findings in this study should be regarded tentatively, in particular because they are not based on probability sampling, and because of the untested psychometric properties of the instrumentation. Generalizations based on these findings are, therefore, limited.

What seems clearest is that health services social workers in this study have attitudes that are highly favorable toward community practice. Responses to questions in Table 1, (community practice philosophy section), suggest that they actually see community practice as one of their primary roles. However their attitudes about community practice, as reflected by scores on the community practice philosophy index did not seem to translate into a correspondingly high degree of contact with the community. It is therefore likely that their actual community practice activities are somewhat less than would be expected given their very favorable attitudes.

Most social workers in the study stated that they were not in regular contact with any people with disabilities unless they were current patients, nor did respondents maintain contact with disability organizations or successfully integrated people with disabilities who could serve as "role models" for their patients. While it is possible that these social workers were engaged in some form of community practice that did not involve much contact with the disability community, it is unclear what those activities might be. However, these findings seem to preclude the

possibility that these social workers were involved with disability rights and other grass roots style organizations that are staffed primarily by people with disabilities.

A small but important minority of respondents, however, indicated rather high levels of community contact. This raised questions about what variables might predict such contacts. Interestingly, this study's findings give a clearer indication of what variables were *not* significant predictors. The community practice philosophy of these social workers was quite similar to those who did not have much contact with people in the disability rights community. Social workers who stated that they had majored in macro practice were no more likely to engage in community practice related activities than their more clinically educated colleagues, nor were social workers who indicated having administrative roles. Respondents in HMOs appeared to be no more restricted in their community practice roles than other health services social workers, and, in fact, most respondents in all settings indicated that they had a relatively high degree of autonomy in their practice (Table 1, administrative restrictions section).

It seemed reasonable, in that case, to speculate that social workers who were highly engaged in clinical activities with patients or their families might be less likely to engage in extramural activity. In fact, respondents who indicated a high degree of therapeutic involvement with families were significantly less likely to engage in community practice activities. However, overall, social workers who indicated high levels of clinical involvement, were only slightly more likely to have low levels of community practice than other social workers in the study.

Advocacy was the only variable identified that seemed to correspond to high levels of community practice. Although considerable research needs to be undertaken before definitive conclusions can be drawn, it stands to reason that social workers with a strong activism orientation may be more highly involved with disability groups and organizations in the community. On its face, it is not surprising that social workers who were highly involved in advocating on behalf of people with disabilities would also be more inclined to have such contacts.

It is surprising that those social workers with macro practice backgrounds were not more inclined to engage in such activities.

While at this stage it is only possible to speculate, it seems reasonable to question whether even social work practitioners with a background in administration or macro-practice coursework end up actually using their community practice skills. Organizational work and general macro-practice education may not be sufficient for establishing community practice roles. It may also be important to expose students to actual activism and community practice roles in their field practicum experiences for such roles to appear in subsequent professional practice.

Alternatively, a history of advocacy may also suggest a complementary proclivity for taking on community practice roles. Social work programs and employers valuing community practice may want to consider recruiting social workers with a background in advocacy, since this may be an important predictor of subsequent engagement in community practice.

#### *Future Research*

Further research will be necessary in order to understand both factors leading to, and barriers to, community practice with people with disabilities. Moreover, while this study focused on community practice and attitudes related to the disability community, more research will be necessary to understand health services social workers' community practice activities more generally. If responses are to be taken at face value, respondents seemed to be indicating that they were inclined to engage in community practice, but for some reason were not establishing contacts within the disability community. This raises questions about whether, and with whom, they may be in more regular contact outside their host organizations. A more open-ended interview approach might yield interesting information about the meaning of this somewhat puzzling finding. Such a study might yield important insight into how *some* social workers in these settings are able to maintain solid community contacts as well as their community practice activities with this population. Even more importantly, such a study might shed light on the barriers experienced by other social workers who appear to see community practice as part of their role, report having few administrative restrictions to their practice, and yet do not maintain correspondingly high levels of contact with the disability community.

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