VIEWS AND EXPERIENCES OF MENTAL HEALTH COUNSELORS TOWARD SOCIAL ADVOCACY

By

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VIEWS AND EXPERIENCES OF MENTAL HEALTH

COUNSELORS TOWARD SOCIAL ADVOCACY

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TABLE OF CONTENTS

Chapter Page

LISTS OF TABLES

Table 1 Frequencies and percentages of what degree participants believed it was a necessary task of mental health clinicians to participate in *social advocacy*.

	Frequency of responses	**% of Responses**
Agree Very Strongly	**n=4**	**10 % (9.5)**
Agree Strongly	**n=5**	**12 %(11.9)**
Agree	**n=23**	**55% (54.8)**
Disagree	**n=7**	**17% (16.7)**
Disagree Strongly	**n=1**	**2% (2%)**
Disagree Very Strongly	**n=0**	**0% (0)**
Missing (None selected)	**n=2**	**0% (0)**

Note. %=Percentage, n=Number.

Table 2 Frequencies and percentages of what degree participants believed it was a necessary task of mental health clinicians to participate in *client advocacy*.

	Frequency of Responses	**% of Responses**
Agree Very Strongly	**n=9**	**21% (21.4)**
Agree Strongly	**n=11**	**26% (26.2)**
Agree	**n=18**	**43% (42.9)**
Disagree	**n=4**	**10% (9.5)**
Disagree Strongly	**n=0**	**0 (0%)**
Disagree Very Strong	**n=0**	**0 (0%)**

Note. %=Percentage, n=Number

Table 3 Frequencies and percentages of which areas of social advocacy were most often advocated for by participants at some time during their professional career (arranged in descending order).

	Frequency of Responses	% of Responses
Child Abuse	**n=17**	**41% (40.5)**
Public Education	**n=15**	**36% (35.7)**
Equal Rights	**n=14**	**33% (33.3)**
Healthcare	**n=12**	**29% (28.6)**
F.D.R. Violence	**n=12**	**29% (28.6)**
Racism	**n=12**	**29% (28.6)**
Same-Sex Marriage	**n=12**	**29% (28.6)**
Access to Services	**n=11**	**26% (26.2)**
Chronically Mentally Ill	**n=10**	**24% (23.8)**
Never Socially Advocated	**n=10**	**24% (23.8)**
Sexism	**n=9**	**21% (21.4)**
Human Rights	**n=8**	**19% (19.0)**
Physical Disabilities	**n=6**	**14% (14.3)**
Poverty	**n=6**	**14% (14.3)**
Employment	**n=5**	**12% (11.9)**
Immigration Reform	**n=4**	**10% (9.5)**
Elder Rights/Elder Abuse	**n=4**	**10% (9.5)**
Other	**n=4**	**10% (9.5)**
Religion	**n=4**	**10% (9.5)**
Energy Conservation	**n=3**	**7% (7.1)**
Welfare Reform	**n=3**	**7% (7.1)**
Language Issues	**n=2**	**5% (4.8)**

Note. %=Percentage, n=Number, F.D.R.=Family, Domestic, or Community, Violence

Table 4 Frequencies and percentages of which areas of social advocacy were most often advocated for in their most recent advocacy efforts (arranged in descending order).

	Frequency of Responses	% of Responses
Never socially advocated	**n=11**	**26% (26.2)**
Healthcare	**n=5**	**12% (11.9)**
Child Abuse	**n=5**	**12% (11.9)**
Access to Services	**n=3**	**7% (7.1)**
Public Education	**n=3**	**7% (7.1)**
Chronically Mentally Ill	**n=3**	**7% (7.1)**
Same-Sex Marriage	**n=2**	**5% (4.8)**
Equal Rights	**n=2**	**5% (4.8)**
Other	**n=2**	**5% (4.8)**
Racism	**n=1**	**2% (2.4)**
Employment	**n=1**	**2% (2.4)**

Note. %=Percentage, n=Number

Table 5 Frequencies and percentages of which methods of social advocacy were most often employed by participants while advocating at some time during their professional career (arranged in descending order).

	Frequency of Responses	% of Responses
Calls/E-mails to Legislatures	**n=17**	**41% (40.5)**
Educating Consumer Groups	**n=16**	**38% (38.1)**
Letter Writing to Legislatures	**n=14**	**33% (33.3)**
Never Socially Advocated	**n=11**	**26 % (26.2)**
Face to Face With Legislatures	**n=10**	**24% (23.8)**
Boycotting Service Providers	**n=9**	**21% (21.4)**
Utilizing Forms of Media	**n=8**	**19% (19.0)**
Demonstrations/Protests	**n=7**	**17% (16.7)**
Other	**n=6**	**14% (14.3)**
Fact Finding Forums	**n=5**	**12% (11.9)**
Lobbying	**n=4**	**10% (9.5)**

Note. %=Percentage, n=Number. Calls/E-mails to Legislatures=phone calls and e-mails to legislatures and other government representatives, Letter Writing to Legislatures=letter writing to legislatures or other government representatives, Face to Face With Legislatures= face to face interaction with legislatures or other government representatives, Boycotting Service Providers= strategically boycotting specific service providers, Utilizing Forms of Media= utilizing various forms of media, Fact Finding Forums= creating and implementing fact finding forums.

Table 6 Frequencies and percentages of which methods of social advocacy were most often employed by participants while advocating in these most recent areas (arranged in descending order).

	Frequency of Responses	% of Responses
Educating Consumer Groups	**n=14**	**33 % (33.3)**
Calls/E-mails to Legislatures	**n=13**	**31 % (31.0)**
Never Socially Advocated	**n=11**	**26 % (26.2)**
Letter Writing to Legislatures	**n=6**	**14 % (14.3)**
Other	**n=4**	**10 % (9.5)**
Face to Face With Legislatures	**n=2**	**5 % (4.8)**
Utilizing Forms of Media	**n=2**	**5 % (4.8)**
Demonstrations/Protests	**n=2**	**5 % (4.8)**
Lobbying	**n=2**	**5 % (4.8)**
Fact Finding Forums	**n=1**	**2 % 2.4)**
Boycotting Service Providers	**n=0**	**0% (0)**

Note. %=Percentage, n=Number. Calls/E-mails to Legislatures=phone calls and e-mails to legislatures and other government representatives, Letter Writing to Legislatures=letter writing to legislatures or other government representatives, Face to Face With Legislatures= face to face interaction with legislatures or other government representatives, Boycotting Service Providers= strategically boycotting specific service providers, Utilizing Forms of Media= utilizing various forms of media, Fact Finding Forums= creating and implementing fact finding forums.

Table 7 Frequencies and percentages of whether or not participants believed they were effective in their most recent advocacy efforts (arranged in descending order).

	Frequency of Responses	% of Responses
Agree	**n=15**	**36% (35.7)**
Unsure	**n=14**	**33% (33.3)**
Does Not Apply	**n=13**	**31% (31.0)**

Note. %=Percentage, n=Number

CHAPTER I

INTRODUCTION

"Passive and totally individualistic approaches are simply not enough to address the proliferative, self reinforcing, and self-perpetuating nature of systems of violence and inequality" (Gerstein & Norsworthy, 2003).

What is social advocacy?

Social advocacy has been a longstanding tradition among mental health clinicians which can be traced back to the early 20th century and the burgeoning of the mental hygiene movement (Kiselica & Robinson, 2001). Social Advocacy can be readily defined as any active initiative to advance the interests of social justice, particularly on behalf of populations or groups that have been disadvantaged, disempowered, or discriminated against through directly influencing social policy for the purposes of advancing social justice. (Florida Atlantic School of social work @ http://www.fau.edu/ssw/socadvocacy.html).

Lee and Walz (1998) defined the social advocate as one who is "called upon to channel energy and skill into helping clients challenge institutional and social barriers that impede academic, career, or personal-social development (pg.9)." Challenging such barriers can be accomplished by providing either direct (advocating alongside) or indirect

(advocating on behalf of) services on individual, community, institutional, or societal levels (D'Andrea, Daniels, & Lewis). Others make use of the interchangeable term 'social justice advocacy', which Cohen (2001) defined as specific efforts designed to influence public attitudes, social policies, and laws to engender a more socially just society."

The following ethical standards appear in the 2005 ACA Ethics Code (Cottone & Tarvydas, 2007, p.378): "A.6.a. Advocacy. When appropriate, counselors advocate at individual, group, institutional, and societal levels to examine potential barriers and obstacles that inhibit access and/or the growth and development of clients.
A.6.b. Confidentiality and Advocacy. Counselors obtain client consent prior to engaging in advocacy efforts on behalf of an identifiable client to improve the provision of services and to work toward removal of systemic barriers or obstacles that inhibit client access, growth, and development." Social advocacy also occupies a section in the 'aspirational ethics' of the Ethical Principles of Psychologists and Code of Conduct (2002).

U.S. psychology occupies a rich history of developing social advocacy initiatives. Numerous advocacy activities have sustained several decades of shelf-life such as demonstrations, placing demand upon public officials, actively educating consumer groups, letter writing, lobbying, performing symbolic acts, creating and implementing fact finding forums, utilizing various forms of media to dispense information, providing legal advocacy, boycotting specific service providers, and simplifying professional and scientific jargon (Bilken, 1976). The American Counseling Association (A.C.A.) also

prescribed a collection of advocacy competencies that included five areas of competence; leadership, environmental intervention, direct intervention, informing the public, and influencing public policy (D'Andrea, Arrendondo, & Ratts, 2004).

The aims of advocacy are to safeguard clients' civil rights, facilitate the access to requisite generic services to clients, and to heighten the social, economic, and political status of clients to a level of parity with society at large (Siggers,1979). Siggers focused on advocacy that emerged from the ostensible need to protect the population of the mentally handicapped from systematic abuse and neglect. At the time the article was authored, Siggers remained skeptical that the idea of advocacy could gain consistent momentum due to there being no movement, according to his knowledge, that drafted psychologists' into the ranks of advocacy. Nonetheless, he audaciously declared that mental health clinicians are needed in advocacy.

Although a large variety of activities considered advocacy exist, in political terminology programs geared toward advocacy could be considered "efforts to resolve fundamental conflicts between institutions and the people they are designed to serve (Bloom & Asher, 1982, p.29)." A multitude of interchangeable definitions exist for social advocacy, most of which center on deconstructing, challenging, and removing systemic barriers that constrict and inhibit access to resources and psychological health of clients and others within society who are the most vulnerable, the most oppressed, and the most marginalized.

CHAPTER II

REVIEW OF LITERATURE

Theoretical Endorsements for involvement in social advocacy

Much of the literature on social advocacy came from various theoreticians, academicians, and activists representing a wide range of disciplines that plea for the involvement of mental health clinicians in social advocacy efforts. Payton (1984) argued that, inherent in psychology, are social implications and responsibilities, therefore social advocacy is necessary. She maintained that the American Psychological Association (APA) should accept the task of engaging in advocacy in both professional/scientific and social dimensions. Jackson (1980) described a key-role for psychologists as "activist-collaborator." He argued psychologists could advocate remedies to social ills by influencing legislation affecting human welfare.

Mays (2000) is among those who believed that there should exist no one whose well-being, future, or health is compromised due to reasons of national origin, race, class, religion, sexual orientation, physical or psychological abilities/disabilities, or as a result of disproportionate distribution of resources. He stated, "The mental health field must not be focused solely on the mental well-being of individuals when they exist in a nation that is trying to understand the senseless torture and death of individuals despised because of their race, religion, gender, or sexual orientation." Mays argued the behavioral sciences must look

beyond the veil of individual behavior to grasp such happenings as why a 12-year old girl intentionally becomes pregnant, why ethnic cleansing occurs, or why an 11-year old child shoots another child. The progress of the mental health field, the progress of the United States, and the progress as global citizens is contingent upon our ability to construct a future that is inclusive of all and fair to all, not just to some (Mays, 2000).

Buhin and Vera (2008) advocated for "public policy changes" as an efficient environment-centered prevention tool in moving toward social justice. The mental health field has an established history of offering its' voice in policy debates on major societal issues such as Affirmative Action and Brown vs. Board of Education. Though social advocacy may be an irregular practice for the overwhelming majority of mental health professionals, it is well within the breadth and scope of their capabilities.

The Task Force on Psychology and Public Policy (1986) was given the task by the APA's Board of Social and Ethical Responsibility for Psychology to examine methods to increase the expertise, involvement, and awareness of psychologists in the public policy process. They identified a great need for clinicians who could transmit the research findings of psychology and the behavioral sciences into language and suggestions easily understandable by the educated public. The mental health clinician as researcher and evaluator can help by marshalling their research skills to help policy makers determine whether a particular treatment, intervention, or program was effective in terms of intended outcome.

Strickland (2000) noted that the future of psychology requires psychologists' to be willing to articulate, teach, and develop a body of science informed by social justice. President-elect Dr. Gary Melton of the American Orthopsychiatric Association believed it

was imperative for the association to take a particular perspective of and association with social justice. Melton believed the American Orthopsychiatric Association could make substantial contributions to social justice advocacy through psychologically focused explications of the schemas involved in international human rights laws. He argued that his organization needed to carefully create programs and policies that facilitate healthy conditions and the social architecture that demands human responses towards those of our people in dire need (Melton, 2003).

Martin (1991) posed the question of whether or not the mental health professional best serves the well-being of their clients by limiting services to individual professional care or if there could be a harmonious synthesis with advocacy and social action as it pertains to needed public services and policy changes. Due to a growing attrition of jobs, inadequate medical care, and school lunch programs she believed that there was a growing responsibility for mental health professionals to join with the mass chorus of the poor, the disabled, and the disenfranchised in letting their voices be heard in protest against these callous injustices. In her earlier work as a professional-activist in the mid 1960's she noted such common mental health concerns as anxiety, depression, panic attacks, and chronic stress disorders among those of the poor and oppressed.

In a masterful critique of the historic interplay between psychology, education, schooling, and policies shaping each child in the U.S., Hyman (1979) challenged the professions' minimal impact and relative lack of consistency on policy making and implementation that has hindered the educational process. He does, however, confess that the mental health profession as "consultants" has helped shape major legislative and judicial decisions involving the desegregation of schools, child abuse, and the testing of minority

children, each having a substantial impact on the children of America. In regards to IQ testing he chided those "cautions scientists" and "careful professionals" who easily comprehended the salient limitations of IQ test scores, but were either grossly ineffective or willfully uninterested in attempting to reach those legislatures who possessed a direct effect on policies which structured schooling in America.

Herek (2007) believed that it was imperative for psychologists to decide how best they can and should address public policy concerning sexual orientation. Given the psychological schemas pervasive through much of the twentieth century which conceptualized alternative sexual/affectional orientations as illnesses, the persecution, devaluing, and discrimination against sexual minorities (which led inexorably to the self-hatred of many sexual minorities) was justified. Because of this, it is unquestionable that mental health clinicians have something valuable to say about the policies that affect social issues concerning sexual orientation such as same-sex marriage, civil unions, or adoption rights of same-sex couples.

The mental health field and other behavioral scientists where challenged decades ago by civil rights leaders to channel their expertise towards the elimination of social problems through various methodologies. In September of 1967 Martin Luther King, Jr. took the podium to address the APA at the annual convention in Washington, D.C. King believed that the opportunity to serve given to the social scientists was a "humanist" challenge of rare distinction. King intimated the role of the social scientist could be employed in such areas as examining the tendency of "upwardly mobile Negro people" to separate from their former community, understanding organized involvement in political action, and examining the

effects of the moral value system of the dominant White society upon the "Negro psyche" (King, Jr, 1968, pps.6-8).

In 1999, through the prophetic lineage of Dr. King who addressed the APA 32 years earlier, Jesse Jackson, at the APA annual convention, professed that "a psychological transformation of thought was necessary if current conditions of market-determined healthcare policies, structural racism, abject poverty, the flourishing of the prison-industrial complex, and cultural violence were to be expunged from the fabric of U.S. society (Jackson, 1999, pps.2-4)."

As the demography of the United States becomes even more diversified, the need for mental health professionals to respond through social advocacy to issues relating to systemic and individual oppression has reached a level of utmost importance (Arrendondo, D'Andrea, & Ratts, 2004). Therefore, it has become imperative and above all urgent for the discipline to develop a systematic approach towards social advocacy that can pose as the framework by which clinicians may approach such a momentous task as social advocacy.

Empirical Research

As cited earlier, much of the research about social advocacy efforts revolved around theoretical endorsements to 'get involved' with the social advocacy movement by not only focusing on individualistic approaches, but by challenging systemic barriers that impede psychological health. However, there have been some empirically attempts to systematize an approach to social advocacy by understanding what areas are being advocated most pervasively as well as the type of mental health clinician who is likely to get involved in the social advocacy movement.

Fairbank and Jarrett (1987) conducted a pilot study examining the extent to which a random sample of the 1984 American Psychological Association membership agreed or disagreed with the associations' active role in professional or societal issues. They developed a 22 item questionnaire to measure the extent to which the sample supported levels of organizational involvement (advocacy and spending resources) in professional and societal issues. The grand means indicated that the sample was more supportive of APA involvement in advocacy for professional issues, irrespective of the method of advocacy. According to the results, most issues regarding advocacy for the profession received higher ratings than social issues for both methods (advocacy and spending resources) of support. Likewise, advocacy involving expenditures of APA resources rated higher than the highest endorsed societal issue. Participants in the study agreed most strongly that the association should advocate positions for and direct resources towards issues most relevant to the profession. However, the participants did not disagree with the associations' involvement in advocacy for societal issues, just not to the degree that the association should advocate for professional issues.

Evans and McGaha (1998) argued that advocacy is a mechanism by which consumers and family members can have a significant impact on policy or decision making. The researchers surveyed consumers of mental health services and their family members to measure the extent of their participation in advocacy efforts. Consumers and family members who were active members representing either the Missouri Mental Health Consumer Network, the Mission Alliance for the Mentally Ill, DMH personnel, and several others met to plan the content and structure of a survey instrument. The plan was for the representatives of these various organizations to determine the best method by which the

survey could be dispersed to their particular constituency. There were 500 consumer participants and 136 family participants with an average of 43 (SD=14.22). The survey contained five open-minded questions and seven questions with response options concerning advocacy and mental health system reform.

Conclusions drawn from the results showed family members were more likely than consumers to be involved in advocacy. Overall, 55% of consumers and 16% of family members reported not being a part of any advocacy group. 22% of consumers and 38% of family members reported that they had been able to make changes to the mental health system without the support of any established group. The most common type of "non-affiliated" involvement by family members and consumers was contacting important legislators and participants in educating the public. Consumers' reasons for non-participation in advocacy groups centered on economic reasons such as scarcity of resources (transportation, money, telephone, etc.). In addition, advocacy efforts tended to conflict with fill-time and part-time work schedules of many consumers. But through contacting important "others" who directly shape public policy, consumers were able to find a "voice." Essentially, the study gave an indication that consumers and family members may require more resources to become full-fledged participants in the decision-making processes that are reflected through public policy.

Dinsmore, Hof, and Scofield (n.d.) argued that existing literature regarding social advocacy competencies of the ACA offered minuscule evidence as to how clinicians are implementing the role of social advocate and what they report are the challenges and benefits that are part and parcel of social advocacy initiatives. In this study the University of Nebraska at Kearney held a one-day training program to acclimate mental health clinicians,

faculty, and students with the newly endorsed ACA-endorsed advocacy competencies. Each participant selected social advocacy initiatives he or she deemed important and generated a plan to carry out those initiatives. Forty participants provided a copy of their plan to researchers and agreed to be contacted three months later to provide information on their progress or lack thereof in the attempted implementation of their social advocacy plan. Each of the goals on the plan were coded into four specific types of advocacy which were personal growth, social advocacy, institutional advocacy, and individual client advocacy. When participants were contacted by phone three months later they were asked to indicate their level of goal completion on a Likert scale ranging from 1 (not started) to 5 (complete), their "perception" of the importance of their particular advocacy goals from 1(not important) to 5 (extremely important), and their perception of the benefits of their advocacy action ranging from 1 (not at all) to 5 (extremely beneficial).

The participants' mean rating for implementing goals was 3.068, importance of goals was 4.083, and benefit of goals was 3.842. This indicated that participants identified "time" as the primary barrier to completing their advocacy goals. Goals related to institutional advocacy and social advocacy received the highest ratings of importance. The study may have suggested that providing time and instruction for advocacy plan development in a workshop training format is beneficial in helping clinicians become more effective advocates by overcoming those reported barriers. Also, "time" being identified as a primary obstacle appeared to be due to social advocacy activity not being a clearly defined or supported part of their job description. The authors argued that augmenting the emphasis on methods to implement systemic change through the mechanism of advocacy in training programs would be of highest importance.

Nilsson and Schmidt (2005) examined specific variables which they hypothesized contributed to social justice advocacy among graduate students in counseling programs at a small Midwestern university. The variables included problem solving skills, social concern, worldview, and political interest. The study aimed to examine the potential relationship between personal and academic variables and activities involving social justice advocacy among the 134 graduate students who participated in the study. According to their conclusions age, number of courses, political interests, concern for others, problems solving skills, and the SAVW-optimistic worldview predicted desire to be engaged in social justice advocacy. The researchers also concluded that students with a greater interest in politics tended to have a more robust desire to be involved in social justice work. Political interest alone was the only variable that predicted an individual's involvement in social justice advocacy. Finally, men and students from marginalized or oppressed groups presented with a stronger desire to get involved in social justice advocacy.

As it appeared, more vigorous research beyond theoretical endorsements was desperately needed in the mental health field. A more scrupulous understanding of what areas are being advocated in most, what factors most likely influence whether or not a clinician gets involved in social advocacy efforts, and which methodology of social advocacy is used most often and contributed to clinicians beliefs that their advocacy efforts were worth their time and effort can make a substantial impact on social policy and the achievement of greater psychological health for their clients and the rest of world.

Purpose of the Study

Mental health clinicians, daily, are charged with the task of working alongside and on behalf of clients in their combined quests to achieve better psychological health.

In the mental health field, counselors' endeavors to become a valuable resource in aiding clients along the journey of achieving better psychological health there can emerge an intricate interplay of societal, institutional, or political forces that impede clients from achieving this psychological health. When confronted with the understanding that these forces are infringing upon their psychological health, the clinician is then faced with the opportunity to help confront these social ills through the utilization of social advocacy. Therefore, it is imperative to move towards constructing an empirically based and highly-structured approach to social advocacy. My purpose in this study was to explore mental health clinicians' views and experiences toward social advocacy, areas advocated in over the span of their professional careers as well as recently, what methods were most often used in social advocacy, and begin to build an understanding of what factors may influence these views and experiences toward social advocacy.

Statement of the Problem

The first question investigated which areas of social advocacy the majority of mental health clinicians were participating in. The second question investigated which methods of social advocacy were being employed most often by mental health clinicians. The third question examined if the mental health clinicians who had socially advocated recently believed that the method(s) that they utilized when advocating for or against a recent policy issue was effective in bringing about (or halting) the implementation of the social policy. The fourth question investigated any significant correlations between those mental health clinicians who reported they did or did not believe social advocacy is a necessary task in the mental health field and those who reported they did or did not complete a graduate level course or professional training centered on social advocacy.

Hypotheses

There was no null hypothesis made for the first and third research questions. The following null hypotheses were examined: The majority of participants who had engaged in social advocacy during their professional career did not engage in methods centered on phone calls, e-mails, or written letters to legislatures or other government representatives. There would be no significant correlations between those mental health clinicians who reported they did or did not believe social advocacy is a necessary task in the mental health field and those who reported they did or did not complete a graduate level course or professional training centered on social advocacy, as relative to whether or not graduate or professional training influenced views toward the necessity of social advocacy in the mental health field.

CHAPTER III

METHODOLOGY

Participants

A total of 42 participants completed questionnaires. The age range was 24-74 (M=45, S.D. =13). Of the forty-two participants, 69% identified their gender as female. 88% of the participants identified their race or ethnicity as Caucasian/White/European American, 2 % African-American, 2 % Hispanic or Latino(a), and 5% as Bi-racial. 64% reported their highest degree awarded was M.A., M.S., or M.Ed, 21% reported Ph.D., When asked which field best described the area of their highest degree, 21% reported mental health counseling, 17 % reported marital and family therapy, 12 % reported social work, 12 % reported clinical psychology, 7% reported B.A./B.S., 5 % reported community psychology, 5 % reported school counseling, and 5% reported other. 45 % reported their primary work setting was a public community based agency, 21 % reported private practice, 12 % reported university (non-academic appointment), 5 % reported university (academic appointment), and 14 % reported other.

Operational Procedures

The subject selection methodology consisted of a convenience sample using a 'snowball method' where contacts in the mental health field received e-mail messages requesting that they complete a questionnaire which was posted to a web page of which the participants were provided a web link and were encouraged to forward the solicitation

script sent via e-mail (see Appendix 2) to other contacts in the mental health field. The participants were informed that they would not be penalized in any fashion for refusing to participate in the study. They were informed that no identifying information would be requested beyond basic demographic information. A copy of the informed consent document was posted to the front page of the questionnaire (see Appendix 3).

I used S.P.S.S. student version 16.0 for Windows to complete all statistical analysis. Frequencies, under Descriptive Statistics and Correlations were utilized to compute the responses on the questionnaire.

Instrument Selection

The instruments used in the study included a 16 item questionnaire, centered on questions regarding views and experiences toward social advocacy during mental health counselors' professional career including several opening items centered on obtaining demographic information. The idea for utilizing a questionnaire to assess levels of involvement in social advocacy as well as the specific categories was adapted from Fairbank and Jarrett (1987). The various methodologies of social advocacy listed on certain items were adapted from Bilken (1976). A solicitation script was used to solicit voluntary participation.

Limitations to the Study

Subjects were solicited by e-mail only and asked to forward the e-mail to other contacts in the field. They were asked to complete a questionnaire centered on social advocacy. They were asked to report on their views towards and experiences of social advocacy. Given the female to male ratio of the mental health field, the majority of subjects were female.

Assumptions

The subjects were asked to report honestly on their views towards social advocacy as well as their prior experiences with engaging in social advocacy, or lack thereof.

Definitions

Social Advocacy was operationally defined as any active initiative to advance the interests of social justice, particularly on behalf of populations or groups that have been disadvantaged, disempowered, or discriminated against through directly influencing public policy for the purposes of advancing social justice. Public Policy was operationally defined as any decision or action of government that addresses problems and issues which often involves the passing of laws. For the purposes of this study the terms 'social policy' and 'public policy' will be used interchangeably. Client advocacy was operationally defined as any direct or indirect initiative to inform consumers about their rights, help them speak for themselves or speak on their behalf, or assist them with complaints about rights and services.

CHAPTER IV

FINDINGS

Results

Results were calculated with the use of S.P.S.S. 16.0 for windows. All percentages were calculated with the use of frequencies (under descriptive statistics in S.P.S.S.). 88 % of the participants reported they had not taken a graduate level course or attended professional training on social advocacy. The majority of participants (55 %) agreed it was a necessary task for mental health clinicians to socially advocate for clients (see table 1). The majority of the participants agreed (42%) it was a necessary task for clinicians to participate in client advocacy (see Table 2). 72 % reported they had participated in client advocacy at some point during their professional career.

The first research question sought to address which areas of social advocacy were most often advocated by participants at any time during their professional career (see Table 3). Results showed child abuse (41%), public education (36%), and equal rights (33%) were the most frequent areas advocated in by the participants in the study. 10% selected 'other' for this option and listed such areas of social advocacy as adoption law, developmental disabilities, foster care, environment conservation, and post adoption services.

To uncover what areas of social advocacy were receiving more current attention than others, participants were asked what was the most recent area in which they had

socially advocated in (see table 4). The most frequently chosen responses were healthcare (12%) and child abuse (12%). When asked to list the year in which this most recent advocacy occurred 36 % reported in between 2006 and 2009

The second research question sought to address which methods of social advocacy were most often employed by participants (see Table 5). Results showed that utilizing phone calls and e-mails to legislatures and other government representatives (41 %), educating consumer groups (38 %), and letter writing to legislatures (33 %) were the most frequent responses. Therefore the null hypothesis was accepted. 14 % selected' other' and listed such methods as education/training/workshops with children and college students, educational outreach in schools targeting youth and other community settings, informal discussions, lobbying professionals in our fields, personal contact with case workers and their supervisors (and their supervisors), sitting on a committee designing a program to improve child abuse statistics, testifying before legislative committees, and volunteering.

When asked what methods had been utilized while advocating for these most recent areas educating consumer groups (33%) was the most frequent response followed by phone calls and e-mails to legislatures or other government representatives (31%) (see Table 6). 10 % reported other and listed such recent method as discussions with friends, hiring practices, sitting on a committee to design a program to be presented to government authorities, testifying before legislature, committees, and voting.

The third question sought to address whether or not the participants believed they had been successful in advocating for or against policy issues related to these most recent areas (see Table 7). 33 % were unsure if they had been successful and 31 % agreed that they had been successful. When asked if they had ever worked in conjunction with grass roots, civil rights or on-campus organizations while socially advocating, 31 % reported 'did not apply', 33 % reported no, and 36 % reported yes.

Correlations (Pearson) were utilized to determine whether or not there was a statistically significant relationship between participant's responses of whether they did or did not complete a graduate level course or professional training centered on social advocacy and their views of whether or not it is a necessary task of the mental health clinician to engage in social advocacy. The results showed a weak correlation of .21. Therefore there was no statistically significant correlation and the null hypothesis was accepted.

CHAPTER V

CONCLUSION

Discussion

Due to the small sample size, interpretations based upon these findings were made cautiously. The majority of the participants agreed social advocacy (as well as client advocacy) was a necessary component of mental health clinicians work in the field, but most of the participants (88%) had never completed a graduate level course or professional training centered on social advocacy. This may have suggested that the importance of social advocacy to clinicians is not stymied by the potential lack of having completed a graduate course or professional training centered on social advocacy. Also, the 88% who reported having not completed a graduate level course or professional training highlighted the importance Dinsmore, Hof, and Scofield (n.d.) placed on emphasizing the methods to implement systemic change through the mechanism of advocacy in training programs.

The majority of socially advocacy typically ranged from 20-30 % with child abuse (40%) being the most advocated area. However, such areas as energy conservation, poverty, welfare reform, elder rights/elder abuse, physical disabilities, language issues, and religion received little attention in social advocacy from the participants in the study and may have suggested a greater need for emphasis on these areas in future social advocacy endeavors sine these areas may affect the psychological

health of clients as more frequently advocated areas do (child abuse, healthcare, etc.). 3 of the 4 most frequently employed methods of social advocacy used by participants at any time during their professional career involved interactions through various communicative mediums with legislatures or other government representatives, suggesting the participants tended to go 'straight to the source" in socially advocating for or against various policy issues. The dominant mode of communication was phone calls and e-mails to legislatures or other government representatives which appeared to be the easiest and least time consuming method, but may not be as effective as face-to-face interactions with legislatures. Outcome measures between these methods of social advocacy involving legislature's demands further research.

The two areas most frequently selected as the most recently advocated areas was healthcare and child abuse. As these two areas have become prominent issues on the national scene, the frequency with which these areas have most recently been socially advocated may be a direct reflection of their national popularity. Of note is the issue of same-sex marriage and the attention it received on the national scene. 29 % of the participants reported they had advocated in regards to policy issues dealing with this area, yet 5 % listed it as their most recent area of advocacy. Another important issue potentially relevant to the findings was the potential influence of participants 'values' on their responses. What roles did values and value systems play in the areas chosen for advocacy by the participants? Also, in what ways did values influence and guide how the participants advocated? For example, of the 29 % who had ever socially advocated in the

area of same-sex marriage, did the majority of the 29 % advocate against legislation affording marriage rights to same-sex partners or for this, and how did their values influence how they advocated in this area? This could further add to the exploration of the influence of personal and academic variables on social justice advocacy among (Nilsson and Schmidt, 2005). Also of interest were the 'situational factors' that affect people's behaviors as much as values and thus may have a strong influence on mental clinicians involvement (or lack thereof) in social advocacy. At the time the data was collected it was just after an election year, the U.S. was involved in war, and the economy was in the midst of a recession. These factors may have influenced the social advocacy efforts of the participants. These questions were beyond the scope of this study, so future research should focus on the role that values, value systems, religious/spiritual beliefs, and situational factors play in which areas one chooses to advocate in and in what ways (whether for or against) do they advocate in these areas.

Another small, but important focus of the study was to explore the self-reported efficacy of clinicians in their most recent social advocacy endeavors. There were almost an equal number of participants who were 'unsure' if they advocated successfully and those who 'agreed' that they were successful in their most recent advocacy endeavors. Of interest is what distinguished these two groups in terms of how they assessed outcome or success; did they use subjective means, or empirical means? The same fervor once given to creating a multitude of methods used to gauge success in individual therapy in traditional therapy models should also be extended toward social advocacy endeavors,

especially since social advocacy has the power to affect the greatest number of people by addressing policy issues and societal structures. Future research would be a tremendous asset in assessing pre-existing measures and creating new measures of outcomes or success rates in social advocacy. Future research could also address how many mental clinicians encourage their colleagues to get involved in social advocacy endeavors.

Shortcomings in the present study also suggested several opportunities for future research. This study involved a small sample size and the majority of the participants were Caucasian females, both of which restrict generalizability of the results. The study was also on a rigorous time limitation and this affected the amount of time dedicated to data collection. Content and item validity were established in the questionnaire, but no methods of reliability were established and this would be an issue for future research. The study was limited by the 'snowball' technique. If a participant was not selected as a contact by the researcher or was not a colleague of one of the participants who were solicited to participate in the study, they more than likely had no access to the questionnaire, thus a non-random sample was established. The questionnaire itself was spread across several focus areas such as mental health clinicians' views towards social advocacy, areas of social advocacy, methods of social of advocacy, and outcome or success measures in social advocacy endeavors. Each area itself demands to be the sole focus of future research studies.

Thus, participants may have actually advocated in certain areas, but at the level of client advocacy and not social advocacy and this would not have been reported in the

study. Furthermore, the list of areas and methods of advocacy was not totally inclusive, and this may have affected the responses.

Another limitation of the study may have been that it involved a potentially biased sample. The solicitation script asked participants to forward the script to other colleagues who might have been willing to participate and this may have overtly influenced the participants to forward it to only those colleagues who they believed participated in social advocacy to the exclusion of those who they believed did not. Participants who participated in social advocacy may have been influenced by legal or job requirements. Despite the limitations of the study, several important areas for future research have been suggested by the researcher which may help to further the understanding and successful outcomes of social advocacy endeavors in the mental health field. The primary utility of the research is best understood as a pilot study and thus provided very useful directions for future research.

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APPENDICES

Appendix 1 Questionnaire

Social Advocacy will be defined as any active initiative to advance the interests of social justice, particularly on behalf of populations or groups that have been disadvantaged, disempowered, or discriminated against through directly influencing public policy for the purposes of advancing social justice.

Public Policy will be defined as a decision or action of government that addresses problems and issues which often involves the passing of laws.

Client Advocacy will be defined as any direct or indirect initiative to inform consumers about their rights, help them speak for themselves or speak on their behalf, or assist them with complaints about rights and services.

1. Age_____

2. Biological Sex:
Male_____ Female_____

3. How do you identify your racial/ethnic background?
Native American____
Black/African American_____
Asian American/Pacific Islander_____
Caucasian/White/European American_____
Hispanic American_____
Bi-Racial_____
Native African____
Middle Eastern____
Other (If so, please list)_____

4. Highest Degree Awarded:
BA/BS____
MA/MS____
PhD____
EdD____
PsyD____
Other_____

5. Primary Work Setting:
University (academic appointment)____
University (nonacademic appointment)____
Medical Center____
Medical School____
Private Practice____
Public Clinic/Community Based Agency____
Other_____

6. Did you complete a graduate level course or professional training centered on social advocacy at any time during or after your collegiate studies?

Yes____ No____

7. It is a necessary task of clinicians in the mental health field to socially advocate for clients in regards to public policy issues:

Agree Very Strongly_____
Agree Strongly_____
Agree_____
Disagree_____
Disagree Strongly_____
Disagree Very Strongly_____

8. In what areas have you socially advocated for or against any public policy issues at any time during your professional career in the mental health field? Please check all that apply.

I have Never socially advocated for or against any policy issues during my professional career____
Human Rights____
Same Sex Marriage____
Energy Conservation____
Racism____
Employment____
Public Education____
Sexism____
Immigration Reform____
Family, Domestic, or Community Violence____
Child Abuse____
Equal Rights____
Healthcare____
Poverty____
Welfare Reform____

Other_____

9. What methods have you utilized in social advocacy at any time during your professional career in the mental health field?

I have Never socially advocated for or against any policy issues during my professional career____
Phone Calls and E-mails to local legislatures or other government representatives ____
Demonstrations/Protests____
Educating Consumer Groups____
Letter writing to legislatures or other government representatives____
Lobbying____
Creating and Implementing Fact Finding Forums____
Strategically boycotting specific service providers____
Utilizing various forms of media to communicate information (news programs, videos, youtube.com)____
Face to face interaction with legislatures or other government representatives____
Other_____

10. What was the most recent area in which you socially advocated for or against a corresponding public policy issue? And in what year did you do so?

I have Never socially advocated for or against any policy issues during my professional career____
Human Rights____
Same Sex Marriage____
Energy Conservation____
Racism____
Employment____
Public Education____
Sexism____
Immigration Reform____
Family, Domestic, or Community Violence____
Child Abuse____
Equal Rights____
Healthcare____
Poverty____
Welfare Reform____
Other_____

*Year*_____

11. What method(s) did you utilize in socially advocating for or against this most recent public policy issue? Please check all that apply.

I have Never socially advocated for or against any policy issues during my professional career____
Phone Calls and E-mails to local legislatures or other government representatives ____
Demonstrations/Protests____
Educating Consumer Groups____
Letter writing to legislatures or other government representatives____
Lobbying____
Creating and Implementing Fact Finding Forums____
Strategically boycotting specific service providers____
Utilizing various forms of media to communicate information (news programs, videos, youtube.com)____
Face to face interaction with legislatures or other government representatives____
Other_____

12. This method (or these methods) that I utilized when advocating for or against this most recent public policy issue was (were) effective in bringing about (or halting) the implementation of the public policy: Please select "Does not apply" if you have never socially advocated for or against a policy issue.

Agree Very Strongly_____
Unsure____
Agree____
Disagree_____
Disagree Very Strongly_____
Does Not Apply_____

13. If you have advocated socially for or against a public policy issue at any point during your professional career did you ever work in conjunction with a grass roots, civil rights, or on-campus organization? Please select "Does not apply" if you have never socially advocated for or against a policy issue at any time during your professional career.

Yes____ No____ Does not apply____

Appendix 2 Solicitation Script

Hello, my name is Jimmy Leverette and I am currently a second year graduate student in the Community Counseling Master's Program at Oklahoma State University in Stillwater, Oklahoma. I am currently conducting a research study (thesis) centered on ***social advocacy*** and my instrument is a brief questionnaire. I would greatly appreciate it if you visited the web link (listed below) and participated in the study by completing the brief questionnaire that will take no longer than 10 minutes. It is posted at the following link: http://frontpage.okstate.edu/coe/leverette

Evidence of I.R.B. approval is posted on the front page of the brief questionnaire and informed consent to participate in the study or decline participation is also available on the front page. And an effort to further protect confidentiality no identifying information except for basic demographic information (age, biological sex, etc.), will be requested from participants. Further, only the researcher and the Instructional Support Specialist will have access to the survey data.

It would also be greatly appreciated if you would forward this e-mail to colleagues in the mental health field whom you feel might be willing to participate in the study. If you have any further questions or comments feel free to contact me via e-mail at jimmy.leverette@okstate.edu.
Thank you very much for your time.

Sincerely,

Jimmy R. Leverette, B.A.
Oklahoma State University

Appendix 3 Informed Consent

INFORMED CONSENT

Title of Project: Views and Experiences of Mental Health Counselors toward Social Advocacy

The principal investigator is Jimmy Leverette, B.A. The advisor to the principal investigator is Donald Boswell, Ph.D. The purpose of this research study is to observe the views and experiences of mental health counselors towards social advocacy in an effort to uncover those methods of social advocacy that mental health clinicians report are the most effective, if views towards social advocacy impede some mental health clinicians from directly or indirectly participating in social advocacy, and which areas are most frequently advocated for (thereby exposing which areas are not advocated for as prevalently). Participation in the research study will help mental health clinicians add to the growing knowledge base of academic research centered on social advocacy.

You will be asked to complete a web-based questionnaire centered on views and experiences toward social advocacy. The questionnaire is estimated to take 10-15 minutes to complete. There are no known risks associated with this project which are greater than those ordinarily encountered in daily life. No identifying information will be requested from individual participants except for brief demographic information. Completed survey information will be stored in a separate Microsoft excel spread sheet and kept private. Only the principal investigator will have access to the data and will enlist the support of the Instructional Support Specialist, Aarond Graham, M.S., if assistance becomes necessary with the questionnaire or the Microsoft excel spread sheet. No form of compensation will be offered throughout the duration of the research study. Participation is voluntary and you can withdraw from the research study at any time without penalty of reprisal.

If you have questions about the research study or questionnaire, you may contact Jimmy Leverette, Principal Investigator, at jimmy.leverette@okstate.edu or Donald Boswell, Ph.D, advisor, at don.boswell@okstate.edu.
If you have questions about your rights as a research volunteer Dr. Shelia Kennison, IRB Chair, 219 Cordell North, Stillwater, OK 74078, 405-744-1676 or irb@okstate.edu.

By clicking "I agree to participate" and completing the questionnaire, you are giving your consent to participate.

I certify that I have personally explained this document before requesting that the participant sign it.

_Jimmy Leverette_____ _3/27/09_____
Signature of Researcher Date

Oklahoma State University Institutional Review Board

Date: Wednesday, April 08,2009
IRB Application No ED0956
Proposal Title: Views and Experiences of Mental Health Counselors Toward Social Advocacy
Reviewed and Processed as: Exempt

Status Recommended by Reviewer(s): Approved Protocol Expires: 4/7/2010
Principal Investigator(s):

-Jimmy Leverette -Donald Boswell

The IRB application referenced above has been approved. It is the judgment of the reviewers that the rights and welfare of individuals who may be asked to participate in this study will be respected, and that the research will be conducted in a manner consistent with the IRB requirements as outlined in section 45 CFR 46.

The final versions of any printed recruitment, consent and assent documents bearing the IRB approval stamp are attached to this letter. These are the versions that must be used during the study.

As Principal Investigator, it is your responsibility to do the following:
1. Conduct this study exactly as it has been approved. Any modifications to the research protocol must be submitted with the appropriate signatures for IRB approval.
2. Submit a request for continuation if the study extends beyond the approval period of one calendar year. This continuation must receive IRE review and approval before the research can continue.
3. Report any adverse events to the IRE Chair promptly. Adverse events are those which are unanticipated and impact the subjects during the course of this research; and
4. Notify the IRB office in writing when your research project is complete.

Please note that approved protocols are subject to monitoring by the IRB and that the IRB office has the authority to inspect research records associated with this protocol at any time. If you have questions about the IRB procedures or need any assistance from the Board, please contact Beth McTernan in 219Cordell North (phone: 405-744-5700, beth.mcternan@okstate.edu).

Sincerely,

Shelia Kennison, Chair

Institutional Review Board

VITA

Jimmy R. Leverette

Candidate for the Degree of

Master of Science in Community Counseling

Thesis: VIEWS AND EXPERIENCES OF MENTAL HEALTH

COUNSELORSTOWARD SOCIAL ADVOCACY

Major Field: Community Counseling

Biographical:

Personal Data:
jimmy.leverette@okstate.edu

Education:
Completed the requirements for the Master of Science in Community Counseling at Oklahoma State University, Stillwater, Oklahoma in July, 2009.

Completed the requirements for the Bachelor of Arts in Psychology at the University of Central Oklahoma, Edmond, Oklahoma in May, 2006.

Experience:
May 2008-May 2009, (Master's Counseling Intern), Student Counseling Center, Oklahoma State University, Stillwater, Oklahoma. August 2007-Present,(Case Manager), Edwin Fair Community Mental Health, Inc. Stillwater, Oklahoma.

Professional Memberships:
December 2002-Present, McNair Scholars Program.

ADVISER'S APPROVAL: Donald Boswell, Ph.D

Name: Jimmy R. Leverette Date of Degree: July, 2009

Institution: Oklahoma State University Location: Stillwater, Oklahoma

Title of Study: VIEWS AND EXPERIENCES OF MENTAL HEALTH COUNSELORSTOWARD SOCIAL ADVOCACY

Pages in Study: 40 Candidate for the Degree of Master of Science

Major Field: Community Counseling

Scope and Method of Study: My purpose in this study was to observe the views and experiences of mental health counselors towards social advocacy. The subject selection methodology consisted of a convenience sample using a snowball method where contacts in the mental health field were encouraged to complete a questionnaire and forward the solicitation script (see attached) to other contacts in the mental health field.

Findings and Conclusions: Child abuse was the area most frequently advocated in and utilizing phone calls and e-mails to legislatures and other government representatives was the most frequent method of advocacy employed. 36 % agreed that they had been successful in advocating for or against policy issues and 33% were unsure. There was a correlation of .21 between whether the participants completed a graduate level course or professional training centered on social advocacy and their views of whether or not it was a necessary task of mental health clinicians to engage in social advocacy. Future areas of research should address personal and situational factors affecting involvement in social advocacy, outcome measures, and graduate level training centered on social advocacy.

ADVISER'S APPROVAL: Donald Boswell, Ph.D