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Advocacy and Accessibility Standards in the New *Code of Professional Ethics for Rehabilitation Counselors*

Ashley K. Waldmann and Terry L. Blackwell

This article addresses the changes in the Commission on Rehabilitation Counselor Certification's 2010 *Code of Professional Ethics for Rehabilitation Counselors* as they relate to Section C: Advocacy and Accessibility. Ethical issues are identified and discussed in relation to advocacy skills and to advocacy with, and on behalf of, the client; to attitudinal barriers as well as barriers to access; and to referral accessibility. Other areas of discussion include knowledge of benefit systems, physical and service accessibility in counseling practice, and confidentiality in regard to advocacy counseling.

Keywords: advocacy, accessibility, confidentiality

Rehabilitation counselors have an ethical obligation to address oppression and discrimination of special populations in an affirmative manner (Blackwell, Martin, & Scalia, 1994). Section C of the *Code of Professional Ethics for Rehabilitation Counselors* (hereafter, the *Code*; Commission on Rehabilitation Counselor Certification, 2010) develops the framework for critical thinking related to counselors' ethical obligations to their clients in the areas of advocacy and accessibility. Expanding on the previous standards, the revised *Code* includes six standards related to advocacy (attitudinal barriers, advocacy in own agency and with cooperating agencies, areas of knowledge and competency, knowledge of benefit systems, and confidentiality) and three standards focusing on accessibility (accessibility in counseling practice, barriers to access, and referral accessibility). These additions to Section C of the *Code* emphasize an ever-increasing need for rehabilitation counselors to implement advocacy and accessibility strategies when counseling individuals with disabilities. In this way, clients are provided opportunities to become fully participating members of their communities.

Advocacy

Advocacy is defined in the *Code* glossary as "promoting the well-being of individuals and groups . . . within systems and organizations. Advocacy seeks fair treatment and full physical and programmatic access for clients, and the removal of any barriers or obstacles that inhibit access, growth and development." Advocacy comes into play by promoting the well-being of clients and addressing barriers in systems and organizations. In the practice of advocacy, counselors address (or help clients address) those structures that are not directly in the realm of the client's control and, in a sense, empower the client to take control of an area wherein he or she may feel helpless. Counseling tends to attribute "excessive weight" to individual factors; that is, it has not traditionally considered the impact of society, culture, and oppression (Ratts & Hutchins, 2009). Thus, counselors need to address the impact of society on the individual, which they can do through advocacy work. Clients live in a world that affects them every day—thus, there is important work to be done on both a social level and an individual level. Oppression can lead to depression, low self-esteem, and lack of educational and career opportunities (Ratts & Hutchins, 2009). Goodman et al. (2004) pointed out, "Unless fundamental change occurs within our neighborhoods, schools, media, culture, and religious, political, and social institutions, our

work with individuals is destined to be, at best, only partially successful" (p. 797). McCarthy and Leierer (2001) suggested that earlier standards concerning advocacy may not be adequate, and they encouraged counselor educators to invest more energy into developing counselors' motivation and skills in regard to advocacy.

Counselors recognize advocacy as an important part of counseling (Neulicht, McQuade, & Chapman, 2010). Leahy, Chan, and Saunders (2003) defined professional advocacy as "applying disability-related policy and legislation to daily rehabilitation practices" (p. 73); in their study, certified rehabilitation counselors rated professional advocacy as their second-most important job function and second-most-frequent job performed, preceded only by case management. Furthermore, clients reinforce the importance of advocacy in the counseling relationship. In a study of clients with disabilities, McCarthy and Leierer (2001) found that advocacy and a consumer-first attitude were the most important qualities of the ideal counselor.

With expansion on the duty to advocate, the revised *Code* distinguishes advocacy with the client and advocacy on the client's behalf. Advocacy with the client focuses on facilitating the development of self-advocacy skills and then working with the individual to develop and implement a plan of action (Ratts & Hutchins, 2009). Advocacy with the client also includes identifying the client's strengths and resources and recognizing signs of internalized oppression (Lewis, Arnold, House, & Toporek, 2002). Internalized oppression is the process by which a person's experiences "as a member of a devalued minority group are internalized and become associated with the self system," which "often takes the form of negative attitudes, beliefs, and feelings about oneself" (Szymanski & Gupta, 2009, p. 110). Rehabilitation counselors can advocate with clients outside of counseling sessions as well. For example, Olkin (1999) listed examples of important self-advocacy skills, such as finding knowledgeable doctors and specialists, self-monitoring and adjusting activities and lifestyle, and finding new ways to accomplish tasks. A counselor can build the self-confidence of clients by helping them practice these skills and by providing them support in the "real world," outside the counseling sessions. Rehabilitation counselors, by virtue of their training and experience as well as the definition of their job role, are best positioned to advocate on behalf of individuals with disabilities. This need to advocate on the clients' behalf becomes critical for individuals who lack access to needed services or resources (Ratts & Hutchins, 2009). As such, advocacy can play a crucial role in promoting clients' well-being. Advocating on behalf of the client includes activities such as negotiating relevant services for the client and identifying allies to confront barriers.

Advocacy does require specific skill sets—some of which are inherent to individual counseling, some of which are unique to advocacy. Kiselica and Robinson (2001) identified the following attributes as skills required for advocacy counselors: the capacity for commitment and an appreciation for human suffering; nonverbal and verbal communication; a multisystems perspective; individual, group, and organizational interventions; knowledge and use of the media, technology, and the Internet; and assessment and research skills. The new *Code* also highlights the importance of acting as an advocate on local, regional, and national levels. In addition to citing the skills necessary for the client level—that is, advocacy with the client and on behalf of the client—Lewis et al. (2002) identified the skills required for advocacy at various other levels, such as the community and political levels. Community collaboration, systems advocacy, public information, and social/political advocacy are all examples of advocacy at levels beyond the client. Community collaboration involves identifying environmental factors that affect the client's development and developing alliances with groups working for change. Systems advocacy involves providing and interpreting data to show urgency for change, developing a vision to guide change with stakeholders, and analyzing sources of political power and social influence in the system. Advocacy in the form of public information involves communicating in ethical and appropriate ways with the target population, and social/political advocacy involves distinguishing problems that can best be resolved through social/political action and maintaining open dialogue with communities and clients to ensure that advocacy is consistent with initial goals.

In addressing attitudinal barriers toward individuals with disabilities, Standard C.1.a challenges counselors to "increase their own awareness and sensitivity to individuals with disabilities" so that their thoughts and actions do not adversely affect clients. The counselor's attitudes are critical not only to the counseling relationship but to society as well. Brodwin and Orange (2008) pointed out that "negative attitudes pose one of the most significant barriers for people who have disabilities. A service provider's positive attitudes and actions serve as a model for other professionals and for society" (p. 164). Olkin (1999) further emphasized the importance of the counselor's attitudes and beliefs about disability. Olkin asserted that such attitudes and beliefs can influence the case formulation and treatment plan, and the author clarified this point by saying, "Of first concern are our own attitudes and behaviors inasmuch as these profoundly affect our conceptualizations about and the stances toward clients" (p. 75). Consequently, knowing that the counselor's attitudes are critical requires that counselors not knowingly participate in or condone unfair discriminatory practices. Furthermore, rehabilitation counselors must continually assess their values, belief

systems, needs, and limitations based on these factors so that they can try to eliminate the effect of any biases on their work with the individuals whom they serve (Blackwell et al., 1994).

Standard C.1.e (Areas of Knowledge and Competency) provides a framework for implementing strategies for client advocacy. This standard obligates rehabilitation counselors to be "knowledgeable about local, regional, and national systems and laws, and how they affect access to employment, education, transportation, housing, financial benefits, and medical services for people with disabilities." In doing so, the *Code* directs that counselors "obtain sufficient training in these systems in order to advocate effectively for clients and/or to facilitate self-advocacy of clients in these areas." Standard C.1.c (Advocacy in Own Agency and With Cooperating Agency) further requires rehabilitation counselors to be mindful of actions taken by agencies that may impede the service delivery to clients and to take steps to correct these actions on the client's behalf.

Standard C.1.f (Knowledge of Benefit Systems) emphasizes the importance that benefit systems can have in a client's life, and it encourages counselors to "provide accurate and timely information or appropriate resources and referrals for these benefits." Benefit systems are important potential resources for clients with disabilities. Examples include workers' compensation—which can provide services such as medical treatment, wage loss benefits, and rehabilitation costs—and social security, which provides income and insurance (Blackwell & Dell, 2008). Other potential resources include transition-to-work programs, vocational rehabilitation, Medicaid and Medicare, independent living centers, supported housing, Temporary Assistance for Needy Families, and food stamps (Fabian & MacDonald-Wilson, 2005). Thus, information about these programs and the services they provide can directly affect the client's life in the form of income and compensation for expenses related to his or her disability, as well as employment, shelter, and food. These systems are important for obtaining other information and resources that benefit the total person and his or her surroundings—and in a broader sense than that of just the tangible resources they provide. The counselor should be prepared to identify these resources and services and refer clients appropriately.

There are ethical challenges in bringing advocacy into counseling. Kiselica and Robinson (2001) cautioned that as the counselor begins to get involved in activist activities, he or she should refrain from getting "carried away" with these activities and making exaggerating claims about clients' problems. The authors also emphasized that advocacy counseling is yet another area where clearly defined boundaries are important in the relationship between counselor and client. In the same regard, the client needs to retain his or her autonomy in the area of advocacy; that is, he or she should be allowed to decide whether advocacy is appropriate or necessary and who is most appropriate to engage in it. Finally, rather than presume the client's need for advocacy, the counselor needs to consider the client's capability for self-advocacy.

Confidentiality

In the glossary, the *Code* defines the concept of confidentiality as "a promise or contract to respect the privacy of clients by not disclosing anything revealed to rehabilitation counselors except under agreed-upon conditions," although this definition is extended under the revised section on advocacy and accessibility:

> Rehabilitation counselors obtain the consent of clients prior to engaging in advocacy efforts on behalf of specific, identifiable clients to improve the provision of and to work toward removal of systemic barriers or obstacles that inhibit access, growth, and development of clients. (Standard C.1.d)

As in the counseling process, counselors advocating on behalf of clients are responsible for ensuring the protection of the clients' rights to confidentiality. In addition, counselors must remain mindful that disclosure of information needs to be restricted to what is necessary and relevant with respect to clients' rights to privacy (Blackwell et al., 1994; Koocher & Keith-Spiegel, 2008). Strein and Hershenson (1991) argued that the nature of advocacy conflicts with "absolute confidentiality" and thus suggested that "a need-to-know criterion can be used, with the information to be disclosed agreed to in advance by the client" (p. 315). Cottone and Tarvydas (2007) emphasized that even when providing indirect services to a client, counselors "must clearly address confidentiality limitations with all the individuals involved" (p. 320). Although not specified in Standard C.1.d, best practices suggest that rehabilitation counselors obtain a written consent for release of information from the client, parent/guardian, or legal representative before disclosing information to third parties.

Accessibility

Rehabilitation counselors have an ethical obligation to actively participate in the process of promoting accessibility for people with disabilities. *Accessibility* refers to "a site, facility, work environment, service, or program that is easy to approach, enter, operate, participate in, and/or use safely and with dignity by a person with a disability" (Job Accommodation Network, n.d.). Standard C.2.a (Counseling Practice) translates these obligations into action by directing counselors to "facilitate the provision of necessary accommodations,

including physically and programmatically accessible facilities and services to individuals with disabilities." Standard C.2.b (Barriers to Access) further requires rehabilitation counselors to "collaborate with clients and/or others to identify barriers based on the functional limitations of clients" and then communicate this information to the appropriate authorities "to facilitate removal of barriers to access." Pope (2005) echoed the importance of accessibility by saying,

A profession's values—including its ethical values—are reflected in the degree to which its structures are accessible to people with disabilities. The profession expresses its values through the decisions of its members to effectively address barriers to access or to maintain those barriers through action or inaction. (p. 103)

Indeed, exclusionary structures and social systems are often identified as a major source of stress for people with disabilities. In a study of people with disabilities, Iwasaki and Mactavish (2005) cited examples of such stress—for instance, "living in a world in between," where systems and services are not structured in ways that "accommodate the needs of people with disabilities" (p. 202), not to mention the general public's negative impressions and misconceptions. Physical inaccessibility is also stressful, including issues with transportation, architectural barriers, and winter weather. Counselors therefore need to assess the counseling relationship and ensure that there are no barriers to service that exacerbate the stressors that people with disabilities experience on a day-to-day basis.

Finally, before referring clients to services or resources, counselors must act to assist clients in ensuring that these are appropriately accessible, and . . . not engage in discrimination based on age, color, race, national origin, culture, disability, ethnicity, gender, gender identity, religion/spirituality, sexual orientation, marital status/partnership, language preference, socioeconomic status, or any basis proscribed by law. (Standard C.2.c.)

Conclusion

The updates and revision to the 2010 *Code* continue to emphasize the importance of advocacy and accessibility and their roles in counseling. Counselors and clients alike have recognized the importance of advocacy in rehabilitation counseling (Leahy et al., 2003; McCarthy & Leierer, 2001). As discussed in this article, advocacy is an important practice with the client and on behalf of the client, and it requires specific skills that counselors need to develop to be competent in the area of advocacy. Addressing attitudinal barriers toward people with disabilities, as well as exploring and increasing the counselor's awareness and sensitivity toward people with disabilities, cannot be overemphasized because the potential consequences of unchecked attitudes and beliefs can be detrimental to the client. In addition to citing the skills and knowledge of advocacy that are so important to counseling, the *Code* addresses the counselors' need to be knowledgeable about laws and benefit systems that affect their clients.

Accessibility issues—such as accommodations in counseling, as well as being able to identify and remove barriers to access and ensure referral accessibility—are crucial to counseling. Addressing accessibility issues may require the need for advocacy on behalf of, or with, the client.

Cottone and Tarvydas (2007) pointed out that "attitudinal and other social and economic barriers, as well as limited opportunities to access appropriate types of skills training, are often the most severely limiting aspects of disability" and that rehabilitation counselors "design and provide interventions to address these problems" (p. 316). The concepts of advocacy and accessibility are inherent in this definition of the job of a rehabilitation counselor. The updates to the *Code* therefore emphasize an important part of a counselor's job and remind rehabilitation counselors of their ethical responsibility to clients.

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About the Authors

Ashley K. Waldmann is a graduate student and graduate assistant in the master's of rehabilitation and mental health counseling program at Montana State University Billings.

Terry L. Blackwell, EdD, CRC, is a professor and chair in the College of Allied Health Professions, Department of Rehabilitation and Human Services at Montana State University Billing.

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Address correspondence to Terry L. Blackwell, Department of Rehabilitation and Human Services, Montana State University Billings, Billings, MT 59101; Email: tblackwell@msubillings.edu

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