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## TECHNIQUES UTILIZED BY THE SYSTEM TO CONTROL ADVOCACY

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## ABSTRACT

Advocacy, by definition and practice, is adversary to the "system." A natural response on the part of a bureaucracy or complex organization is to control and limit the impact of adversary elements. This is generally a desirable survival response on the part of a complex organization, but in the case of developing an advocacy program, such a response may be so strong as to prohibit the effective development and carrying out of the advocacy role. Nine techniques utilized by the system to control the development of advocacy are presented. These techniques are given the headings of, The myth that advocacy is not needed; Shifting the power base of advocacy; Stall; We're not ready for that; You are interfering with treatment; You must use channels; The meaningless compromise; Disloyalty to the team; and Redefining the role of advocacy. Brief discussion is presented as to why social workers have failed as advocates. However, the social work literature reveals an increasing awareness that social workers must also be trained and prepared to take an advocacy posture.

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### Introduction

Since the advocacy function is by definition and practice, adversary to the "system," a natural response on the part of the bureaucracy or complex organization is to control and limit the impact of such an adversary element. This is generally a desirable survival response on the part of a complex organization, but in the case of developing an advocacy program, such a response may be so strong as to prohibit the effective development and carrying out of the advocacy role.

Although most everyone feels they can accept criticism, in reality, people go to excessive lengths to control the criticism voice against themselves. This is even more true as you study complex bureaucratic organizations. As individuals we must constantly be on alert to allow self-critical input; organizations must do the same. Critical negative feedback from within and without is essential to the continuing survival of any organization. Advocacy can be one mechanism for such essential feedback. First, however, the advocacy role must be effectively developed.

It is the purpose of this paper to present some of the techniques utilized by social service and care-giving bureaucracies to control the development of advocacy and the actual implementation of an advocacy program.

The Myth that Advocacy is Not Needed: Panitch<sup>1</sup> has a relatively complete review of the literature concerning advocacy and social work. The majority of this literature is dated late 1960's and early 1970's. This literature points up that the real ideal of advocacy as an adversary to the system in which it is found has not yet arrived in social work. Advocacy in the present social work literature still looks upon the social worker as advocating on the part of the client, and yet being a part of the system which he is supposedly to oppose in his representation of his client. This, from a practical standpoint and a very realistic standpoint, is mythology. A social worker closely tied to the system cannot effectively advocate on the part of his client. For example, how is a social worker to advocate on the part of a client who is rebelling against the very ideals and attempts of service from the particular social worker himself?

This type of professional attitude on the part of many people in the helping profession is a major block to the development of advocacy programs in a variety of agency settings. Such tunnel vision of the advocacy concept sees the service-giving agency as good and advocacy as needed only against other "external community elements" or agencies. On the basis of practical experience and the literature, it is the contention made that advocacy then in its working and pure sense, has not yet arrived in social work.

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<sup>1</sup>Arnold Panitch, "Advocacy in Practice," Social Work, May, 1974, pages 326-332.

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This stance is not only seen in agencies, but also in schools of social work. Panitch stated the same concern in the following manner: "For many social workers, a combative stance which is an essential part of the kind of partisan alignment that advocacy implies, is not natural. As a result, most social workers lack both the orientation and the skills necessary to engage in effective advocacy."<sup>2</sup> Social workers, by training and practical experience, receive the feeling that they are helping people and, as such, they are to a considerable extent, blind to the fact that helping people is defined for them by social work modes of action and are often neglectful of the client's own wishes. The 1969 publication of the Ad Hoc Committee on Advocacy<sup>3</sup> has not resulted in the progress for advocacy which many had hoped for. Again it seems that social work failed to see the confining ramifications of "advocating from within the system." Social workers, as advocates, are more systems people than in strong partisan alliance with individual clients. This particular point is substantiated in the work of Hallowitz.<sup>4</sup>

Hallowitz states that his perception of advocacy is in the context of treatment and, as such, is "minuscule." This is true, but even in the context in which he presents advocacy, he does not project an understanding of the posture of advocacy. In his discussion of case examples, the following is related:

"Mrs. P took the necessary steps toward making application for the training program, but the authorities procrastinated and were about to reject her. Mrs. P asked the worker to intercede for her. He raised the question about her trying further herself, suggesting that she might succeed if she persisted. His assessment was that she had the requisite strength and ability. She did present her case again, and this time she was accepted."<sup>5</sup>

His approach is a treatment stance and not an advocacy stance. The posture of advocacy is to take action on behalf of the client, within the context of the client's goals. The advocate is not to worry about creating dependency in the client. Such concerns smack of traditional social work "worries." Worries which have often stifled casework success. The posture of advocacy is a client oriented action response, not one of therapy.

With these comments in mind, it appears that social workers themselves are poor candidates for clients who need advocates to fight their cases for them. The question still remains--who protects the clients from social workers? It remains all too true that those most willing to act on the behalf of others in terms of what is in the others' best interest, are those who are most apt to infringe upon those others' rights.

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<sup>2</sup> Arnold Panitch, "Advocacy in Practice," Social Work, May, 1974, page 239

<sup>3</sup> NASW Ad Hoc Committee on Advocacy, "The Social Workers as Advocate, Champion of Social Victims," Social Work, 14:16 (April 1969); Patrick.

<sup>4</sup> Hallowitz, "Advocacy in the Context of Treatment," Social Casework, (July 1974) pages 416-420.

<sup>5</sup> Hallowitz, page 418

This then is perhaps the most subtle and most inhibiting factor utilized by systems to control the development of advocacy. The feeling that existing organizational structures and social workers will be able to advocate and will advocate on the part of their clients, is mythology.

Shifting the Power Base of Advocacy: A very subtle technique utilized by the bureaucracy to control advocacy is that of shifting the power base from which advocacy operates. Take, for example, the advocate who is directly accountable to the state hospital administrator. In such a situation, the advocate has direct line contact to the top of the administrative bureaucracy without any lower echelon limiting of his function, inhibiting of his communication, and diluting of position. What happens, however, is that when the hospital administrator feels the pressure from the advocate's role, he may state that he does not have time for direct supervision of the advocate. The administrator then assigns the advocate to be under say, the chief of social services, or the chief of psychology, or the medical officer, or whatever. What this does is to force the advocate to go through another layer of bureaucracy and it also allows the administrator to more easily wash his hands of the actions of the advocate and not take a stand on deserving issues brought forth by the advocate. The advocate has less credibility in the eyes of the people he is dealing with since he does not have the direct access to the top echelon of administration. Also, the advocate is more controlled since now he has another individual above him who makes recommendations as to his salary, his job performance, etc. If the advocate is directly accountable to the highest administrative position, then he has less layers of bureaucracy which he has to please and take into account in his performance of the advocacy function for the people he serves.

Stall: This technique is utilized by the bureaucracy, not only to control advocacy, but also in many other situations. It is particularly effective, however, against advocacy because of some of the unique features of the advocacy position within the system. What occurs in this technique is that the organization accepts the advocacy statements and goals, but stalls by putting up minor roadblocks, or states they will do their best within three months, six months, etc. The time goes by and nothing happens. The advocate again pushes forward and they say, "Yes, this will be done," but in the end, nothing occurs. The advocate must be aware of this agreement, BUT...technique.

The bureaucracy which is comprised of numerous individuals interacting with one another can take a great deal of confrontation and assault. The advocate, on the other hand, is an individual, and the stall technique wears him down until he can no longer push for the particular item of concern. He becomes, in the jargon of everyday life, "burned out." He gives up--he no longer has the energy to pursue the interest he was formerly striving towards. Time allows the item to lose its importance. Time is on the system's side which can share stress and survive. The advocate, standing alone, is vulnerable and the stall technique is difficult for the advocate to focus upon and combat. Many times the advocate cannot accept the time delays of the system, even at the risk of being viewed as "unreasonable."

We're Not Ready for That: How often have we presented an idea which is sound and reasonable, humanistic, and appropriate, only to have people agree wholeheartedly with us, but say, "We are not yet ready for that." Anyone can think of a dozen examples relating to this technique. One that comes to mind is the opening of a locked treatment unit. The excuse for only too long a time has been that the community is not ready for unlocked areas. The point here is that the only way you get the community ready, or you get patients ready, or you get organizations ready, is to take the action that demands their getting ready. The advocate must accept the responsibility of the community.

and present in opposing logical rights of patients, students, inmates, etc. It is not the function of the advocate to wait until the time is right. It is the advocate's function to present in a partisan fashion the needs and wishes of his clients.

Take, for example, the desire on the part of two retarded residents of a state institution to be married. For medical reasons, there is no possibility of conceiving children in this marriage. Although the hospital administration and the State Department of Public Welfare support the rights of these retarded individuals who are wards of the state, to get married, they claim that they do not feel the time is right to set a precedence of this nature for residents of state institutions. They do state, however, publicly in their professional and ethical standards that the retarded have virtually the same rights as other individuals. They strive towards normalization and espouse the principles of human dignity and civil rights, but they say the time is not right to set this precedence. The advocate cannot accept this technique by the system to maintain the status quo. The advocate must act on behalf of the two individuals wishing to be married and represent their case to the utmost of his ability. He cannot be inhibited by the fact that the "time is not right."

You are Interfering with Treatment: Another way that the bureaucracy attempts to control those who would perform the advocate's role, is by claiming that the advocate does not understand what the organization's function and performance and role really is. This is especially true in the care-giving professions of mental health. It is only too often heard by those in an adversary position, speaking on the behalf of a patient, that they are "interfering with the patient's treatment." What this means is that the establishment devalues the advocacy position by claiming that the advocate is interfering with the patient's treatment and, thus, is actually providing a disservice to the patient. A typical example of this is the issue of placing patients who have been committed to a state institution on provisional discharge.

Provisional discharge is one means by which patients can leave a state hospital. Virtually all patients who are committed, leave the hospital via provisional discharge. This is regardless of their symptom remission, changed behavior, or changed social environment. There is nothing in the law that states that patients who are committed must leave by provisional discharge, or that this is the most desirable discharge status. The system likes provisional discharge because it is a means of control and power. This control and power over patients makes social workers fond of provisional discharge status. In the community, the local sheriff and police like provisional discharge since it is easy for them to return a patient to a state hospital if they do not feel he is behaving acceptably. In the case of married patients, the spouse likes provisional discharge because it gives them the power over their mate.

A question then arises that if everyone likes provisional discharge, why is it a problem? Well, everyone doesn't like it--the patient does not like it. To the patient it is an anchor around his neck. It limits his civil rights and makes him anything but a full-fledged citizen--a goal of the treatment process.

It is not so much a problem that there is the provisional discharge status, the problem is the way that it is used. It is used in this manner: professional staff in the hospital and the community state that provisional discharge is "good for this person--he needs the security of provisional discharge status to help him overcome his aberrated behaviors." When the advocate states on behalf of a patient that that person does not need provisional discharge, that

the patient can be directly discharged, that there has been sufficient symptom remission or change in the life situation of that person, immediately the professional helping hospital and community persons state that the advocate is interfering with the patient's treatment.

Interfering with the patient's treatment or the client's development is a broad category. In the welfare department it may mean that the advocate, speaking on behalf of a client, espouses the client's right to have social relationships that perhaps the county welfare department feels are highly questionable. When the advocate becomes involved and informs the county welfare department that their agency does not have the right to define who this person may have as acquaintances and who they may not, the county welfare department immediately says that the advocate "does not understand the situation, is ignorant in terms of the social dynamics involved, and as such is interfering with development of the client, i.e., treatment.

You Must Use Channels: Suchotliff<sup>6</sup> referred to this technique of the establishment to control advocacy as "the myth of channels." It is a very real and everyday technique that the system uses to control the function of the advocate. This is a very difficult to be dealt with by the advocate because formal organizations are very complex, the bureaucracy is very complete and, theoretically, there actually are channels by which action can be carried forth and by which complaints can be voiced and change can occur. These channels, however, are mythical. In actuality they do not exist. Take, for example, an advocate in a state hospital who has, as a part of his function, reviewing any adverse techniques utilized in treatment programs to assure the patients' rights, freedom, and welfare are protected. In this case a particular treatment unit does not wish to be burdened by this review process on the part of the advocate and, as such, puts into effect a short adverse program, realizing that the chances of being "caught" for depriving someone of dessert after meals or smoking privileges, etc., are very slim. What happens is that when the advocate does discover such a program, he should, in fact, take this through channels and first go to the unit director and state the situation as he sees it, and then let the unit director handle the problem. This is handling the problem at the lowest possible level which should be a guiding rule for the advocate in most instances. The advocate, however, based upon past experiences, realizes that there would be little change in this unit's attitude towards the clearance of programs using adverse techniques. The advocate realizes that within a month or two another program utilizing adverse techniques would not be appropriately cleared through channels. The advocate is aware that the mechanisms are not working whereby there is an objective and impartial analysis of the programs utilizing adverse techniques to assure that the expected behavior outcome for the patient is worth the adverse element utilized to obtain that outcome.

In this example, what is seen is that the system would not change, that the channels by which the advocate wishes to change the system are ineffective and that the advocate, if he is to realize change and protect the rights of patients in this instance, must go outside channels. What this means is going to higher superiors, or it may mean that the faulty element of the system be exposed to the public. Exposure to public opinion is a difficult step for the advocate to take, but oft n a very necessary one. As an aside, it is interesting that those in high administrativ positions never use channels and that only "little people" have to follow channels.

<sup>6</sup> L.C. Suchotliff et al, "The Struggle for Patients' Rights in a State Hospital," Mental Hygiene, Volume 54, No. 2, April 1970, pages 230-240.

The Meaningless Compromise: This technique is most easily highlighted by example. It is important and often overlooked by persons performing the advocacy function. This example concerns the request of an advocate to open the doors of a state hospital. The state hospital had ten psychiatric units of which all but two had locked doors. The administration, in dealing with the advocate's request, stated that two units would have their doors open but that it was in the best interest of the community and the clients themselves to keep the remaining six units locked. The advocate is tempted by this compromise because, in a sense, he obtains his goal and in another sense it is an easy way out of an obviously "confronting situation." However, in this instance, the system allows for the opening of the two most obvious units that should be open. If the advocate accepts this compromise, then in the future his stance for opening the other units is weakened. This is true since the persons who were most obviously deprived of their freedom are now free to move and the need to keep the other units locked can be more easily rationalized. Compromise is an important part of any interaction between opposing persons or groups. The advocate must be willing to compromise, but the advocate cannot be hoodwinked into a meaningless compromise.

Disloyalty to the Team: Suchotliff<sup>7</sup> recognized another technique utilized by the system to control advocacy, and appropriately named it the "disloyalty to the team argument." This is often heard by staff at institutions who take a divergent position from the norm of action developed in the past. In other words, this technique is not only heard by the advocate, but by others who oppose what tradition has outlined as the proper course of action. Generally there is a team--a physician, a nurse, a social worker, psychologist, technician, etc.--and the team decides what is in the best interests of the resident. If someone opposes the team, or opposes the normative ideas or statements of the team, then the comment is immediately made that, "one individual--the doctor, the nurse, etc.--does not decide the treatment program for this patient." "Here we operate as a team." "We work together because we know that two heads are better than one." This may be true, but it is by no means always true. What it often means is that the team is a small group in which norms are strictly enforced. If you deviate to any extent, the rest of the team quickly points out the error of your ways. The role of the advocate demands that one does not blindly conform to the traditional approach, and the normative action of such things as the treatment team's decision. The advocate is in a key position and has a key function in terms of opposing traditional norms that have been generated and evolved out of the treatment team approach to therapy. This puts the advocate in the position of being disloyal to the "team."

If the advocate accepts the treatment team, hospital employees, administration, etc., as his reference group, he will be unable to perform the function and role that he, by his position, must perform. The advocate must obtain a degree of aloofness and detachment from the team and the organizational system so that he is able to keep in perspective the interests, welfare, and rights of the client. He must not be persuaded by the disloyalty to the team threat or the threat of the withdrawal of approval from colleagues or the organizational system.

Another point somewhat related to this is that many staff feel that if the complaint is not generated by the client, then the complaint is illegitimate. If one looks at the characteristics of the depressed patient, the chemically controlled patient, and the retarded resident, such logic falls to pieces.

<sup>7</sup>Suchotliff, page 235.

Redefining the Role of Advocacy: Another means by which administrators and organizations can control the functioning of the advocate is by means of redefining the working role of the advocate. This point is clearly brought out in the following example.

In one state hospital, the role of the advocate originally concerned patients entering the hospital, in-resident patients, and former patients who were now discharged. After the advocate pleaded the case of former patients who were having community problems of a variety of sorts which involved challenging the services rendered by community-based social service agencies (mostly welfare departments), the advocate found his position description redefined. The community agencies voiced concern to the state Department of Public Welfare and the hospital administration regarding the advocate's role. These community agencies successfully controlled the advocate's function, and eliminated the adversary "community" element by pressuring the state and hospital administration into redefining the advocate's role. The new role excludes assisting patients who are discharged. The reason given for limiting the advocate's function was that if the advocate pleaded cases out in the community, the community would never be able to sell their need for an advocacy position, since such services were already partially available. It is of interest to note that nine months have since past and no effort has been made by these community agencies to obtain an advocacy position. It seems clear, at least to these writers, that this was an attempt to control the advocate's function rather than to develop and expand the advocacy program.

#### Summary

There are many techniques utilized by the system to control adversary elements, and the above presentation is by no means exhausted. If any one particular item was overlooked, it was the fact that the most damaging mechanisms for controlling the advocate's function is personal attack against the advocate himself. Suchotliff et al stated that if an advocate is going to advocate for the rights of clients, he must be prepared to fight for his own rights as well. The advocate must fight against the establishment and the techniques of the organization to control the effectiveness of his operation. This will mean that the advocate must fight for his own rights as well as the rights of those individuals he represents. The advocate, by the very aspect of his adversary approach, will be in constant battle on one issue or another. It is part of his job to realize that this is "normal." He must further realize that it is normal for the bureaucracy, the establishment, or system--whatever you want to call it--to resist change and many of the ideas that the advocate will be presenting. They will resist because, to them, it will mean a loss of power, it will be a change from what has been traditional in the past, it will mean a loss of control over those they serve. They will fight the advocate, not only at the professional level, but on a personal level as well. Accusations will be made against his personal life as well as his professional conduct as the heat of battle increases. The advocate must be prepared for this and, to a certain degree, he must accept this. The authors of this article have stated before, and repeat again, that unless the advocate is in a constant state of conflict with the system he is operating in, he is not performing his job.

What this means is that many people are not of the character that they can be advocates. They cannot accept the pressure, the personal attacks, the criticism, the critical posture of advocacy, etc., that go with the job. Social workers, by training, are particularly unqualified to perform as advocates. The advocate cannot be unbiased, he cannot be accepting, he cannot be understanding and tolerant. He must be aggressive, outraged, and willing to do battle

when he is confronted with infringements upon the rights of people. For social workers who are taught to be accepting, understanding, objective, uninvolved, they are in particularly poor stead for becoming and serving as advocates. A latent effect then of social work training has been to create a warm, accepting, social worker who desires the approval of all those with whom he comes in contact. These characteristics make social workers the poorest of candidates for advocacy. This, however, is not a stagnant situation, and the literature reveals an increasing awareness that social workers must be trained and prepared to take an adversary posture. The only stance that is demanded and effective in many instances in the helping process.

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