

ONCE THE CUTTING EDGE: SOCIAL WORKER TO LEGAL ADVOCATE AND BACK AGAIN

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Twenty years ago, the author began working as a legal advocate for a federally funded protection and advocacy program, investigating complaints of abuse and neglect in a state hospital. Shifting from a social worker to a legal advocate, then back again, brought much to reflect on in terms of advocacy, empowerment, and intervention practice. This narrative shares her reflections on those cutting edge days in mental health, a professional adventure intense with high and low points. Themes that the author draws on in social work education include professional stance, advocacy, empowerment, issues of organizational and management ethics, and legal intervention as a policy instrument. The ongoing need for legal advocacy to re-establish the legal floor of necessary services is underscored.

A man in a *New Yorker* cartoon says to another man at a bar: "I was on the cutting edge. I pushed the envelope. I did the heavy lifting. I was the rainmaker. Then I ran out of metaphors" (Cullum, 1995). At the risk of taxing old metaphors, this narrative presents the process of shifting from social work to legal advocacy. What is interesting is the process; what is important are the themes: those shared and not shared between these different perspectives in working with and in empowering others. What is provocative remains the question: What is advocacy? Is it the man in the *New Yorker* cartoon, his face covered in crisscrossed band-aids, talking to another man at the bar: "I've been on the cutting edge too long" (Mueller, n.d.)? By definition, advocacy puts us out on limbs that can be easily sawed off. Advocacy often places us as much at odds with our own organizations as it does with society at large, putting other valuable issues on the other side of the saw: salaries, promotions, and professional status. We know the risks are real. To advocate for our clients on a continual basis makes us tired in ways we do not foresee at the onset of our professional careers. I am here to talk about the sting of those cuts and bruises as much as the rewards for a job well done.

The Backdrop

The PAIMI Act (P.L. 99-319, the Protection and Advocacy for Individuals with Mental Illness Act) was passed in 1986,

following Congressional hearings on abuse and neglect in residential facilities such as state mental hospitals. The PAIMI Act funds protection and advocacy programs in the fifty states that allow activities such as the independent investigation of complaints of abuse and neglect by individuals with mental illness. Within the scope of the public law and mandated by its provisions, the PAIMI program within each state established its own priorities, with the help of its mental health advisory board, governing body, clients and family members, as well as public input from interested citizens. While there was widespread support for this bill by members of the burgeoning disability rights movement, it was initially opposed by the professional organizations for psychiatrists and the state mental health program directors. Opposition to the act was largely based on the fear that legally oriented advocates would interfere with treatment:

"...minimal federal funding for token protection-advocacy agencies in each state that will review treatment programs that in many instances are subpar because of the neglect of the federal government to equitably fund the national mental health system" (Protection of Mentally Ill Persons, 1985, p. 52).

This publicly funded legal advocacy program was injected into an already contentious mental health service environment in the states. It further escalated the struggle between the rights and needs of people with mental illness, largely pitting the law against medicine, and by association, against the helping professions: nursing, psychology, and social work. It was, at the time, a new type of intervention of law into mental health and one that could only be considered "cutting edge." From 1987 to 1994 I worked as a legal advocate with a PAIMI program in a protection and advocacy system in one of the states. I began as the mental health advocate and ended as their mental health program director seven years later. When I began the job, a colleague said that everyone who knew the state was asking: Why would anyone want to do such a job?



The State of the Art

To establish a sense of the state of the art as an outsider, I did an initial study of the state's history of protective investigations concerning institutions. There was still in the state the older administrative authority over state institutions called the Board of Charity and Reform, consisting of a few members appointed by the governor. I was already well aware of the general level of investigations from a previous job with another state institution. A person wrote them a complaint. They contacted the superintendent of the institution to address the issue. The superintendent did or did not address the issue, but generally reported its successful resolution; in most cases, that was the end of it. A letter stating its successful resolution was sent to the complainant.

I contacted the state Department of Health and Human Services for the responses

of the child and adult protective services offices. Even though I explained my new job as an advocate, the conversations proceeded like this:

Me: How involved were the state protective services? How many calls did they get regarding patients at the state hospital?

Child protective services consultant: We have never had a complaint brought to our attention.

Adult protective services consultant: Can you imagine how awful it would be to investigate complaints at the state hospital?

When I first began to meet with state hospital staff, I tackled the same question from the other end. I was told they did their own investigations. Complaints from patients were handled by the same committee that handled complaints from staff. I was told by the lead committee member (who had taken the complaints for the past five years) that in the past five years there had not been a single complaint from a patient. None. Zippo. Amazing! All of these were red flags to me, but business-as-usual to them. How to begin?

The Beginning

In the beginning, it was not difficult to gain access to the facility. The federal law had been studied by the state attorney general's office, so I came with a 6-page copy of P. L. 99-319, a mission, and a smile. I had access to patients with complaints, access to their records, and access to the facilities. But how to actually begin? My liaison said I could visit with patients on his hall, the adult intake unit, just by meeting with the patients in the TV room during their coffee time. The other halls could be figured out later. I can't say I was very comfortable since I was suddenly moving into the patients' space without their permission, but it was my best offer and I took it. Within a few minutes a curious patient asked who I was, followed by another who asked if I would like a cup of coffee. I sat with a couple of patients at the table, while a few others watched TV or came or went from the room.

Thus began the famous coffee caper. Almost predictably, after a few such meetings,

my liaison wanted to talk to me. There was a concern among the nursing staff about "...how I was going about my work," he said. The point of contention was that I had "taken" the patients' coffee. Offering to pay for the coffee did not end the discussion. It was simply not going to work out on that hall the way I was going about it; never mind that I was not the one who had even thought of such a plan. What I could do was post the hours that I would be available in a small interview office next to the nurses' station. So, a direction for access was set up. From there, access to patients all over the hospital came about in the easiest of ways. A patient made a complaint to me about something common like lost clothing, signing a release form for access to his records to represent him. By the time I returned in a couple of days—after reading his records and with some direction as to how to follow his complaint—he was gone. Discharged. As it turned out, the patient had been remaining at the hospital because he had nowhere else to go. The hospital was holding him for a reason other than mental health; perhaps one that might be called "benign protectiveness." What had they done? They knew that I had checked out his records, and they imagined what a lawyer might find in it. They imagined they were in trouble for keeping him at the hospital. So, they asked if he had any relatives anywhere. He said that he had an aunt who once lived in Kansas City, so they asked him if he'd like to go there. He said something like, "Sure," and off he went on a long bus ride to Kansas City. Off the bus, straight to a shelter. Ah, bus therapy! Alive and well. I was shocked at this strange by-product of simply meeting with a patient.

What happened after that was something for the record books. Within a few weeks, when I walked the grounds of the state hospital or met with a patient, I started to hear the same comment, "Are you the advocate? Are you the one who gets people out of here?" My first thought was, "Huh? Get people out of here?" That was not the focus for our program and certainly not a priority we had chosen for the state, but it quickly became the invisible caption that went with me on the hospital grounds. Without much additional

effort, my name and phone number were passed freely among the patients—and for that matter, passed freely among the employees—who found that they could leave anonymous messages of complaint and concern.

So the troubling issue of access was settled...at least for a while. Several years later, as issues between my agency and the state hospital heated up, the access issue rose again for a time. While conversing with a superintendent during a troubling time, I mentioned that one of the states had the advocate arrested for stepping onto state grounds. "Oh yeah?" he says, obviously running the idea around in his head. I watched him quizzically—understanding that although he'd known me for several years, he could still suddenly have me arrested. I said, "It didn't end well for the state. Once the media got hold of the information, the state realized it was a terrible public relations mistake and withdrew the complaint against the advocate." "Oh yeah, I guess that wouldn't be such a good idea," he said, although obviously still savoring the pleasure of having me arrested in his own mind.

What to do? I had an advisory council to work with, a governing board of trustees to work with, a staff with attorneys, advocates, and a director. All played a part in setting priorities, an ongoing dance between the players involved. So, when I first headed out to work at the state hospital, I had lots of advice and priorities supporting me. Or did I? The answer was yes and no. There were priorities. One was to work complaints at the state hospital. But much of the prioritizing was left to me on site as the advocate, and later as program director, with the ability to influence all the other decision makers with my priorities. I decided to create my own master plan of goals for the state hospital, and see how well I could work my way through it. Never posted, advertised, or even passed upward in my own agency, the list stayed in a hidden place in my private outpost. It included: a patient bill of rights, an internal investigative process, an external investigative process (protective services and the police, as appropriate), and, yes, a hospital advocate. Process, process, process. Those were my goals for tenure with

the agency. Little did the state know how much work would have to go into a big lawsuit based only on constitutional law and precedent, and how much more I sought the entangling webs of policies and process. I am proud to say that all of these goals were crossed off the list by the time I left town.

In the meantime there were many changes, behind the scenes and not-so-behind the scenes. Old forms of restraints were suddenly gone from current use. Hard and soft restraints, like nets that were once used to bag and quiet people, disappeared. The state hospital formed multiple new review committees. Policies were scrutinized, dropped, modified, and revised. The hospital decided to get itself accredited.

On other occasions, there were attempts at co-optation by the superintendent, staff, state mental health director, and by the directors of the community mental health center system. Efforts by the staff were typical enough. For the superintendent this meant invitations to meet him and his wife for dinner out-of-town and out-of-sight; I left the idea open with neither yay or nay. For the state mental health director, there were strange discussions of my relationship with the superintendent, framed as “the good marriage.” From the statewide community mental health directors, the form of the co-optation was an increasing assault on my native humor streak. “Keep her laughing,” they said to each other; that is, until the day I advised them that their strategy would never succeed.

High Points

In 1988, the President made an appointment that left a state without one of the members of its Congressional delegation. A special election was called, with a 30-day period for voter registration prior to the election. At the state hospital, this event created one of the most colorful small chapters in the election, unknown and unreported even by local media. During this pre-election special registration period, I took a complaint from an adult patient considering his request to be able to register to vote. The unit director had denied his request, and the patient had been told that

the policy of the hospital was that only those who had been registered to vote in their home county before admission to the state hospital were eligible to vote while they were placed in the state hospital. With a phone call to the Secretary of State by one of our attorneys, administrative turmoil quickly took the place of such barriers. Given that it was the final week of registration, the state hospital attempted to get the cooperation of the County Clerk of Courts to provide a registration period at the state hospital, which the Clerk of Courts refused. In lieu of that, every social worker was to suddenly put aside their daily work to ask each patient if they would like to register. Then, a state hospital bus brought a load of patients to the county courthouse—some of them in shackles from the forensic unit—to register them directly. Reportedly, turmoil inside the courthouse ensued. The courthouse staff and the public reacted immediately to this very visible action by the state hospital; the Clerk of Courts recanted her decision and agreed to set up a station at the state hospital for registration, as well as later for voting, directly at the state hospital. The last I heard, the Clerk of Courts was still out looking for me as the cause for her debacle.

The high watermark? The day the state hospital agreed to support the Patient Bill of Rights listed in federal law—the Mental Health Systems Act of 1980 (42 U.S.C. § 9501 seq.)—which had been passed by Congress, then rescinded by the Reagan administration. The one section providing a model patient bill of rights had been left intact in federal law. This section had been restated in the PAIMI Act as worthy of consideration and acceptance by the states. In a long series of discussions, the hospital agreed to accept the Patient Bill of Rights as presented in the law, although they were not required to do so (the law asked states to “review and revise, if necessary, its laws to ensure that mental health patients receive the protection and advocacy services they require” [42 U.S.C. 10841]). My liaison was the hero of this story, and I give him and the state hospital enormous moral credit for this decision. The state hospital was, at that time, painfully far from this model. There was no question that we had many traumatic ordeals

facing us as we worked through the particulars of this law and its practical application; but model groundwork was being set. One hurdle remained: they wanted it in state hospital policy only. We wanted it to go through the state's Administrative Procedures Act, giving it the force and effect of law. We won.

The hiring of an internal patient advocate by the state hospital was another high point. Once we had a statement of rights to worry about between us, the state hospital began to get serious. One day, the hospital liaison that I worked most closely with said, "We have our own advocate now. Now we will be ahead of anything you do." He was so self-assured, and so self-satisfied about it all. I showed little on my face, letting him think it was a bitter pill for me to swallow. I tried hard not to show my elation, not to let him see my hand reaching up to cross that goal off my list. Games and negotiations, of course, working with a hospital advocate who was trying to get between the next crisis and me. But also another set of legs on my side; someone who could work internally to correct things that were obvious or not so obvious. We had access to every unexpected investigation. They fought to hide them, but we won.

Other high points matched my secret master list of goals. When invited before the state legislature, the question put to us was: How can we avoid being sued? Fortunately, we were ready with a list of state needs. Much more than we could have hoped, but not too much for the state to handle, and not enough to discourage anyone enough to surrender to the headiness of a class action fight. We asked for funding for a number of community-based programs in the state; enough to change the future. In addition to the obvious community candidates, another need was the agreement to move twenty-five patients out of the state hospital and into the community; twenty-five people who had been dually diagnosed with developmental disabilities and mental illness. You know the ones—moved back and forth from one state institution to another, assumed not to be community-bound and treated as though they never would be; not even able to call one institution home. Suddenly the state was offering the funding for them to have a

chance at living in those community-based programs.

Low Points

Obviously, there were many low points; sometimes on a daily basis. The spike that the car repairman said had been pounded into my tire was surely the most sobering, as the tire suddenly blew flat in high-speed traffic on a mountain pass. I also had to pause when one of the guards on the forensic unit snickered to me about how they'd considered whether or not they could get away with locking me in one of the back cells of the unit. There were also the constant obstacles and barriers that people in institutions are particularly good at constructing.

Not surprisingly, there came a time when the state hospital just wanted to fight. Apparently they thought it was time to take on my agency in the area that they thought themselves most likely to win: the right to refuse psychotropic medications. They never expected the temporary restraining order that ensued. While they assumed themselves to have an inside track with the court, some clever and careful planning defeated them at the get-go, finally shining the media spotlight on them. We had a shrewd local attorney to thank for that maneuver.

There was also the moment when the intensity of the conflicts made relationships a casualty: in this case, with my hospital liaison with whom I'd had productive communications for about five years. The institution developed its own construct of what was going on, and of course, I had mine. As the record was exposed, the glare of what had really happened cut fiercely between us. Both he and the patient advocate expressed surprise that I was taking the issue personally. I suggested that we should all be taking it personally—after all, what else is there? There was a sense of inevitability about it the whole thing: the crossing of the Rubicon, the end of our ways of doing and being. We were about to become our agencies. Yet—and surely to the consternation of some players—that proved less than true over the long haul. There was too much between us for one grueling event to stand between us. The dedication of my dissertation

captured this separate but shared moment with him:

With this study I also commemorate a night when my state hospital liaison...sat in a chair at 2:00 am with a dog in his lap, trying to decide if it was all worth it. At the same time I was sitting in my house with a cat in my lap, trying to decide if it was all worth it. Last I knew, we both decided that it was (Overcamp-Martini, 2002).

The End

In the end, of course I am leaving aside much of what happened. Troubles increased at the hospital; tensions intensified between us and them; and finally, a lawsuit that led to another lawsuit—this time class action—followed by a negotiating team process and an eventual court-monitored settlement. No doubt there developed many different (and hopefully improved) ways of doing everything from the old way. In the meantime I made my own decision to take my leave as the attorneys took over the main action of the program. The adventure was largely over by that time, and it was time for me to finally move on.

Some jobs are harder to leave than others. Once ensconced in the safety of academia, with the struggles of legal advocacy fading quickly from first alert, a ringing phone broke through in the way that it would in a novel. The State Attorney General's Office, now from another state, requested a deposition from me. I refused to give one. He told me that his office would subpoena me to force my deposition. Nevertheless, I said that I would not give the deposition voluntarily. I heard later that my forced deposition was the supposed threat that brought about early negotiations about access issues. It seemed likely enough. I did not even check if any of this was true. I had moved on.

What followed was dissertation research that took up the changes that had occurred in the state mental health environment as a result of the passage of the PAIMI law. Long interviews with consumers, family members,

PAIMI staff, and mental health providers delved into the changes wrought by the introduction of legal advocacy in another state. The research re-created much of what I knew about legal advocacy, but recast much of what I knew in different forms:

When I think now of advocacy, my mind's eye first sees the participants in my research who shared and from whom I learned. Secondly, my mind works back to my own practice. It is a different practice now. My memories are new again—revisited and recast. I now have names for things that I did not have before. There is more context and surely more texture. There are more pathways; a bigger container. My practice no longer exists without my research (Overcamp-Martini, 2002).

I got to be one of the ones on the cutting edge. There are, no doubt, enough other stories from this era to write several books. It was a time with so much in it that I still find myself—twenty years later—occasionally second-guessing other strategies I might have tried in those days when there were few rules and no precedent. I left with nasty wounds and a few deep scars, but with that same old smile on my face. What I helped bring about was the opening of a system that had dead-ended itself. What I got was the opportunity to change something, to study something changing, and now, as a social work educator, to teach the changes. So finally, I can respond to the psychologist from the local mental health center who offered his opinion as I began this job that my job must be an awfully useless thing to be doing since 99% of the complaints that patients made would turn out to be false. He said it with the snide offhandedness of condescension. To him, wherever he may be, let me say: rather, I found something more like 99% of them grounded in something quite true for them, for staff, or for the state hospital. There may have been something different

about how they saw the problem, but they were right to have complaints nevertheless.

I haven't kept up with the changes in that state. I left it to those who came before and after me, and I moved on. No doubt the state has moved far beyond where it was then, but few ever had the air of such a trailblazer about them as those of us who lived on that early cutting edge.

Themes

Several themes emerged as I reflected on my work as a legal advocate, a researcher, and a social work educator in areas such as advocacy, empowerment, and legal interventions:

Many Crossings

I mentioned my crossing of the Rubicon in regard to personalized relationships with the state hospital, but there were several crossings that felt final in some way. While my own work with people felt little changed in style if not in direction, what other people thought of me changed substantially because of the work I was doing. I had to get used to this several times in several ways. The first time I met with the twenty-plus social workers at the state hospital to discuss advocacy and my role in patient complaints, I knew I had made such a crossing. Discounting the two social workers who could not manage to stay awake for an hour, the other social workers were, at best, cool and distant. Although I was fortunate to have experience in the same institutional system in the state as a social worker, the assumption seemed to be that perhaps I was "not quite right" as a social worker to begin with. Along with checking around town about my personal habits, contact with the other institution did nothing to damage my credentials. Yet the questions seemed to remain: how did I go wrong? How could I have gone to the other side?

In truth, there was little change in how I conceptualized my work with people, as strong as I had become in client rights, due process, and individual and group empowerment. Obviously there had been a change in the mission, supervision and strategies of my supervising agency. The work of the legal

advocate is based on the pursuit of the client's "expressed wishes" rather than the social worker's determination of the "best interests" of a client. As a social worker I consciously tried to find out clients' wishes and desires, as well as to engage them in an understanding of their rights in the process of agency work. As a legal advocate I recommended the same professional stance for the state hospital social workers. A social worker willing to build the intervention with the participation of the client will find him or her more engaged in the activity. A social worker willing to expose the client's procedural rights within the agency as well as in the external situation will generally receive their respect for doing so. This professional stance sides with the client even if the agency's actions do not. What we are not here to do is to provide protection for other professions like medicine; our voice should not simply echo the doctor's voice. Rather, we negotiate relations between professionals and agencies and the client. I prefer to think of the expressed wishes/best interests debate as a continuum of stances: with social work enhanced by moving the fulcrum closer to the expressed-wishes stance of the legal profession. Current philosophy and terminology do so in any case: self-determination, empowerment, and strengths perspective, to name a few. We need to move our work closer to our talk.

Who's the Advocate?

By establishing the PAIMI Act, Congress defined the model of advocacy that consumers want most as that of legal advocacy. Who wants something less than having their expressed wishes represented, which is the purview of the attorney? From my research participants I learned that consumers would prefer to have an attorney in their pocket at all times, so to speak, when they walk through our treatment systems, so their own voices would be strengthened and heard. While they did support advocacy efforts from all professionals, it was also clear that they felt the need for legal support to balance professionals' determinations regarding their best interests. Although the PAIMI law directed toward less strident measures than legal intervention itself whenever possible,

there seemed no doubt that the possibility of a lawsuit acted as good leverage for negotiations that could advance the client's or clients' interests.

Working as a legal advocate with social workers, the tension in the question of "Who's the advocate?" was something I experienced continually in my dealings with social workers. Educated to the assumption of advocacy in their work, they had seemingly not considered the possibility that they could be outdone by another professional perspective. Advocacy is a part of our job as we envision ourselves as professionals, but is rarely simply the act of doing our job. Advocacy is the part where we go further out on that limb; where we speak for another or even in the voice of another. We fight for what they want us to fight for. Sometimes that is to choose something more or something different than our agency would choose, and then we must make a decision as to how far out on that limb we will go for that client. In fact, lawyers and legal advocates make some of those same choices. Sometimes I stalled the work for clients in the pile of work with other clients, letting them get a few days of medication into their system before they decided whether they wanted to fight the medication, for instance. Most of the decisions were simply further out on the continuum representing the wishes of the client more often than not.

The legal and mental health professions have taken tentative steps toward each other in these past twenty years. For the legal profession there has been the development of an interdisciplinary field of law called "therapeutic jurisprudence," which focuses attention on the practical consequences of the implementation of legal interventions (Wexler & Winick, 1991). This discipline acknowledges the dependence of both law and policy on the cultural context, and suggests that social science may help determine how the law is affecting people therapeutically—have they been more helped or hurt by the law? Similarly, the mental health professions have developed a concept of "jurisprudent therapy," which emphasizes the benefits to social science of an informed legal perspective. Mental health research, practice, and professionalism are

studied for congruence to the standards of justice, law, and the due process for mental health clients (Drogin, 2000). Hopefully, this work will lead us to share more middle ground as professionals, building on the strengths of each profession for the good of people with mental illness.

What is Empowerment?

The concept of empowerment has clearly been a significant one in recent social work literature. We tend to assume the psychological and social definitions as most important to the helping professions, in which we facilitate a "process, a mechanism by which people, organizations, and communities gain mastery over their affairs" (Rappaport, 1987, p. 122). Empowerment entails psychological and social dimensions, but also macro and legal dimensions. One part of the legal dimension is often overlooked: that of giving authority or legal power to another. The PAIMI legislation opened this door wider by giving people with mental illness easier access to due process and legal representation. As social workers, we can also empower our clients by shifting some of the power of our own expertise by sharing knowledge (Hasenfeld, 1987) of the systems in place to protect them, or perhaps what needs to change for legal systems to protect them. In my experience, it is this shared sense of power that seemed to bring about the real change for a client. According to one of the PAIMI staff, when the client is brought into his or her case as a partner, something very different happens than when an advocate goes off to do the work on his or her own. We might all recognize in it the nod we give to client self-determination and participation in their own treatment:

There's something about keeping the client really, really close in the loop...that makes a difference in the client's life, and it's very interesting. And I think it has something to do with—that somehow gives a sense of control to the client—that they're being informed about what's going on

with their case, you know. That they're not being left out of the loop, that they're being given a chance to comment and give information and have a chance for feedback, and all those things, as opposed to someone just sort of taking it over and just running with it and doing it, you know. Even though it's probably still ultimately going to be handled in the same way...And it's something that when we do it like that, it just is great. And it doesn't take much more time and effort and that's something when we do it well, it's just awesome (Overcamp-Martini, 2002).

Organizational and Management Ethics

In the excitement and activity of setting up new programs we often forget that we should assume that our own beneficence is not sufficient for organizational protection of clients. There is no doubt that external systems have been necessitated by our own refusal to address the obvious problems of bringing client and staff into a closed organizational system with unequal power and access to power. Institutional abuse is what Armstrong (1979) called the subject mental health practitioners would most "rather not talk about" (p. 348). We tend to think of ourselves as private practitioners, when in fact we generally work for and on behalf of organizations—whether they are institutions, agencies, or facilities—which direct and mold our work to support the organization. However, just as a private practitioner is well advised to set up a protective administration around her/his work in terms of legal and supervisory supports, we need to demonstrate our willingness to set up protective and advocacy systems wherever we are, as well as advocate for the strengthening of weak systems already in place.

When we develop a new program, a part of those plans need to focus on the due process systems for complaint and remedy within our

organizations, as well as linkages and support of the interaction with protective and advocacy systems outside our organizations. As managers, we need to educate our staff to make the exposure of our protective and advocacy systems to clients an integral part of our work. In my own experience as social worker, legal advocate, and social work educator, the willingness to set forth the rights of clients as a part of practice is a positive practitioner strategy that works well to increase trust with clients.

Legal Advocacy as Policy Instrument

Legal advocacy can be an effective policy instrument in the mental health service environment, as it has also proved itself to be in other areas such as disabilities. It is also necessary at a time when the political environment is challenging the role of government at any level, up to and including services that are vital to the health and well being of many of our clients. The weakness of "taxpayer will" toward providing revenue for services for other citizens has been one issue. The relationship of the federal government to state government has certainly been another. When the PAIMI legislation was first proposed, the National Association of State Mental Health Program Directors (NASMHPD) testified to Congress their objection to the bill. Why not just give them the money to do a good job to begin with, rather than fund token agencies to review them as inadequate? They knew the outcome of the review; they just didn't want the blame for it. A part of this pushmi-pullyu strategy between Congress and the states has been the instigation of legal advocacy as an alternative federal strategy to grants-in-aid and other direct but targeted funding processes. States can be sued by federally funded agencies for services that fall below a court-approved services floor. In my own tenure as a legal advocate, it was not long before there were negotiated discussions of strategy to obtain needed services—what is sometimes called "funding by litigation"—which became acceptable even to state governments in the courts of last resort. Many social workers, as well as much of the public, would be surprised

to find out how their own state providers may have pressed an external advocacy agency to fight with them or even sue them, so that at least a services floor would be preserved.

Support for such external protection and advocacy organizations has not always been clear, even on the level of the professional organization well distanced from particular organizations. Although supported by several professional organizations during the Congressional hearings, passage of the PAIMI Act did not enjoy the visible support of my own national organization, NASW (National Association of Social Workers). This was at a time when NASW had called for support of alternative strategies of advocacy as implementation of one of our ethical obligations toward clients (Ad Hoc Committee on Advocacy, 1969).

The Once and Future

A man in a cartoon talking to another man: "OK, you design the cutting edge system and I'll turn it into a worn out cliché" (Mueller, 2001). Over the past twenty years legal advocacy has become a part of the mental health and disabilities landscape in most states. In the process of itself becoming institutionalized, how does it keep from becoming co-opted over time? For a strong and self-reflective organization, this critical question becomes the touchstone of reflection. When are there too much game playing and negotiation and not enough confrontation in the public glare? What does it take to get systems moving, and then to keep them responsive to the people and their problems?

Best I can tell, however, that the cutting edge has not really changed. As I write, I recognize that those same old problems—and some new and different ones—exist in the state where I now live and perhaps in every other state. We seem to be losing the social commitment to each other, the willingness to pay our money to the government to then provide the means for care and treatment for others. Even with the lack of dedicated resources, the lack of public and political will to address the problems that plague us, we easily forget the potential for legal intervention. It would seem to be a time to remind the public

that there is a legal floor to services that must be provided.

References

- Ad Hoc Committee on Advocacy. (1969). The social worker as advocate: Champion of social victims. *Social Work, 14*(2), 16-22.
- Armstrong, B. (1979). A question of abuse: Where staff and patient rights collide. *Hospital and Community Psychiatry, 30*, 348-351.
- Cullum, L. (1995, September 25). I was on the cutting edge [Cartoon]. *The New Yorker, 71*(29), p. 59. N.Y., N.Y.: F-R Pub. Corp.
- Drogin, E.Y. (2000). From therapeutic jurisprudence...to jurisprudent therapy. *Behavioral Sciences and the Law, 18*, 489-498.
- Hasenfeld, Y. (1987). Power in social work practice. *Social Service Review 61*(3), 469-483.
- Mueller, P.S. (n.d.). I've been on the cutting edge too long [Cartoon]. *The New Yorker*. N.Y., N.Y.: F-R Pub. Corp.
- Mueller, P.S. (2001). *OK, You Design the Cutting Edge* [Cartoon]. Retrieved June 18, 2007, from <http://www.psmueller.com/cgi-bin/cartoon-sample.cgi?category&sequence=41>
- Overcamp-Martini, M.A. (2002). *The Protection and Advocacy for Individuals with Mental Illness Act: Stakeholder Perceptions in the State of Utah*. Unpublished doctoral dissertation, University of Utah, Salt Lake City, Utah.
- Protection of mentally ill persons from abuse and neglect. (1985). *Hearings before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce*. H. R. 3148. August 2, 1985. Washington, DC: U.S. Government Printing Office.

- Rappaport, J. (1987). Terms of empowerment/exemplars of prevention: Toward a theory for community psychology. *American Journal of Community Psychology*, 15(2), 121-148.
- Wexler, D.B., & Winick, B.H. (1991). Therapeutic jurisprudence as a new approach to mental health law, policy analysis and research. *University of Miami Law Review*, 45, 979-989.

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