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Social work as a profession and social workers as individual professionals often labor within the constraints of structural ambiguity. The historical emergence and location of the profession within the structure of a political economy whose normal functioning simultaneously creates the miseries of the profession's clients and the funds to serve them, poses a series of contradictions internal to the field and to most of its practitioners. The central expression of this conflict is hidden or mystified in social work education, thus preserving the legitimacy of the social structure while delegitimating or invalidating its oppressed populations. This process occurs through the utilization of defect or deficit-based problem definitional paradigms, thus justifying various forms of therapeutic interventions which deny the structural foundations of problems, or depoliticizing problems by absorption into the area of management and technological problem-solving. Transferring political conflict centered on the distribution of power and control over resources to the design and implementation of services derived from a defect model paradigm implementation expresses this latter tendency.

Previous research has documented the extent to which the agencies and organizations typically directed by social workers, or where social workers constitute a considerable part of the professional work force, are tied firmly to dominant thought structures and ideologies (Rose: 1972; Warren, Rose, and Burgunder:

1974). The prevailing problem definitional paradigms, organized to synthesize defect-based projections of problems with residually styled service programs, also carry with them typical organizational and interorganizational strategies. These latter forms of stabilizing and turf maintaining activities reaffirm, in turn, the legitimacy of the local interorganizational field and its member agencies. As these agencies reflect the distribution of power and wealth through their structural location and ideological patterning, support for them or cooperative participation with them, by definition, contributes to reproduction of the structure and legitimation of the prevailing social order. Following Warren, et al, we are forced to conclude that the political character of most social work theorizing, whether it focuses on defining problems or addressing practice, rationalizes the social order and thus can be seen as a participant in its institutional thought structure, creating "a common frame of reference regarding the nature of social reality, of American society, of social problems, and efforts at social change and human betterment" (Warren, et al: 1974, pg. 19).

The institutional thought structure depicts a broadspread manner of thinking about the problems experienced by people who become the clients of social agencies legitimated to function within the social structuring of human service systems. The ideological convergence of these service delivery systems and their member agencies are both a reflection of their organizational patterns of interaction and the basis for its ongoing reproduction. Service provider systems require ideological convergence to sustain hegemony over competing claims and organizational actors. In The Structure of Urban Reform, Warren, et al empirically detailed the escalating intensity that accompanied the shift from competitive forms of interaction between agencies with a common ideological base to zero-sum conflictual interactions which occur when an agency bearing a structural problem definition with an internally consistent intervention strategy enters a local interorganizational field.

It is in these few instances of confrontation by an alternative construction of social reality (Berger and Luckmann: 1966) that the structural ambiguity experienced by human service system providers expresses itself without equivocation. The agencies enmeshed in the institutionalized, defectpremised thought structure and in the community interorganizational field depart from

their typical stance of isolation, passive cooperation or coordination with others to forge alliances targeted at removal of the "deviant" organization from the local interorganizational network (Warren, et al: 1974).

These summary comments and contextual assumptions are presented as the background for a more focused discussion of community organization as a central survival strategy for community-based organizations or agencies that rely on typical social welfare funding streams, but which also attempt to operationalize a social structural problem definition and practice. The remainder of this paper will be devoted to a brief case example of such an agency, an articulation of its organizing strategy for survival, and a concluding set of suggestions.

The Sayville Project

The Sayville Project is a communitybased, mental health after-care agency located on the South Shore of Long Island, New York. Its funds come directly from the New York State Office of Mental Health (OMH) through the OMH Community Support Systems (CSS) program. The Sayville Project has been in existence since 1976, beginning as a social work education program and internship site,* but expanding in 1979 to become a "legitimate" service provider when the Office of Mental Health awarded it a contract to deliver case management services to former State Hospital patients dumped into unprepared and under-serviced communities. Now in its fifth year of operation as a CSS program, with a budget four times the size of its original funding, and a "psychosocial club" component to complement its more individualized case management function, the Sayville Project serves as a useful example of the development of organizational interaction and community organization strategies that are internally consistent with the agency's perspective on problem definition and intervention approach.

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The problem definition used by the Sayville Project is identified as an "advocacy/empowerment" orientation to confronting the realities of the ex-patient clients it serves. The concept of an advocacy/empowerment approach derives from an explanatory paradigm which takes as its central concept the necessity to understand the systemic relationship between a person's context, history and identity. In the case of former psychiatric patients deposited in communities as part of the economic policy of deinstitutionalization (Rose: 1979; Scull: 1977), the focus is on the interaction-between the person's experience in the total institution of the mental hospital (Goffman: 1961) and the forging of mental patient identity (Rose and Black: 1985); on the harsh objective conditions that contour the reality of life in communities (Hynes: 1977; Comptroller General: 1977); and on the omnipresence of a "maintenance therapy"-psychotropic drug medical regimen as the organizing framework for most forms of after-care services.

Numerous contributions to the literature (Lamb and Goertzel: 1971; Reich and Siegal: 1973; Lander: 1975, among others) attest to the fact that State mental hospitals emptied their beds at a rapid rate between the years 1955-75 (Bassuk and Gerson: 1978) without a concommitant shift in mental health funding from institutional care to community-based care (Rose: 1979). The Report of the Comptroller General of the United States (1977) confirms studies at lower jurisidictional levels regarding the role of the profit sector in exploiting the housing needs of ex-patients; the profits accruing to the pharmaceutical industries (Lerman: 1980); and the benefit to stressed State budgets (Scull: 1977) that derived from the fragmented policies and short-sighted practices that occurred before rising recidivism rates and community outrage combined to force states to prepare some type of mental health after-care service system.

Led by the National Institute of Mental Health (through its Community Support Program), states began to invest money in developing programs designed to sustain ex-patients in community settings. Pivotal to the new services were case management programs dedicated to creating viable service plans where there previously were none, identifying and conducting outreach to clients for referral to community-based agencies, and advocating for clients' needs. As with the transition from state hospitals to

communitybased services delivered through the previous NIMH program of Community Mental Health Centers, the change often proved to be far more cosmetic than substantive, more a relocation of medically dominated, defectbased services than an alteration in program paradigms taking into account the structural transition to community living. Cooptation of new programs by local service delivery systems had been empirically demonstrated in earlier social service reform adventures (Rose 1972; Warren et al: 1974). The usurpation of the thrust for change by prevailing structural and ideological interests was predictable, once the funding sources were determined to utilize traditional mental health service providers as a major part of their implementation strategy.

Taking the objective reality of community life to be an oppressive antagonist of ex-patients because of its addiction to profit housing, poverty and medicalized program options, the Sayville Project determined that its primary commitment was toward the transformation of oppressive environments and the conditions which these circumstances imposed upon the already dominatd identities of discharged mental patients. The commitment to pose the objective reality into whichthe mental hospitals had thrust vulnerable people as a problem to be confronted, and to see the people (ex-patients) as an oppressed population rather than as medicalized objects, set the stage for the type of zero-sum conflict described above. This was so <u>not</u> because the Sayville Project emerged as a new organizational actor on the local interorganizational scene, complete with the legitimation incurred by Office of Mental Health funding - that, in itself, was commonplace as new agencies or agencies new to the State hospital/ex-patient system proliferated in response to new dollars. The conflict ridden or intensely turbulent interactional arena emerged because the ideological paradigm of the Sayville Project contradicted that of the entire local mental health structural apparatus and turned its taken-for-granted, defect-based conceptual machinery (Berger and Luckmann: 1966) into part of the problem to be addressed.

Anticipating the attack from the entire local interorganizational network of community agencies engaged in social service and mental health service delivery allowed the Sayville Project to construct its survival strategy and organizing objectives. It was clear from the outset that any organizational strategy dependent upon coordination with the agencies in the local interorganizational field was suicidal - contradictory ideological paradigms

cannot co-exist cooperatively, and with the power and self-declared hegemony in conventional agency operations well within their control, any strategy calling for operative or coordinative interaction promised a certain early demise, whether through cooptation or confrontation. The available possibilities had to be assessed: who could be identified that held existing agency policies and practices in contempt, for whatever reasons?

Evaluating potential coalitions and alliances, as always, produces strange agreements. It is critical to understand the nature of coalitions and their degree of internal consistency for strategic planning. When we began to examine the potential for alliance building within the community where our program was located, we had to assess the political situation within the community. As outsiders, we could not know the various affiliations of different individuals and seemingly non-partisan associations and organizations. Constituency building requires time and outreach effort, activities we had already assumed as prerequisites for any community-based program, and absolute necessities for social programs working with stigmatized client groups. Our community organizing interactions had alerted us to the fact that ex-patients were being viewed as responsible for their own circumstances and held accountable for their structurally imposed oppressed conditions by many community people; that there was an active antagonism towards the State hospitals for discharging people into the community; and that there was no consciousness at all about the converging role of State economic policy, mental health policy related to deinstitutionalization and the profit sector housing arrangements which were used for all ex-patients in the community where were located.

This political matrix suggested an active campaign to alert community constituencies to the history and outcome of deinstitutionalization, together with a systematic analysis of who the real beneficiaries had been. Community education programs prepared for delivery to church, civic and professional associations were designed to focus on the role of the State in determining mental health policy, on the role of the profit sector in opportunistic expansion of beds to accommodate State hospital dischargees, and on the neglect shown toward both ex-patients and communities by the entire mental health/social services systems. Ex-patients were portrayed as the victims of economic policies which also victimized communities in parallel fashion. Both were

out of control of what was happening to them, both were thrust upon one another; and both were maligned by hospital systems and social service departments who were forced into community-based service delivery, a form of service with which they had little to no familiarity and equally little experience and competence. And neither benefitted, although the State budget office, the pharmaceutical industries, the profit sector and the profession of psychiatry did (Rose: 1985).

The central focus of constituency building contains within it the necessity to shift the problem definition from one which sees clients pejoratively into one which contemplates a structural definition of the situation. This was the purpose of the organizing strategy originally developed. It sought to identify community antagonisms, legitimate the emotionality of the peoples' feelings, while redirecting the target of their anger from individual expatients toward regressive social policies, medicalized definitions of community-based needs, and exploiting profit-based businesses dominating housing options. Legitimating the anger felt by community people was a new and enlightening experience for most audiences for, in previous contacts with service providers, they were presented with attitudes which did little beyond rationalizing the system's policies and attempting to induce guilt among the people for feeling negativelytowards the "frail" and "vulnerable" population. Proposing an ongoing agency-community working committee for mutual problem-solving, further education and mutual investigation of the entire situation met with great success.

The agency-community group, which might include representatives from other service providers serving the same target population in the geographic area, becomes a focus for discussing problems which exist in the community. It can engage in efforts to problem-solve in relation to an individual's problems; it can serve as an information exchange; it can anticipate forthcoming policy issues and obtain material for review from distant bureaucracies which affect agency practice and/or clients' lives (but which generally go unknown by community people); it can direct attention to and invite representatives from other subsystems which have an impact on client's lives (e.g., SSI or Medicaid) to attend meetings and explain their agency's role; and it can expose community people to the conflict situations which regularly confront advocacy/empowerment oriented agencies.

An agency which creates such a group or association has responsibility for providing leadership to it. Leadership must take several forms, one part of which is simple logistics (for example, making up name, address and telephone lists for everyone, arranging meetings and making sure everyone has transportation). Leadership also expresses itself, especially in early meetings, through issue clarification developed by elaboration, thematization, development of thematic patterns and problematization moving on to action strategies and critical assessment (See Rose and Black: 1985, Chapter III). In the form of education, issues related to the lives of clients are introduced, discussions initiated, and preliminary exploration of feelings and thoughts engendered. For major issues, study committees or sub-groups are formed, led by agency staff members. These issues are investigated further and elaborated. Position papers may also be prepared which can be brought to the larger group for deliberation and action.

Drawing from our own experience, our agency-community group developed a policy paper on After-Care Rights and Responsibilities. This paper began as a discussion at an Agency-Community Association meeting where staff introduced some of the daily life problems and issues* confronted by former patients. The issues were referred to a sub-group headed by agency staff for development and elaboration. Eventually, the subgroup returned to the whole Association with a draft of a position paper for representation, refinement and approval. The discussions provoked by the draft document led to significantly broadened perceptions among community people about such issues as homeowner domination, medication, regulating agencies, etc. Drawing on the work of the sub-group, the entire Association then approved the final position paper, drafts of which were prepared by agency staff as summaries of sub-group discussions. Action strategies were then offered which, in this case, led eventually to a set of legislative hearings and proposed legislation. Community people were able to see political action as a process of critical analysis and were able to understand systemic characteristics which previously were hidden.

*See appendix for a visual presentation of the complexities of daily life for ex-patients.

The reaction of other service providers to Agency-Community Association group position papers further develops the community participants' consciousness of the institutional thought structure and interorganizational context within which services are delivered. This process of expanding awareness of interorganizational structure and ideology is furthered through regularly inviting selected community people as representatives to all inter-agency meetings, with particular emphasis on their attendance when conflict-laden issues are most likely to emerge. It is crucial for community representatives to participate in these meetings because the actual experience of inter-agency confrontation, the opportunity to hear other service providers articulate their positions, and the presence of community people itself all contribute to community constituency building. Briefing of community people before such meetings, while helpful, is not nearly so important as "debriefing" afterwards. Hearing their accounts afterwards and correcting any distortions is crucial to ensure that community people fully understand the bases for conflict. Over time, through discussions of what took place and why things happened as they did at such meetings, community people can begin to see reality from the perspective of the advocacy/empowerment program.

The process of carefully explaining interorganizational clashes to community participants invited to inter-agency meetings is critical in the early stages of community development. In our case, for example, community people could not understand why the staff of the local mental health clinic felt so antagonistic toward advocacy/empowerment agency staff over the issue of confidentiality. Hospital and clinic staff were continually exchanging information about clients with one another, as well as with adult home owners or SRO management. We absolutely refused to participate in this medium of exchange. The situation became so heated at the local level that we chose to escalate the issue out of the local interorganizational arena to the Regional Office of the State Office of Mental Health. All participating agencies were told to come to a meeting at the Regional Office. We participated, but only on the condition that at least one community representative from our association could attend. The mental health providers took the expected position of expediency, arguing for sharing of client information among mental health professionals. The presumption was that ethical conduct in this situation exists

imply because professionals are involved. We refused to cooperte, to the point of making clear that even unanimous agreement of he whole group would have no bearing on our position. The relaive insignificance of mental health policy when compared to contitutional law was made as the basis for our view. When the deial of constitutional protection was connected to the convenience f the very same agency people who placed ex-patients in the proft housing market, community people began to see ex-patients' relity more clearly.

The community representatives, after the meeting, had to be nformed of the assumption behind each agency's position, and each gency's role in the conflict had to be elaborated in significant etail for the community people to comprehend the basis of the onflict and its meaning. This type of time-consuming activity is equired if knowledge and trust are to be built. Simple, rhetorial repudiation of the other agencies is transparent selfggrandizement and will produce estrangement among community peole just as quickly as other forms of transparent selfighteousness.

Careful cultivation of community support, in the context of a ostile interorganizational environment, also can prove to be efective in advocacy efforts. Joining in preparation of position apers can lead to jointly authoring legislative testimony, conacting local legislative representatatives, co-presenting at egislative or administrative hearings, making written comments on tate, city or county agency policies, regulations and/or guideines. Forwarding copies of positions on issues to all locally lected representatives can produce an impact, or have that potenial. Efforts to establish contact with local representatives at ity, county or State legislative offices are directly connected o community organization and legislative advocacy efforts. When lected officials see position papers and written commentaries rom an Association in their district, and they know that the comunity people serving as members of the organization hold offices n other, larger community groups (e.g., civic or neighborhood ssociations, church social action committees, etc.), the potenial impact can be significant. Locally elected representatives ften hold no positive view of mental health system track records, nd can often be looked to for consultation on and/or sponsorship f legislation. They also can be seen as potential allies in conlict situations with the State hospitals and/or other service

providers. Keeping these officials updated on local activities of importance retains their interests and sustains their support. It can also present them with useful issues of community importance, that, in turn, can add to their own local support.

Similar contact can be initiated within the vertical funding system or outside the local interorganizational network. People in regional or central office planning positions are often beset by problems in implementation of their programs and by community opposition. When agencies bring community groups and representatives together with regional or central office planners, the latter can see that community organizing strategies can produce positive - or non-hostile - outcomes, a relatively new experience for them. Equally new is the community-legislative relationship in support of ex-patients and programs directed toward their needs as community residents.

Marked progress in community organization is shown by growing consciousness among community people of the difference between the advocacy/empowerment program and other service providers in the definition of clients' needs or problem definitions, in practice principles, in appreciation of community context, and by their increased concern about ex-patients' well-being in the community. Community members can be invited into adult homes or any other residential facility by ex-patients living there. Facilitating such visits promotes an increased capacity among community people to understand former patients' daily life. In crisis situations, when landlords and homeowners deny access to workers, community people who have developed relationships with residents can become involved as active and especially effective participants in the struggle against landlord domination. Maintaining contact with residents in the homes can be a vital source of support both for them and for agency workers. The possibility of community involvement in a struggle, which may later become an issue for legislation, contributes to the further isolation of landlords from sources of community support. It also forces community people to observe the role played by other agencies: which agencies stand firm behind residents' rights, which side with landlords?

Critical appraisal of a process such as this is a step which must be taken and initiated by program leadership. The purpose of recounting the steps in the process is political education: the conditions in the home are reflected upon and connected to the way

the residents are forced to live; income levels are reviewed, and the amount of SSI dollars going to the landlord are compared to the spending allowances available to people; the items which each resident must purchase from the meager leftovers (after rent) are reviewed; the impact of living this way on self-image and self-confidence is posed as a question to the people. Through this process, community people, whose initial political posture is often one of moral outrage, can be engaged in reflecting on oppressive conditions producing advocacy-targeted issues. Through the process of critical reflection, the significance of community advocacy activity takes on deeper meaning to those involved. Community people become better able to see the advocacy/empowerment agency and its approach to practice more clearly; that is, the agency's intentions, its approach to problem definition and its ways of relating to clients. As this process unfolds, the perspective on other agencies in the interorganizational system also sharpens, thus strengthening the agency-community alliance.

Once a program has reason to believe its principles and practice orientation are at least partially understood and accepted by constituencies in its host community, the role of community groups can be expanded. A positive relationship with a neighborhood or community civic association, which has the largest and most representative membership, can lead to a commitment from the agency to get association approval prior to any major changes or expansion of program activities. Meeting with some regularity with association executive board members, or on an as-needed basis, program directors can provide a continuous funnel of information to association directors, solicit input from them where appropriate, and maintain continuous communication. Where agency decisions related to funding arise, association members can be informed well in advance about the contract process as well as about who has the decision-making power. Any problems in funding requiring a meeting with staff people from a funding source should include community representatives from the Association as well. In funding crises, the relationship between agency staff and community association members, if characterized by honesty and shared experience, can lead to active community support in the form of demands for sustained funds, community advocacy for the agency and political pressure applied to sustain funding. Our program has enjoyed all of these benefits, because of our commitment to doing the community organization work in the manner described above.

Our experience has been that, at first, community people rarely want to know the detail necessary to understand the complexity of creating and operating any community-based program, much less a program constructed out of an alternative (advocacy/empowerment) paradigm. However, agency staff who are genuinely open to dialogue, interested in learning community members' thoughts and feelings about issues, and free from typical professional condescension, can open possibilities for a more sustained and developed agency-community relationship. When staff of an advocacy/empowerment based agency reflect on their rather tenuous position within the local interorganizational field and recall that there will be no support forthcoming from that system, transferring energy, resources and commitment to constituency building among organizations, associations and individuals in the host community becomes a preferred activity as well as a necessary strategy for survival.

Communities are the settings or environments where people participate in daily life. Integration of the ex-patients into their social environments as people or citizens, rather than as aberrations, deviants or medicalized objects depends upon an agency being able to develop a context where the existing community anger, stereotypes, and distances can be confronted. Equally important in recognizing the social reality of deinstitutionalization and the provision of services to sigmatized populations is the awareness of what it means to be in a "host" community, and what community peoples' feelings are about the issues related to an agency, its clients, or its imagery. The larger context for conceptualizing these matters is the shrinking role both individuals and localities have in making critical decisions that affect daily life. In addition, community people have to deal with the fears engendered by the "mentally ill," fears derived from the use of institutionalization as a treatment of first resort for the many years preceding deinstitutionalization.

Conclusion

We have attempted to demonstrate that a community organization strategy must provide a base for developing a constituency of support within the community if a community-based, alternative paradigm program is to survive. It must develop an approach to political education which will support taking issues into advocacy

renas for legal, political or legislative action. It must strug-
le to cultivate an understanding among involved community people
f the practice approaches and problem definitions held by the
gency. This latter dimension is produced as part of an ongoing
ffort to help community people break down the barriers between
hem and the ex-patients residing in their community. This strug-
le, in turn, emerges as community people are able to transform
tereotypes and widely-held medicalized perceptions into concrete
nderstandings of ex-patients as socially human, subjugated and
owerless. Thus, the community organization approach advocated
ere is one which does not simply see community people or or-
anizations as useful objects to be manipulated for agency objec-
ives, but rather sees direct corrolaries between the community
nd the ex-patients. Both are dominated by external forces, often
ot directly known (e.g. Why does inflation rise faster than in-
ome? How does X community benefit from defense spending?); both
ave decreased power to determine what happens in their immediate
nvironments (e.g. the use of eminent domain to locate a community
esidence for developmentally disabled adults around the corner,
espite the unanimous opposition of neighbors); and both are sub-
ect to manipulation by government and media.

Seeing parallels at a thematic level between community mem-
ers and ex-patients allows for the creation of an organizing
trategy which is devoid of objectification and contempt, which
ncourages community people to express their feelings and doubts,
hich mandates agency leadership in the representation and connec-
ion of this antagonism to the larger social reality. Such a
trategy totally contradicts community members' past experiences
ith State mental health authorities, service providers and en-
repreneurial landlords by encouraging community input into issues
elevant to their concerns; by attempting to figure out quick
esponses to problems experienced by community residents relating
o the ex-patient population; by bringing people together in an
rganization to learn about information and policies generally
ept hidden from them; by requiring community involvement in
nteragency settings where previously negotiated arrangements were
orked out and mystified by professionals; and by asking community
embers to know something about the reality experienced by the ex-
atients living in their community so that together they can act
o change this reality. The community organizing strategy also
arallels an advocacy/empowerment direct service strategy in its
eformulation of problems, identification of potential action

strategies, and critical assessments of actions undertaken. As community people experience the principles involved in a practice where they, too, are the participants, their capacity to comprehend and consciously support the program's work with ex-patients is enhanced.

Community organization thus develops as both a desired and necessary activity. It exists as a form of practice which analyzes the needs of a given target population for a decent, socially alive life and struggles to produce the contextual and relational climate in which clients can feel and see themselves as active participants in their communities. It also provides the political base for the organizational survival of an agency more committed to the struggle for social justice than it is to prevailing thought structures and interorganizational networks. This commitment requires a corollary commitment to the social development of clients, to community development in the context where clients live, and to a conflict-based orientation to the interorganizational field and its surrounding ideological environment. Coupling community organizing, constituency-developing strategies to an empirically validated need for a conflict orientation to service system interaction allows innovative, structurally oriented agencies the possibilities of survival and the probability of practicing without the additional burdens created by structural ambiguity.

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