

The Challenges of Dual Relationships and the Continuum of Care in Rural Mental Health

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This chapter presents an empowerment-based approach to understanding dual relationships in rural mental health service delivery. The changing nature of therapeutic relationships with individuals who suffer from serious psychiatric disability requires innovative and creative strategies, as well as a comprehension of the ethical dilemmas inherent in consumer growth and recovery. The Chapter concludes recommendations for incorporating a vision of recovery in mental health systems that is embraced by administrators, providers, and consumers together.

Whether mountains or plains, farmland or desert, places with small populations, few formal resources, and multiple needs and roles present significant challenges to mental health systems in rural areas. Social workers and other providers who plan to work in rural areas, particularly in the mental health service system, must understand the complexity and unique character of rural service delivery. They must also be leaders, guiding institutions and individuals beyond outdated traditional practices and philosophies no longer relevant. The transition of rural mental health to a recovery model requires leadership in developing innovative and flexible service technologies that empower employees and consumers of service.

People in need of services in rural areas have a range of mental health needs, and communities differ in their capacity to meet those needs. However, one population is particularly important to consider in relation to rural mental health – adults with a serious and persistent psychiatric disability. In general, people who suffer from schizophrenia, schizo-affective disorders, bi-polar disorders, major depressive disorders, and other severe conditions are considered part of this population. Services for this group will be

the focus of this chapter. Serious disorders require the most intensive services; in fact, in rural areas, the local mental health center may be the only possibility for services. Access may be difficult due to long distances, lack of public transportation, and consumers' economic insufficiency. Attempts to cope with the "wide open spaces" through new age technology, for example video-teleconferences, lead to an impersonal experience, with clients traveling long distances to reach video equipment, then feeling empty and frustrated by the result. Finally, individuals with serious mental disorders are most impacted by the nature of their condition and require the most intensive treatment.

Two issues are particularly cogent to mental health services in rural areas in regard to this population: dual relationships and an adequate continuum of care. First, a discussion of some of the multi-faceted relationships that develop in rural areas, due to the nature of small communities and the evolving change in roles of consumers with serious disabilities will be presented, with an emphasis on the related ethical quandaries. Second, the continuum of care that has traditionally been in place – emergency services, hospitalization, outpatient services, community support, supported employment, and clubhouse programs – may no longer meet the needs of consumers who have progressed in their recovery. Rural mental health systems' capacity to accommodate growth and recovery of consumers will be addressed. Finally, the chapter will close with recommendations for a partnership model that promotes empowerment and recovery in rural areas.

The Lens of the Authors

This chapter is co-authored by two people with different areas of expertise and experience. The second author, a woman with a bi-polar disorder who was a recipient

and provider of mental health services in her rural community for over 20 years, collaborated with an academician who previously served as a mental health clinician and administrator. Thus, the authors combine two different starting points and two different lenses with some common ground to discuss what is needed and what works for rural mental health service systems. This chapter integrates the above perspectives through research as well as narrative that consists of a series of real-life vignettes told by the second author.

Power and Powerlessness of Consumers with Psychiatric Disability

To be effective leaders in rural areas, social workers must understand the nature of serious psychiatric disability within the context of stigma and the distribution of power. Power and powerlessness are important in regard to service, as power and stigma intersect with rural isolation and a person's psychiatric condition. People with serious psychiatric disability have to contend with a variety of issues that are "embedded in the nature of mental illness and the history of psychiatry" (Manning, 1998, p. 90). These issues emanate from the disease model of care that has developed over many decades (Segal, Silverman, & Temkin, 1993). In addition to coping with their condition, people with disabilities face labeling and diagnosis, the learned helplessness that develops from persistent conditions, the deficit ideology associated with psychiatric problems, and the pervasive stigma that follows people with disability and their families. The conditions that accompany psychiatric disability -- poverty, loss of self, and institutional disempowerment -- cannot be separated from personal power.

Loss of Self

The psychiatry disability impacts personal power because of the losses of self (Manning, 1998). Estroff (1982; 1989) describes the “narrative of loss.” First is the loss of personal history. The significant persons in a consumer’s life often are providers of service, who did not know the consumer prior to the disability and now know the consumer only in relation to disability. Second, consumers experience a change in their perception of themselves as a result of the condition and how others react to them as the condition progresses. Consumers are no longer who they originally thought themselves to be (Chesler & Chesney, 1988; Estroff, 1982; 1989). Finally, consumers experience a significant change in roles within their families and within the communities that determine their social place and space. In rural areas, the changes are more evident due to a lack of anonymity. In urban areas, people encountering each other on the street generally do not know each others mental health history; however, in rural areas, it is not uncommon for everyone in town to have some information about a person’s condition. These losses have a profound impact on consumers’ perceptions of themselves as persons with power.

Poverty

Poverty erects a substantial barrier to accessing the resources, information and relationships that increase personal power; it is one of the residual effects of a serious disability. The quality of life for consumers is substantially lower than some of the poorest groups in the general population (Lehman, Ward, & Linn, 1982; Rosenfield, 1992). Most consumers contend with substandard housing, difficulty finding competitive employment, and inadequate access to dental and medical care. In addition, poverty limits access to recreational and social opportunities.

Policies such as Social Security Insurance (SSI) perpetuate poverty. The formula for getting off of SSI is so complex, most consumers and providers have difficulty understanding the prescribed path to self-sufficiency. Although the stated goal of self-sufficiency is positive, the procedures and requirements of this bureaucratic policy trigger fear of failure rather than nurturing and encouraging hope for success. In rural areas these impacts are magnified. Access to support groups or basic services may be limited or impossible due to lack of transportation or financial hardship.

In rural areas, employment opportunities are scarce, and the competition for jobs with other rural citizens is intense. For example, in January 2003, eighty-one workers were scheduled to lose jobs from a local K-Mart store in a rural area. The same day there were only 8 job listings at the workforce center (P. Rheume, personal communication, March, 2003). Further, if consumers are honest about limitations resulting from their condition, they risk being discriminated against during the hiring process. Supported employment opportunities are usually minimum wage and not adequate for consumers at higher levels of recovery. Economic opportunities are often accessed through the institutions of the community, which can also be disempowering.

Institutional Disempowerment

Community institutions (e.g. mental health systems, human services, employment services, etc.) also reduce the power of people with psychiatric disability (Chesler & Chesney, 1988). Failure in guaranteeing human and civil rights, lack of access to adequate medical and psychosocial care, and barriers to education, employment and public/private services all reduce power. The rights of persons with psychiatric disabilities have traditionally been abused; social workers support civil rights

conceptually, but in practice were found to routinely disregard those rights in practice (Wilk, 1994). True informed consent in psychiatric institutions is simply not practiced by providers (Lidz, Meisel, Zerubavel, Carter, Sestak, & Roth, 1984). Consumers are often uninformed or misinformed; their civil rights are unintentionally eroded.

Stigma

The context for psychiatric disability in rural areas is permeated by stigma, despite efforts to normalize mental health problems and the substantial research linking psychiatric disabilities to imbalances in brain chemistry. Stereotypes that develop are especially prevalent in rural communities where differences are more apparent. For example, the culture of “being neighborly,” in which everyone knows about everyone else’s business, provides few protections to privacy. Gossip is pervasive because it travels in a smaller circle; the anonymity of the city diffuses gossip because there are more people.

In rural communities, the police scanner is a major channel of communication. People experiencing a psychiatric emergency may find that their personal experience has been broadcast across the county. Consumers facing involuntary hospitalization are often jailed prior to transport, and usually handcuffed and shackled for the trip to the state hospital. The names of people with traffic violations, substance-related crimes, and more serious offenses, are printed regularly in the local newspaper. Court decisions, fines, and sentences are also printed. A rural family member said, “It’s the smallness, it’s the publicness. When the sheriff comes to get your mother, everybody knows...and...it’s a big problem...a biiiiig problem!” (Manning et al, 1994, p.8). A consumer related that, after his name was published in the police scanner, he experienced discrimination in the

community and was banned from entering three local businesses (Van Pelt, personal communication, March, 2003).

People with mental disabilities view stigma as a major barrier to empowerment (Miller, 1991). Individuals may want to avoid services, as they do not want to draw attention to themselves and their problems by being identified with the mental health agency. One rural consumer said, “I feel like I have something contagious like AIDS...or like I have leprosy.” As a result, people in rural settings are less likely to talk to friends, family, neighbors, and other community members concerning their illness for fear of repercussions. The reactions of others affect how people with mental illness integrate into the community and how they experience their social and interpersonal world, all of which perpetuate stigma.

People with mental disabilities internalize the stereotypes and misperceptions of others. The shame, lack of expectations, and fears of rejection then become a stigma of the self. Many rural consumers do not have the option of experiencing feedback from the larger society. Thus, the ability to envision how things could be different is reduced. A consumer researcher said, “We stigmatize ourselves through denial, lack of acceptance, language and isolation... We picked up on the language of professionals and use it to stigmatize each other” (Manning et al, 1994, p.8). Consumers are sometimes not supportive of each other when one person experiences disempowerment within the system.

The result of internalized oppression is a pervasive doubt in one’s own strengths and capacities and a lack of realization that one’s responses to the environmental challenges of daily living are normal. As one consumer described, “We either make too

much allowance for the illness or not enough...still looking for middle ground” (Manning et al., 1994, p.8). Rural consumers are often left to flounder alone in finding this middle ground. This dynamic increases the caregiver’s power as an expert and reduces the consumer’s power by obliterating the recognition of one’s own experiential knowledge and expertise.

The consumer’s recognition of personal power through the process of recovery, and the assertion of self-determination can be perceived as a threat to caregivers. Consumers are hesitant to threaten their caregivers. In the fast-paced, high-tech culture of today, the connections to the extended family or community who care for each other have been eroded. Care taking has been assigned to the “professionals” and “experts” who work for bureaucratic systems. Ken Agtuca (personal communication, Spring, 2003) argues that, while the computer has generated a larger community, it “has, in turn, lost much of the glue which bound it’s humans to their humanity.” Without a network of social support, consumers depend on mental health providers for care taking.

Attention to the dynamics of power and powerlessness is useful in order to engender change. Rural areas are in a unique position to develop flexible and creative opportunities for people with psychiatric disabilities because of the scarcity of resources. Innovations such as consumer providers, consumer-run programs, and the extension of the continuum of care through clubhouse models and consumer support groups have begun. However, mental health center staff lack training opportunities and support necessary to facilitate these extended services and the complex ethical issues embedded in dual relationships and continuum of care challenges.

Dual Relationships in Rural Mental Health Programming

Changes in program and technology have resulted in new ways of providing services and new roles. Curtis and Hodge (1994) note that “The advent of community support services, with their strong consumer-oriented philosophy and non-traditional, often quite public methods of delivering services, challenges some of the lines that have been traditionally drawn between ‘professional’ and ‘unprofessional’ behavior” (p.14). Community support services now emphasize the role of “consumer choice and empowerment” in programs, and concepts such as recovery, partnership, and self-help are changing the way services are delivered (Curtis & Hodge, 1994, p.14).

The new emphasis on partnership and empowerment has changed the distribution of power between provider and client. The nature of the helping relationship “is becoming less prescriptive and more collaborative” (Curtis & Hodge, 1994, p.15). In addition, the mental health provider is increasingly called upon to be “the bridge” that helps integrate their clients into the community (Curtis & Hodge, 1994, p.15). These connections of support in the community require “informality and intimacy” between provider and client. In addition, the activities that create consumer integration into the community are with community agencies and individuals, rather than within the mental health organization where the provider is employed (Curtis & Hodge, 1994). These changes require providers to acquire new skills and challenge the traditional mind-set about professional roles and boundaries. The first step is understanding the nature of dual roles, boundaries, and professional socialization.

Dual Role Relationships

Dual role relationships are those that include a primary professional relationship that are therapeutic in nature, as well as relationships with other role functions (e.g. colleague, student, or business contact). Dual relationships are especially pertinent in rural areas due to a scarcity of resources and the closer proximity of relationships. People who live, work, receive, and provide services in rural communities find themselves in multiple relationships. The postmodern society is complex, and most people fill multiple roles (Loewenberg, Dolgoff, & Harrington, 2000). Clients and providers may find that they are members of the same mosque, church, or synagogue, political party, or school district. They may they find themselves at the same parties, social events, and recreational activities. It is also often the case that providers and consumers run into each other in the grocery store, at the gas station, at the barber, at the theater (if the town is big enough to have one), and in other local businesses. Everyone is a captive audience in a rural area where facilities and activities are shared by all. Care providers and consumers who identify with smaller subgroups (e.g. immigrants, refugees, AA groups, people diagnosed with AIDS, gay and lesbian citizens) also face an increased possibility encountering each other in social and public settings (Loewenberg et al., 2000). A person may receive therapeutic services from a mental health agency and also have paid employment at the same agency in which the person's clinician is also a colleague. The employed consumer may provide mental health services to other consumers who are also friends. The employed consumer may be supervised by her therapist's ex-wife, complicating discussions of work issues in therapy sessions. Mental health employees may also provide therapeutic services to people who are also a part of their social support system, or with whom they conduct business in the community.

Professional Boundaries and Socialization

The issues ingrained in dual-role relationships are intertwined in the definition and understanding of professional boundaries. Boundaries are the “highly personal translations of moral codes in our relationships with others... they exist in all relationships, expressed overtly or covertly by symbols and behaviors” (Curtis & Hodge, 1994, p. 21). The boundaries in relationships help to communicate and define what each person can expect from the other, as well as what is not relevant or appropriate to the relationship. Ethicists and practitioners underscore the importance of clarity of boundaries. Clear boundaries help “practitioners and clients understand the nature and purpose of their relationship with each other” (Reamer, 2000, p. 104). The norms and standards for dual role relationships and professional boundaries are derived from theoretical models of intervention and the socialization of providers.

The professional socialization and training of social workers has emphasized a wide range of theoretical models for practice with clients. Further, theory evolves over time, so that the student is provided a range of conceptual ideas, which, ultimately, may have conflicting or contradictory assumptions about the distribution of power with clients and the nature of professional boundaries and obligations. Psychoanalytic insight therapy and object-relations theories based on the medical model were the traditional models of psychiatric casework. The medical model, with the client defined from a perspective of disease and pathology, reinforces the retention of power in the hands of the provider “expert.” The traditional mindset of the medical model is still evident in the socialization of social workers.

Feminist, existentialist, cognitive-behavioral, empowerment, and recovery models (to name just a few) are more recent innovations (Rhodes, 1992). These theoretical models have different assumptions about the nature of the relationship between client and provider in relation to the distribution of power and the boundaries of the relationship. Power is shared between consumer and provider with the goal of empowering the consumer. Empowerment is “the ability of individuals ...to make choices that give them control over their lives” (Manning, 2000, p.126). A fundamental assumption is the importance of the consumer’s self-determination. Relationships are viewed as multidimensional, with providers responding to basic needs and social support issues, as well as therapeutic issues. In these relationships, “the role of the staff may be unclear to both the staff and the consumer, and even vary from contact to contact” (Curtis & Hodge, 1994, p.24).

These more recent innovations require new understandings about the nature of the relationship between providers and consumers. For example, perspectives about personal disclosure are changing, even within the psychoanalytic community. A recent study on self-disclosure found that revealing personal information was not harmful to clients (Barrett & Berman, 2001, para. 12). Disclosure “serves to enhance the bond between therapist and client, and it’s by enhancing that bond that provides the atmosphere where improvement can occur” (Barrett & Berman, 2001, para. 12). Self-disclosure can be both “appropriate and healing” (Curtis & Hodge, 1994, p.25), particularly in the area of community support. The changing nature of the helping relationship leads directly to consideration of ethics.

Ethical Considerations

For the purposes of this chapter, ethics will be considered the process of seeking answers to practical questions about how to act, or what anyone does in asking what is right, good, or obligatory (Frankena, 1982). In the process of making an ethical decision or resolving an ethical dilemma, the practitioner, “through the experience and responsibilities of practice, reflects on the moral and ethical issues that are brought forward and uses a reasoning process to resolve them” (Manning, 2003, p.132). The reflection on ethical issues is always about issues of good and harm – evaluating the potential impact of practitioner decisions on those affected by the decisions. The helpful or harmful impact is related to the relationship between providers and consumers. Thus, both must be involved in assessing the potential impact.

Dual role relationships have the potential for ethical dilemmas. When the provider relationship is not distinct from other relationships, there is a possibility that the client may be exploited or harmed. The difference in power between client and provider and the potential of confusion for both the client and the provider when roles are ambiguous or blurred increase the vulnerability of the client (e.g., for exploration or harm see Reamer, 2000). Since the complexity of blurred roles cannot be avoided in rural areas, collaboration between all parties in assessing potential good and harm is essential. The following discussions about dual relationships will identify some of the potential good and harm that can arise from the nature of these relationships. Dual role relationships that involve therapeutic and social roles, blurred roles, and evolving roles are considered.

Therapeutic and Social Roles

The boundaries that define the nature of a therapeutic role frequently come into conflict with social situations and opportunities that arise. Decisions about what level of social involvement providers should have with a client who is also a colleague are complex, as the following example illustrates.

While I was a staff member at the mental health center my therapist (a staff member at the same agency) held a Thanksgiving Day potluck at his home. An open invitation to all staff members was printed in the weekly office memo. When I read the memo this dilemma went round and round in my head. Was I a “staff member” invited to a party? Or, because I am also a consumer, did this invitation not apply to me? I took a positive approach, decided I was a “staff member” and put an RSVP note in his box. My therapist responded with a note saying it was not appropriate for me to attend this dinner. The invitation to all other staff did not apply to me.

The rescinded invitation felt like we were trying to avoid a scandal, as if our relationship (confidential client-therapist) was an affair we had to keep secret. There was no discussion of the shades of gray. I was not perceived as a person capable of distinguishing between the holiday social gathering and a therapy session where intimate details of one’s life are revealed. I think the “no” response felt safer to my therapist, rather than entering into a discussion of his feelings and the complexity of the situation. I didn’t bring it up for discussion because as a “consumer” I felt the power and authority in his “no.” I didn’t want to listen to a complex

explanation of his “no,” as receiving one “no” was painful enough.

In this case, the need to negotiate a change in boundaries that reflected the change in roles and relationships was not addressed. The clinician was not willing or able to talk directly with the consumer provider about his dilemma. Several ethical issues permeate the above confusion, including labeling, boundary negotiation, and the isolation of providers. At the beginning of the client-clinician relationship, the clinician labels the client. Diagnosis is mandatory in order to receive and pay for services. The nature of the label is such that often a person’s identity becomes interpreted through the label (Segal et al., 1993). Thus providers and others may view a person’s feelings, behaviors and experiences through the lens of the diagnosis. This results in a diminishing sense of the person and a magnification of the label. The consumer in the above example became diminished as a staff member, and her identity as client became paramount. This contributed to a diminished sense of personal power on the part of the consumer-staff member and distorted the clinician’s perception of the consumer’s capacity to respond appropriately to the situation.

Caregivers often distance themselves from the person because of their diagnosis. Professional socialization and theoretical perspectives, as noted earlier, have often encouraged this distancing. Caregivers have been taught that ethics and boundaries require them to be distant, and that the human side of a caregiver should be hidden from consumers. A therapist recently noted, “The system did not allow me to be human” (Van Pelt, personal communication, 2003).

The ethical issues regarding disclosure are connected to the types of disclosure, and the degree of intimacy in the details. For example, Hill (quoted in Goode, 2002, para. 23) points out that revealing personal problems and details of sex lives are not in the client's best interests. However, "Here's what I think, what do you think?" is different from "spilling your guts." In the above dilemma, the re-negotiation of traditional boundaries was not a consideration. The clinician was reluctant for his client/colleague to see his human side – his home, significant relationships, taste in décor, taste in food, etc. – even these things would be revealed to his other colleagues and no intimate details about his life would not be exposed. This either/or mentality leads to a rigidity that prohibits creative problem-solving with his client about what is in her best interests at a particular point in time.

Boundaries are ways to think about what is in the best interests of the client. Providers have a fiduciary responsibility to their clients. A fiduciary is a person who has a duty, created by his/her undertaking, to act primarily for another's benefit in matters connected with such an undertaking. This duty is both a legal and an ethical obligation. The best interests of the client must be identified through collaboration with the client and are directly associated with the goals of treatment. Curtis and Hodge (1994, p.22) use a sports metaphor to describe the nature of boundaries and ethics. The relationship between provider and client is the "playing field," the goal is the purpose of the relationship. Ethics are the "rules of good sportsmanship" and boundaries are "the size of the playing field."

Boundaries are sometimes perceived as rigid, permanent doctrine rather than a fluid process of negotiation according to what is in the best interests of the client, taking

into account the personal idiosyncrasies of the clinician and the theoretical model applied. The goals of empowerment and recovery for those with a serious psychiatric disability require a different size playing field than the goal of personal insight in a relationship based on psychodynamic assumptions. Further, a person who has traveled some distance in recovery, to the point of employment as a caregiver, requires a very different size playing field: one that will enhance integration as a staff member in the organization. A person more seriously disrupted by their disability would need a smaller playing field with more structure and clarity about role to provide support and safety in relation to therapeutic needs. The “closed” boundaries discussed above restricted the consumer staff member’s opportunity to participate in an activity offered to all other staff, regardless of her capacity to participate appropriately. The clinician was likewise restricted from collaborating with his client to assess the potential impact of her attending the social event.

Finally, the clinician and the consumer-staff member were approaching the dilemma in isolation. The changing assumptions of helping – recovery, empowerment, and strengths based approaches – promote new challenges to clinicians and consumers in regard to the nature and boundaries of the relationship. Those changes must be discussed openly between clinicians and clients, between clinicians, supervisors and administrators, and between peers in both groups. Collaboration and dialogue are very useful in negotiating ethical dilemmas. Through sharing the dilemma of changing boundaries, practitioners and clients increase the resources for support and the options available to consider. Collaboration decreases the sense of isolation for therapist and consumer-provider and enhances the ethical-reasoning process through including multiple

perspectives (Manning, 2003). Collaboration among and between different individuals with different roles also has an impact on the organizational system. The system is helped in reforming traditional boundary requirements that are no longer relevant, and is accountable for providing the support necessary to clinicians and consumers in relation to changing roles and the subsequent change in boundaries.

Dual Roles and Injustice

Consumers who are perceived as staff in one situation and a recipient of services in another often experience dual role strain, and sometimes injustice. It is difficult “to have one foot in two camps.” This discussion about mental health consumers, supported employment workers, mental health staff, and economic justice helps illustrate the complex hierarchical structure within the system.

The supported employment program employs Carla, who works in medical records. Some consumers think she has staff status because her job is located at the mental health center, but the system (her supervisor) has made it clear she is not a staff member. Luis drives the van and picks up consumers living in three different counties who come to the Clubhouse. He is paid for the time he spends transporting clients to and from the program, but not for time spent at the Clubhouse when he becomes a “recipient of services” for several hours.

One evening after a field trip our group of seven stopped at a restaurant for dinner. Two mental health staff members (the organizers of the trip) took turns driving the agency van. They would be reimbursed for their meal because dinner was part of their workday. The two consumers, Carla and Luis, each paid for their

own meal. They are a part of the supported employment program, sometimes perceived as staff by other consumers, but on this day they were “recipients of services.” Also on the trip were two consumers who were not employed by the system, and myself, a consumer and former staff member. On this day I was considered a “recipient of services” although I played the same support role I did when I was employed as a group facilitator.

This realization about the complex hierarchical structure came to me when Carla commented, “I don’t get my meals paid for when I go on trips.” The blurred roles sometimes make it appear that she is a staff member working at the mental health center, although she doesn’t have the same privileges as staff. The impact of these dual roles on supported employment workers is not recognized, acknowledged, or discussed. The system has created complex rules in an attempt to be fair to everyone, but many consumers, not to mention some staff, do not understand the rules. Most consumers do not understand how the system works and what place they have in the hierarchy.

In the above scenario, the organizational system promotes powerlessness for consumers through a confusing blend of therapeutic programs (supported employment) and agency needs (medical records staff). In the business world, a consumer with a disability can be hired and given reasonable accommodations to do the work successfully. Consumers who hold regular staff positions that are labeled as “supported employment” may not be eligible for benefits that would be ascribed to any other person in that role. This becomes a social justice issue of fairness in the distribution of goods and benefits acquired through employment. Agencies must evaluate carefully the distinctions

between supported employment and regular staff positions, particularly in light of economic consequences to consumers, who already experience poverty associated with their condition.

In addition, a deficit ideology or “blame the victim” mentality may be underlying issues of hiring, and distinctions between regular and supported positions. Psychiatric disability as a deficit has been pervasive in research, theories, and intervention models of the mental health system. Phrases such as, “lack of skills, lack of work histories, lack of interpersonal or daily living skills, lack of symptom control, [and] lack of compliance with medication” reflect a focus on what was missing, rather than a strengths based assessment of what could be mobilized to help (Rapp, Shera, & Kisthardt, 1993, p.728). Mental health systems can reinforce strengths and empower consumers through hiring practices that recognize each individual’s assets and integrate consumers into the workforce as legitimate staff members whenever possible.

Administrators and clinicians, in collaboration with consumers, must revisit organizational design and policy strategies to encompass the changing roles of consumer employees and to accommodate the complex blend of therapeutic and organizational issues. Policies that guide decision making in regard to salary, benefits, reimbursement for travel expenses, etc. must be reviewed in light of the changing roles and the economic justice issues therein. Clarity about inclusion in staff meetings, access to the agency facility (e.g. keys), and other ambiguities can be discussed openly and incorporated into policy and procedures to provide support to providers and consumers in all of their multi-faceted roles.

Evolving Roles

Roles and responsibilities change as clients become employees, then resign, and re-emerge in consumer roles. The episodic nature of a serious psychiatric disability is such that a consumer may have symptoms re-occur periodically and need some form of support throughout the recovery process (Anthony, 2000). Symptoms do not prevent recovery, however. Although roles change (e.g., from staff to consumer and consumer to staff), everyone in relationship with that person may continue to view them through the lens of the former role. Additionally, consumers may find themselves in roles that have been outgrown, or are not reflective of current strengths and abilities.

I became a member of a supported employment work crew after an extended leave following many years as a consumer case manager. I was unable to regain a case manager position, and supported employment was the only option. My supervisor was blind to my real strengths; my experience and understanding of what it means to live with and recover from a major mental illness. One Wednesday afternoon I was assigned the task of hanging mini-blinds; the little corner brackets and tiny screws frustrated me. At the same time I was attempting to hang the window shades, a staff member (who is not a consumer) was leading a group discussion about wellness and recovery. In his attempt to entertain, educate, and stimulate the group he was making up extreme examples of things a person might do that could trigger symptoms of mental illness and land a person in a locked psychiatric ward. With my background in recovery I felt a strong desire to participate in the discussion and provide relevant and useful information to the group, but my position with the work crew did not give me opportunity to interact with the group.

I felt torn between what I am capable of doing and can do well and the task I was assigned to do. I felt angry, but did not feel I could express it. I believed that if I just “hung in there” and kept doing my job, if I endured, I would once again be recognized for my skills and allowed to share my knowledge of healing and recovery with others. I was put into the box with other people who have been diagnosed with a mental illness and are expected to learn basic job skills. My skills as a group leader were no longer acknowledged, and I could not find an avenue to resolve the oppression I felt. I was not a staff member, and I was instructed not to do things that would lead other consumers to believe I had the role of staff, although most related to me as if I was staff. The mental health center with all its policies, rules, and regulations was right and I was disempowered.

As a consumer I learned not to express anger. The anger gets turned around and pointed back as your personal problem rather than being perceived as an expression about a dysfunctional program with rules that need to be reviewed and revised. My supervisor could not see me as an individual with the ability to help others on their path of recovery. I was a consumer who needed to be managed. I had the power relevant to my diagnosis and membership in the supported employment work crew. In addition, I realized that when I returned to work at the mental health center the structure that allowed me to do my job no longer existed. I did not have access to office supplies, keys, and a place to work. The support I once had from other staff members did not exist.

There are several considerations apparent in this complex situation – access to appropriate roles, provider perceptions, learned helplessness, and restricted opportunities

for consumers. First, the consumer did not have access to a role appropriate to her existing skills, strengths and experience. The paucity of employment options in this rural area left her with no option except supported employment. The agency did not utilize her existing skills and strengths from her previous case manager experience in the supported employment role. Her ability to act as a role model to other consumers, because of her success in the recovery process, was inhibited by the lack of vision of providers and the agency's narrow perceptions of employment possibilities.

The consumer label also becomes the interpreter of feelings and behaviors. If a consumer is angry, or expresses anger, it is because of the diagnosis, the condition, rather than a human expression relevant to the situation. "If you verbalize a problem with the way the system treats you, it is easily turned around and made into a personal problem. If you are honest in expressing your anger it can be the cause of additional labeling. This creates an environment where consumers learn not to express their feelings, because it isn't safe" (personal communication, Van Pelt, 2003). The process of labeling – the caregiver as expert applying the label to the consumer – accentuates the experience of "power over" the consumer and inhibits meaningful communication between providers and consumers (Manning, 1998).

In addition, powerlessness is reinforced by the learned helplessness experienced in a person's history with the mental health system. Deegan (1992), an expert on consumer experience, notes that consumers often experience a personal sense of fear and a pervasive sense of helplessness. These feelings emanate from the history of being acted on by mental health institutions and judicial systems. Involuntary hospitalization, forced medications, shock treatments, lack of self-determination in treatment planning, and the

absence of adequate informed consent processes have reinforced the consumer's lack of control over major events and choices in their lives (Manning, 1998). One consumer noted that consumers "tend to be totally intimidated by the system...[which wants] to break their will to change their behavior" (Manning, et al., 1994, p. 44). The therapeutic process is often experienced as something more like behavior modification than support to recover.

Institutions also can create a dependency on the part of consumers (Chamberlain, 1978; Deegan, 1992). Compliance and adaptive behaviors are encouraged in hospital and community treatment programs. While these behaviors are conducive to institutional treatment, they are least effective for self-determination and community living (Manning, 1994). Deegan (1992, p.12) identifies consumers' lack of self-determination over their lives as a "central attitudinal barrier." Learned helplessness develops as a result of consumers getting the message that they cannot make choices about their lives because they do not have the capacity to think and to reason. Thus, "a process of dependency, irresponsibility, and despair..." develops. Consumers become "experts in being helpless" and the attitudinal barrier is reinforced by the same system attempting to help them. (Manning, 1998, p. 91).

These issues are magnified in rural areas where the nature of the community is the context for helplessness. The increased social isolation of individuals because of their condition, their economic circumstances, and restricted opportunities promotes increased fears and distorted perceptions. In addition, the scarcity of mental health resources causes consumers to feel like a "captive audience," where they must adapt to the service system's requirements and the perceptions of providers or risk loss of services altogether,

since there are no other alternatives. One of the solutions to this ethical risk is the development of a flexible and extended continuum of care.

Continuum of Care for Rural Mental Health

Rural mental health providers are challenged to develop opportunities for growth and empowerment and to extend the continuum of care for consumers who are moving through the recovery process and functioning at a high level. Traditional programs for consumers are not adequate for the recovery model (Anthony, 2000). Anthony (2000, p. 159) defines recovery as:

A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability. (p.159)

Consumers who outgrow supported employment and clubhouse programs find that competitive employment becomes their only option. Providers expect that people who are well should move on to competitive employment in the community, but suitable employment is not always available and community placement and integration does not work for everyone. Further, the social isolation increases as recovered consumers find fewer peers who are at the same level of recovery.

This is what I have such a difficult time describing because it is so invisible to the outsider – to have experienced the extreme of being so sick that I was locked up for mental illness – then to grow in recovery and wellness to the point that my illness is invisible. That doesn't mean the illness does not exist; it only appears non-

existent. Like a dancer, an actor, or a painter makes his art look easy, effortless – it only appears easy and effortless due to the years of work and training prior to the performance or painting.

At this time I was experiencing symptoms of my bipolar disorder, feeling pressured, experiencing insomnia, and the increased anxiety and questions of self-worth that go with seeking employment and receiving rejection letters. I know how normal and capable I appear to the outside world. My history was speaking to me. I could not ignore my internal reality - knowledge of my past hospitalizations triggered by stress. I felt the external pressures that I should be positive and move forward, and the overwhelming external expectation that I should work. I felt extremely vulnerable, the reality of my limits (that I can't always verbalize but I know from experience) conflicting with outside pressures to face the stress of everyday responsibilities. The mental health center offered no support for my situation. The new vocational program focused on minimum wage labor for consumers who receive SSI or SSDI benefits. As a former employee with job skills I was expected to move on with my life and be independent.

I was sent out into the world to experience competitive employment, as the mental health center did not have the support services that meet the needs of consumers who are capable. I was seen as regular, normal, healthy – rather than a person who has recovered from a serious illness. The support I received from sharing the gift of recovery with other consumers seemed irrelevant to administrators. After twenty years of receiving services and ten and a half years as a service provider, it was like coming to the edge of a cliff and then a sudden drop. It was like I had outgrown what the family could provide for me. But there was no gentle transition; no time to develop wings. I was out.

The landmark research by Harding and associates (Harding, Brooks, Ashekaga, Strauss, & Breier, 1987a, 1987b; Desisto, Harding, McCormick, Ashikaga, & Brooks, 1995a, 1995b) has provoked a new way to think about psychiatric disability –recovery is possible and a progressive deterioration is not the norm. Rather, environmental and social factors interacting with the individual have an impact on the potential for recovery from a serious psychiatric disability. This research (conducted over three decades) promotes the necessity to develop continuum of care opportunities that provide meaningful activities and employment possibilities for consumers at every level of functioning. Leadership must incorporate the vision of recovery in all planning, policy, and practice efforts in order to design a continuum of care for rural mental health.

Anthony (2000, p.163-64) argues:

Recovery is such a paradigm shifting notion that its fundamental assumptions and principles must constantly be reinforced. Recovery is a vision incompatible with the mission of the mental health system of the past century. The leadership must demonstrate through their words and actions that they and everyone else in the system need to ‘buy in’ to this dramatically new direction. (pp.163-164)

Social workers, with consumers, can assume the necessary leadership for this change in paradigm. The first step is a change in attitude. Expanding the continuum of care to accommodate consumers ready to transition from mental health institutions to full integration in the community requires new attitudes as well as new programs and activities. Recovery program activities will follow the changes in attitude. The following steps are useful in promoting the paradigm of recovery.

Awareness of the Recovery Process

Recovery is a process that is inextricably connected to relationships with other consumers, and to employment. The loss of employment through a mental health system is tremendous -- like losing an entire family. In the previous discussion about competitive employment, the administrator's expectation to move on and get a job in the community reflected a lack of awareness. She acted as if illness was not a factor and no longer existed; if illness did not exist, then recovery did not exist. Everything to sustain recovery had to be rebuilt independent of the system whose goal it is to help people recover.

Programs are strengthened when providers and administrators recognize and acknowledge the history and experience of consumers. The awareness of a developmental process of growth, rather than "starting over" is necessary. It is important to have a place for new people entering the system, but just as important to save room for those with more experience. Consumers and others with the interest and ability to work in the system, should be invited to participate in discussions about programs and in orientation of newcomers -- both staff and consumers.

Acknowledge and Address Recovery

Mental health programs need another "rung on the ladder" to promote wellness. Consumers who have achieved a level of wellness get "burned out" and quit attending Clubhouse or other recovery programs. The program no longer meets their needs and frustration develops in regard to the lack of relevant opportunities for growth. An inadequate continuum of care promotes the expectation that consumers should be satisfied with program offerings even those that are uninspiring and irrelevant to their level of functioning.

The needs of consumers change through the process of development. Individuals at a higher level of recovery are able to nurture others, but no one is nurturing them. These consumers would benefit from role models that are successfully navigating the trail to recovery. For example, a support group of peers – people who are experiencing the same challenges and are ready for the next step – would be helpful. In rural areas there is less availability of support groups in the community, separate from the mental health system, and these should be a priority as part of a continuum of care.

Further, supported employment or underemployment in the community is all that is available. In rural areas, there are simply not enough job opportunities. Systems must focus on the development of consumer roles and program offerings that provide the link between the system and the community. One of the standards of a recovery model is consumer involvement in the system (Anthony, 2000). Consumers and family members should be targeted for potential recruitment for all positions available in the system, as well as voluntary service on boards and committees. In addition, consumer-run programs and groups should be promoted and available for consumers at all levels of recovery.

Success stories seem to disappear without acknowledgement *as if success never happens*. Only the people with the most serious illnesses are being served and the ones who are better disappear. Wellness needs to be recognized and celebrated. The loss of the voices of wellness creates a void in role models for recovery, so necessary for others to learn from and to create hope. Providers can recognize individuals who are more integrated into the community and learn from their successes. The recovered individual has something to offer other consumers. This is often recognized by other consumers, but is not always so visible to providers. Conversely, providers rely on only one or two

consumers for leadership. These individuals are asked to take a leadership role in every activity, every committee. The consumer who is skilled but not compensated often becomes burned out - the bright light of the meteor rising in the sky and then burning itself up (Manning, et. al., 1994).

The fence between “consumer” and “staff” is becoming more difficult to maintain as the level of education and expertise among consumers increases. The lines blur, and the boundaries the system has created to protect against liability, combined with traditional professional socialization, become barriers to recovery at the highest levels. The step of incorporating a higher degree of wellness stresses staff and existing programs. Staff members have a particular role within the system defined by job descriptions and supervisory practices. In the Clubhouse environment, staff might empower a consumer through the opportunity to volunteer for work that is within staff responsibilities. However, when the quantity and quality of a client-consumer’s work justifies a paid position, conflict arises with the agency. The consumer may then be pushed out. The process of recovery must be acknowledged by staff, administrators, and consumers in order to be addressed. Perhaps a new organizational metaphor is needed, continuum of care as a circle, inclusive of everyone, rather than a linear or hierarchical structure.

Develop Collaborative Partnerships

Collaborative partnerships between consumers and professionals require the redistribution of power. Divisions that develop between staff and consumers are disheartening to all involved. Experts on consumer empowerment (Chamberlain, Rogers, & Sneed, 1989) aptly state:

The line between those who give help and those who receive help has become deeply engraved, like a trench . . . as I write these words it is difficult for me to imagine how true collaboration could take place between such unequal partners. (p.93)

Consumers reach a level of recovery that requires the redistribution of power. The recovered person sometimes has skills that are equal to or surpass staff in assisting recovery in others. Providers benefit from exerting power through positive action, feeling responsible, and engaging their talents in the therapeutic process with consumers. However, the power of providers can become an obstacle to the empowerment of consumers (Manning, et al., 2000). As long as consumers are dependent and needy the perception is that they can be helped, but when they grow beyond dependency they threaten the system. Thus, a system of recovery requires the ability of providers to use their talents in the service of sharing power.

First, providers and consumers have to acknowledge that an inequality exists. Consumers may feel less access to power while staff perceives an equal sharing of power. For example, staff will say, “It is your Clubhouse,” while decisions are made in meetings when consumers are not present. A clubhouse meeting to discuss issues may result in the staff thinking the issues are resolved, but consumers have a different experience. Consumers end up feeling oppressed. Meanwhile issues of power and control are not resolved.

Collaborative partnerships require dialogue, trust, and participation. The most important lesson from a partnership experience is the ability of professionals to “learn to let go of power gracefully” (Manning, et al., 2000, p. 132.) Empowerment requires the opportunity for consumers to address problems themselves, whether the outcome is a success or a mistake. In turn, consumers can only share power by assuming increased responsibility, which requires enhanced skill building and access to information and knowledge. A partnership model is not “open season” for all decisions for consumers or providers. Rather, there are “various decision-making arenas” that are appropriate and relevant to consumers and to providers (Manning et al., 2000, p.131). Consumers should have access to decisions regarding policy and program while professionals are responsible for clinical decisions that meet professional standards. The feedback from consumers in a collaborative process is crucial to determine the consumer experience of those standards. In all events, those impacted by the decision should have the opportunity to participate through dialogue.

System and Structural Change

Recovery and empowerment of consumers requires an “innovative shift” in the way the mental health system works with staff and consumers (Manning, 1998). A paradigm shift is necessary. The structure of the system often precludes access to resources, opportunities and decision-making power, and mental health systems are high in “structural inequalities” and “resistance to change” (Swift & Levin, 1987, p. 77).

First, as was noted in the discussion about dual relationships, structures and processes that promote dialogue among and between consumers, staff, and administrators are critical. Participation in the decision processes of the organization by all stakeholders

promotes self-determination and provides feedback to decision-makers about the complex issues developing through the changing roles, needs for service, and environmental contexts that affect relationships. Administrators are essential for this interaction, because without their support and agreement, system change cannot happen. Consumers must be involved in order to experience ownership of the decisions and enhance the opportunities for self-determination. Providers are in dire need of support to enact the necessary program, role and relationship changes that facilitate recovery. Consumers should be active participants in all major functions of the organization, including planning, program development, policy development, budget decisions, and evaluation (Manning, 1999).

Next, policies and procedures of the system can be reorganized to support risk-taking that is necessary for empowerment of consumers and staff. Townsend (1998) recommends contracts that encourage providers and consumers to critically reflect on the risks of partnership, discuss the nature of the risks, and work collaboratively on problem-solving the risks. Together consumers and providers can educate each other on the ethical implications of changing roles and boundaries, and make recommendations for policy.

Mental health institutions can re-structure budgets and re-consider priorities in order to respect the diverse contributions offered by consumers through experiential knowledge (Townsend, 1998). Thus, consumer-run programs, peer support groups and peer coaches could be reimbursed for their skills. This creates new levels for the continuum of care for consumers of service, and for consumer providers of service.

Finally, all stakeholders in the mental health system and in the community must re-examine attitudes about psychiatric disability. The landmark legislation passed in 1990, the “Americans with Disabilities Act” mandated that people with disabilities not be required to be normal in order to participate in the ordinary activities of everyday life such as working, playing, traveling, etc. (Davidson, et al., 2001). What is necessary for those activities are that people be capable of performing the essential functions, with some reasonable accommodations. Thus, “although we know that this impairment is not going to go away anytime soon, you still have the talents, strengths, skills, or even potential, to make a worthwhile contribution that justifies the extra effort or expense involved” (Davidson, et al., p. 378). Mental health systems must find innovations that provide opportunities to consumers to be “let in to their communities of choice *even while they remain disabled* [italics in original]” (p.386). Therefore, the focus of the system must be on developing the community and integrating mental health services into the community. Consumers in rural communities need “the cultivation of ‘mediating structures’ that cut metaphoric curbs into the social sidewalks of the mainstream community” (p. 386). Providers and consumers at all levels of recovery can share this endeavor.

Conclusion

Social work in rural mental health, to borrow a phrase from the actress, Betty Davis, is not for sissies. Rural mental health systems tend to lag behind mainstream, urban systems of care, and, thus, have less experience with the newer innovations. Leadership in initiating new models of care and the associated role changes is necessary.

Rural health care requires commitment, leadership, and creativity. Beyond those abilities and characteristics, a belief in empowerment, the strengths and capacities of consumers, and the recovery process is essential. Social workers are well prepared in terms of knowledge and skills to do this work.

The emerging paradigms of empowerment, recovery, partnership models, consumer activism and self-determination require a redefinition of professional boundaries and personal disclosure; an “unfenced range” where the necessary fences are negotiated, fence by fence (K. Grombacher, personal communication, July, 2003). The traditional norms and standards do not facilitate the therapeutic activities and relationships necessary for community support and recovery, particularly in rural mental health service systems. Yet, new standards and norms have not been clearly delineated. Changes in mental health service delivery have placed different expectations on providers to “exercise independent judgment and to ‘do the right thing’ ” without direction, supervision, or defined norms and rules (Curtis and Hodge, 1994, p. 15). Practitioners tend to exercise judgment based on past training and experience, which may lack an understanding of the new paradigm of care. Therefore, practitioners are “on their own” in defining what is ethical and therapeutic in regard to the dual role relationships they encounter in the rural service system. Forging a partnership between consumers, providers, and administrators is a first step toward solving these challenges in rural service delivery. Further, the results of this collaborative relationship will contribute to new ways to understand the above dilemmas.

A homeless man, overhearing a discussion about dual relationships at a homeless shelter, chimes in and asks, “What are

dual relationships?” And I think I can’t possibly explain how complex this is, so I try to come up with a simple explanation. And immediately he understands, shakes his head and says, “We all have to help each other out.” At first I think, “No, you don’t understand at all how complex this is...there are all these levels, all these facets, all these boundaries and rules and ethics.” But I let it go and didn’t try to explain any more. In the days following this exchange I thought about what the homeless man had said. It seemed like maybe it is as simple as reaching out to each other and listening to each other. I can travel this complex maze, as I have, through systems, and academia, and come up with a truth about the need to collaborate. Or, I could skip over all the complex stuff and still have the same simple truth about the importance of listening to each other with compassion and empathy; listening to more than the words, listening with the heart.

“We all have to help each other out.”

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