

Database:

Health Source: Nursing/Academic Edition

ADDRESSING THE SOCIAL NEEDS OF MENTAL HEALTH CONSUMERS WHEN DAY TREATMENT PROGRAMS CONVERT TO SUPPORTED EMPLOYMENT: CAN CONSUMER-RUN SERVICES PLAY A ROLE?

Rehabilitative day treatment programs offer significant social opportunities to mental health consumers. Community mental health centers choosing to convert from day treatment to supported employment must decide how to respond to the loss of day treatment social activities. This paper describes the potential role for consumer run services.

INTRODUCTION

Many community mental health centers (CMHCs) are converting from rehabilitative day treatment programs (DT) to supported employment (SE) programs. Conversions entail a social loss for consumers, since DT programs typically provide meals, an accepting social environment, and structured social activities including parties and outings. Two years after one CMHC shifted from DT to SE, consumers, staff members and families consistently identified the loss of social opportunities as the primary negative consequence (Torrey, Becker & Drake, 1995). This paper describes how several CMHCs have attempted to meet the social needs of consumers since converting from DT to SE.

Experiences

The authors interviewed local consumer leaders and key administrative leaders from three CMHCs that have converted from DT to SE. The interview elicited the ideological and practical approach that each CMHC adopted when addressing the perceived social needs of consumers.

A common aim. All the interviewed CMHC leaders had a similar long term vision for meeting the social needs of consumers. They hoped that, in time, consumer-run services would develop to offer social opportunities to consumers and that the CMHC role would

be limited to teaching consumers social skills and linking consumers to integrated, community-based, social offerings. Consumer-run services were not, however, available in any of the local CMHC communities at the time of DT closure. Consequently, while trying to facilitate the development of consumer services, CMHC leaders had to decide whether to provide social activities run by professionals.

Early experiences. All the CMHCs opted to offer some social programs when they closed DT. One CMHC tried to minimize the impact of DT closure by continuing to provide the purely social segments of their DT program. This CMHC offered lunch at the DT site, employed a consumer to organize evening and weekend outings, worked with local churches to create social programs, and provided van transportation to consumers for the events. The social events continued to be well-attended years after DT closure.

Other CMHCs stopped providing organized social occasions, instead arranging for drop-in centers where consumers could gather when not at work. To emphasize the program change, the drop-in centers were in donated church space, not at the former DT site. The drop-in centers were staffed by CMHC staff members and volunteers who, wanting consumers to create the program, did not actively structure the time. Consumers, accustomed to DT, looked to staff members to provide activities. Attendance dwindled over time and, at one CMHC, the drop in center closed after 6 months.

Several CMHCs attempted to link the SE focus of their programming with the social needs of consumers. One CMHC held periodic vocational banquets in which the vocational achievements of consumers were announced and celebrated. Another CMHC hired a consumer to bring peers together to discuss topics such as "coping with work" and "recovery skills."

Later experiences. All the CMHCs found it challenging to facilitate the development of consumer-run services. At one CMHC, more than 4 years after shifting from DT to SE, efforts to create consumer-run services came to fruition. Ingredients that led to active, well-attended consumer-run services included dynamic consumer leadership, state financial support, and technical and political support from the state and the CMHC. Consumer leadership contributed an inspiring vision of future possibilities, a collaborative style which engaged consumers and CMHC staff members, and a sustaining passion for the work. Funding covered the costs of a nondepressing environment and paid the consumer leader a competitive salary. Critical technical and political support included advice on structuring the corporation, administrative coaching, and strong advocacy at the state level.

Consumers believe that a key to the success of the service has been its focus on supporting recovery: the service encourages and supports individuals to move ahead in their lives. The clear mission has helped build an environment of hope and high expectation. Mutuality in relationships and personal responsibility for behavior are highly valued while passivity and dependence are seen as old, understandable ways of being that people can learn to overcome. Social activities are not the primary sustaining purpose for the service but flow out of the larger mission.

Consumer-run services are now a separate corporation from the CMHC, reporting to their own board of directors. Consumers gather informally at the sites or participate in organized activities, including groups on "living with distressing voices" and "therapeutic drumming." At this site, consumers also operate a crisis respite program designed to help each other get through stressful periods without hospitalization.

The social impact of DT closure over time. At all the CMHCs, leaders gave examples of individuals who are more socially involved in their communities since the shift to SE, either through new work connections or closer community engagement. Still, leaders believe that a small number of consumers, particularly those with severe depression, negative symptoms, or poor physical health, have difficulty initiating action and may suffer socially. Active outreach and individual attention by clinicians, vocational specialists, and consumers minimizes the potential negative social impact of DT closure.

DISCUSSION

The recovery ideology makes the goal of CMHC services very clear: encourage and support each consumer in his or her effort to minimize the negative impact of mental illness and to move ahead with life. The conversion of DT to SE is a natural outcome of a shift from a support and maintenance ideology to a recovery ideology for mental health services. Instead of dedicating resources to DT, which provides a supportive enclave for consumers, CMHCs support consumers in their efforts to obtain and maintain integrated, competitive employment and other normal adult roles in their communities. With the shift in ideology, the role of CMHC staff members no longer centers around protecting consumers from stress in an effort to prevent relapse and declining functioning. Staff members, instead, become a resource dedicated to the recovery of those they serve. They instill hope, encourage positive risk taking, and use their knowledge and experience to help consumers effectively meet their life goals (Torrey et al., 1998).

The same ideology that drives CMHCs to convert DT programs to SE leads to consumer-run services as a solution to the loss of social opportunity. Consumer-run services have been reported to address the social needs of consumers in many locations throughout the country (Kaufmann, WardColasante & Farmer, 1993; Mowbray, Chamberlain, Jennings & Rees, 1988; Mowbray & Tan, 1993). To be consumer-run, however, the services cannot be directed, created, and run by CMHCs. Rather, CMHCs must play a role like that of community organizers in disadvantaged communities, nurturing the growth of consumer-run services by supporting the change process without controlling it (Freund, 1993; Rubin & Rubin, 1992).

The transformation from DT-supplied social opportunities to consumer-run programming is challenging to actualize. Both consumers and staff members are accustomed to the idea of active staff members providing protective and nurturing social opportunities to consumers who are considered vulnerable. Several CMHCs discovered that when DT closes, consumers do not immediately organize an attractive, active, social environment in borrowed, CMHC-staffed space. Rather, they tend to wait for the staff to recreate a DT environment or stop participating. Services that are operated by CMHCs or churches fall

short of the potential empowering benefits of services that are actually operated by consumers (Mowbray & Tan, 1993).

Because the development of consumer-run services takes time and depends on many factors, such as securing funding and identifying strong consumer leaders, which are beyond the immediate control of CMHCs, successful consumer-run social opportunities are often not in place when DT closes. CMHC leaders face difficult decisions. Putting significant resources into providing social opportunities attracts consumers but maintains an organizational structure in which the CMHC continues as the active parental agent and consumers continue as relatively unempowered recipients.

Recovery-oriented consumer run services, when developed, can offer significant social benefits. Relating to others who have suffered similar painful experiences is a critical element in the recovery of many consumers (Deegan, 1988). CMHC staff members with the inherent constraints of their professional roles, cannot match the social opportunity and deep human connectedness that consumers can offer each other. Consumer-run services extend and compliment professional CMHC services. Though difficult to establish, they have life-transforming potential.

REFERENCES

- Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 11(4), 1-19.
- Freund, P. D. (1993). Professional role(s) in the empowerment process: "Working with" mental health consumers. *Psychosocial Rehabilitation Journal*, 16(3), 65-73.
- Kaufmann, C. L., Ward-Colasante, C., & Farmer, J. (1993). Development and evaluation of drop-in centers operated by mental health consumers. *Hospital and Community Psychiatry*, 44, 675-678.
- Mowbray, C. T., Chamberlain, P., Jennings, M. & Reed, C. (1988). Consumer-run mental health services: Results from five demonstration projects. *Community Mental Health Journal*, 24, 151-156.
- Mowbray, C. T. & Tan, C. (1993). Consumeroperated drop-in centers: Evaluation of operations and impact. *Journal of Mental Health Administration*, 20, 9-19.
- Rubin, H. J. & Rubin, I. S. (1992). *Community organizing and development* (2nd ed.). New York: MacMillan.
- Torrey, W. C., Bebout, R., Kline, J., Becker, D. R., Alverson, M., & Drake, R. E. (1998). Practice guidelines for clinicians working in programs providing integrated vocational and clinical services for persons with severe mental disorders. *Psychiatric Rehabilitation Journal*, 21(4), 388-393.

Torrey, W. C., Becker, D. R., Drake, R. E. (1995). Rehabilitative day treatment vs. supported employment: II. Consumer, family and staff reactions to a program change. *Psychosocial Rehabilitation Journal*, 18(3), 67-75.

~~~~~

BY WILLIAM C. TORREY, SHERY MEAD & GEORGE ROSS

WILLIAM C. TORREY, MD, IS MEDICAL DIRECTOR OF WEST CENTRAL SERVICES, ASSISTANT PROFESSOR OF PSYCHIATRY AT DARTMOUTH MEDICAL SCHOOL, AND A RESEARCH ASSOCIATE OF THE NEW HAMPSHIRE-DARTMOUTH PSYCHIATRIC RESEARCH CENTER, LEBANON, N.H.

SHERY MEAD, MSW, IS DIRECTOR OF STEPPING STONE AND NEXT STEP PEER SUPPORT CENTERS, CLAREMONT AND LEBANON, N.H.

GEORGE ROSS, BA, IS ASSOCIATE DIRECTOR OF HOSPITAL AND COMMUNITY AFFAIRS, WEST CENTRAL SERVICES, LEBANON, N.H.

~~~~~

By WILLIAM C. TORREY; SHERY MEAD & GEORGE ROSS

Copyright of *Psychiatric Rehabilitation Journal* is the property of Center for Psychiatric Rehabilitation and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.