Treatment Plan for Clients of Vocational Centers And Special Care Residential Units

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ABSTRACT: This paper explores the possibility of using panels to trace the history of a client's right to quality life. The distinguishing mark of this approach is that the client is viewed in the perspective of becoming more truly personal rather than on being human. The focus is on relations. The three streams of associations that make us who we are exist at the level of psyche, other persons, and the environment. That approach to client care allows us to fine tune the fragile ratio of client needs to staff resources. The process is illustrated through the development of a treatment plan for an adult female resident exhibiting bipolar disorder and paranoid schizophrenia.

Human nature. Walter Kirn's essay on the back page of the September 16, 2002 issue of Time magazine criticizes Dr. Michael First, an associate professor of psychiatry at Columbia University, for suggesting that "There is evidence that relationships and how people interact in particular relationships can be discovered in a way that's very similar to mental disorders." Kirn wonders if psychiatry hasn't gone nuts; how do you treat a Relational Disorder, or RD "as it will inevitably be referred to on daytime talk shows, …" What makes the diagnosis controversial, he says, is that a relationship can't make an appointment, or what if only one person shows up for the appointment, or "if they both come, what if only one feels poorly"?

Kirn is right if First's point is that persons have relationships. But what if we turned things around? Rather than think of persons as having relationships, why not think of persons as being the output of relationships? The problem with the Cartesian view of relationships (and Kirn's criticism) is that it introduces a dualism between the self and relations. We think the self underlies experiences, but we can never point to it as "I", "subject", or "ego" without invoking those experiences. However, the view of the "I", "self" or "ego" as arising out of associations offers a direct way of dealing with the subject of experiences.

The distinction between being a person and being human makes the point. While it is true to say that all persons are human, it is not the case that all humans are equally personal. We become personal through our associations, some freely chosen, others determined by heredity and environment. The advantage of working with a "person-making" process (henceforth P-M) rather than with a static view of human nature is that the process perspective allows us to monitor and regulate the associations that define clients. So what makes humans personal? We appear to be characterized by three main types of associations. The first arises at the level of a psychological self, while the second and third stream of P-M associations take place at the level of other persons and the environment, respectively.

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Entrusted care unfolds as a process rather than as an event. Staffs can monitor the associations that make us persons and adjust the fit between a course of action and a client's basic rights. The psyche includes a review of a client's natural tendency towards good and evil, the client's reasoning abilities, and all psychological states such as happiness or sadness. Thus staffs can monitor proposed action to maximize the client's psychological state of happiness. The second window to becoming more personal is the social self. We need others to become who we are. The quality of the social self depends on the ethical nature of personal relationships. The failure to treat others as ends is an affront to their dignity as well as a missed opportunity to become more personal. The social self exists as the output of loving and non-loving relationships. Love promotes unity, while lack of love generates disunity. The more individuals empower each other, the greater the unity between them. The third connection to becoming more truly personal exists at the environmental level. The point of this maintenance step is that persons form an organic whole with the environment. In the same way that others constitute an extension of the self, so the environment plays a role in defining who we are. Thus a healthy environment contributes to the integrated life of a healthy person. Dirt and clutter are more than skin deep. Pollution promotes dualism. It invades and divides being personal.

Staffs use the model to express and safeguard client rights. The rights of clients are filed into one or more of the three P-M outlets. Whenever a client is out of sorts, the conditions affecting the client can be sorted and remedial action taken. In this task, staffs navigate between the universal character of human rights and the particular conditions that put those rights at-risk. Client rights are relative to circumstances. A human right is always expressed in the shifting sands of particular conditions, but P-M allows us to see the push and pull of principle and practice in clear light. For example, while a mentally challenged client has a right to confidentiality and privacy, that right is expressed through others. This situation limits that client's right to staff's interpretation of what the right entails. The associations between the push and pull of rights and resources are expressed on the arms of P-M. The issue is how the client's right to privacy (staff's interpretation of that right) plays out on the arms of psyche, other persons and the environment? Conflicts light up the arms of P-M. The traditional model of being human lacks that transparency, while the proposed model readily identifies possible sources of action. For instance, if the client is unhappy, nasty towards others, or uncomfortable in an environmental setting, it might be that the push and pull of the client's right to privacy is poorly expressed. The model provides a process to scrutinize the associations that make us persons. It functions as guard dog, pointing to a possible source of conflict. Once a possible conflict is identified, the role of in-house administration is to redesign associations to better protect the rights of vulnerable clients.

The Panels. Panels serve as a map. They provide a synoptic view of a client right. The key panel is number four –the practice panel—since it expresses a summary of the associations that define a client. Practice arises as the outcome of a synthesis between theory and circumstance. In practice, everyone's right to quality life is tempered by particular conditions. So the panels provide a glimpse into the history of a client's rights. For instance, a client's right to privacy is driven by a demand for the ethical treatment of persons, is given the force of law, and is animated by recent developments in relevant disciplines like psychology and religious studies. At the same time, that right is fettered by circumstances such as the availability of resources. The

push of ethics and the pull of circumstances are expressed in one or more of the three associations that define us. A client's treatment plan is dynamic, changing depending on cultural morality, the availability of fresh resources and the introduction of new circumstances. In this paper, principles of law and psychology are employed to illustrate how the model works. A more detailed log could include additional perspectives such as religious studies (spirituality and religion), biology, chemistry, and political science. At the same time, I have opted to include a brief detail from each of the major ethical theories in this treatment plan, though this generates the possibility of conflict between guiding principles and could be seen as being too permissive by some critics. The basic panel appears below followed by the test case.[1]

One →	Two →	Three →	Four (P-M)	← Five	← Six
Human Rights	Ethical Theory	Law	Psyche Others Environment	Disciplinary Perspective	The Particulars

Test Case: Client Scenario

Background. Young woman in her late 20's who is verbal and has a moderate to mild mental challenge. In her early twenties began to exhibit symptoms indicative of mental illness. She has been diagnosed as having a bipolar disorder as well as paranoid schizophrenia.

Current Status. She currently attends a vocational center through the week. She has had several recent hospitalizations for aggressive self-destructive behavior. She currently presents as very confused and unpredictable. She recently came into her day program and related to staff that she attempted to stab herself in the abdomen with scissors at home. She has also repeatedly told staff that other participants have called her names (slut, whore, and pig). There is nothing to indicate that this is factual. She is very fixated on her father who does not live with the family. He has diagnosed mental illness and at times will promise to visit her and just not arrive. He will also repeatedly tell her to stop talking foolishly or he won't come back to visit her. Mother will also tell her that if she doesn't "smarten up" her father will never visit her again.

While attending her vocational program during the day, she will walk over to the sink to grab a glass of water and pout it on staff, participants, or herself. Regularly after she has had her lunch she will continuously tell staff that she wants to leave and go home. Some of her medication is supposed to be given at noon but mother will not send it to the Vocational Center to be administered. She becomes increasingly agitated, yelling and making attempts to leave the room where staffs are supervising her.

Family Situation. Lives alone with mother. Mother repeatedly changes medications and states all of the current situations are attention getting behaviors, blames "full moon and PMS" for everything. Mother has frequently refused to come to the Center to pick up her daughter when she is very agitated. Has also removed her daughter from hospitalizations earlier than doctors would wish.

Staff Concerns. The client is becoming increasingly agitated, unpredictable, and disruptive to everyone around her. Concern is great that she will injure herself or someone else very soon. She also repeats the same sentences over and over and louder and more insistently. The client's medical and social conditions put her rights at-risk. Only some of the conditions of the client's treatment plan are fixed. The question facing staff is how to act in her best interest,

that is, how to vary the associations that characterize her medical, psychological, and social conditions (bi-polar, paranoid schizophrenic, family problems). In other words, what associations of "push-pull" checks and balances between guiding ethical principles and particulars are in the client's best interest? So we begin with a broad sweep of the guiding principles.

Panel One. Human Rights

Guiding Principles: Vulnerable persons are individuals whose diminished competence and/or decision-making capacity and/or physical challenges make them less likely to be autonomous, have informed consent, or be able to directly input into choices that are in their best interest. The declaration of human rights is based on a belief in the absolute value of individuals and the principle of a just society. The protection of human rights is the cornerstone of a true democracy, one in which free and informed citizens direct their own outcomes through representative government. The challenges facing staffs include becoming more aware of ways in which they might unwittingly discriminate against the client's rights. Feedback loops are put in place to ensure that the client is given the opportunity to input into the decision-making process.

The matter is ongoing. Section 24 of the Human Rights Act of Nova Scotia suggests that training programs be established in human rights; "to develop a program of public information and education in the field of human rights to forward the principle that every person is free and equal in dignity and rights without regard to race, religion, creed, color or ethnic or national origin."[2] The special status of vulnerable persons is clear in Tri-Council Policy Statement: Ethical Conduct For research Involving Humans.[3] But in a world of scarce resources, and a world where mistakes are made, everything involves tradeoffs, a balancing of harms and benefits, beneficence and nonmaleficence (to avoid or minimize harm). Vulnerable individuals are entitled to special protection against abuse, exploitation or discrimination on the grounds of duty-based principles of fairness and dignity. This belief translates into the design of special procedures for the care of residents in vocational or residential settings. We expect high standards of care throughout the system, though treatment choices are individualized.

Following is an accepted list of clients' *standing rights*.[4] Codes of ethics will focus on some or all of the following guiding principles. (1) Autonomy: the right of individuals to direct chosen outcomes. Privacy and confidentiality are essential to personal autonomy. (2) Informed consent: the right of clients to be informed of the consequences of a treatment choice. Consent is critical to autonomy. (3) Privacy: the right to limit access of information to ourselves, including a right not to be touched, or observed, unless conditions warrant it. (4) Confidentiality or secrecy: the act of limiting knowledge about an individual. (5) Every individual has a right to quality life, though disagreement exists on when life is worth living or whether it is worth living to preserve certain states of body and mind. Generally, quality life refers to a state of existence free from pain, or the presence of pleasurable states of consciousness; (6) Clients have a right to express their own values, attitudes, and beliefs without fear of reprimand from staff. (7) Anonymity: every client has a right to protection from undesired attention. (8) Solitude: the client's right to enjoy a lack of physical proximity to others.

Panel Two: Ethical Theory

P-M is designed to capture tradeoffs between competing ethical claims. While these claims announce why staffs need to act in a client's best interest, they do not tell us how to get

there. The list of guiding principles, virtue based and principle-based, include Aristotle's Virtue ethics, Aquinas' Natural Law theory, Kant's Deontological ethics, and J.S Mill's Consequentialist or Utilitarian ethics. Professional codes of ethics do not always distinguish one theory from another. But this is not necessarily problematic. For instance, the American Nurses' Association Code (1985) advocates the use of Utilitarian and Deontological principles side by side, not only on the same opening page of the text, but in the same sentence![5] P-M uses whatever works best. Following is a brief review of principal ethical theories.

Aristotle's virtue ethics teaches that we become virtuous by doing virtuous things. He stresses action. The client is encouraged to practice a desirable behavior and eventually becomes virtuous in that regard. Aquinas' ethical theory is more speculative since it is based on the innate laws of human nature. Natural Law, he says, is "the rational creature's participation in Eternal Law"[6]. Eternal law is expressed in Scriptures as the law of divine governance. The human is made in the image and likeness of God (Genesis 1:26). Thomism suggests the existence of two intuited precepts of moral action; (1) persons are rational (2) persons naturally seek to do good and avoid evil. The theory says that we become more truly personal by following these innate precepts. The two theories appear to be complementary. While Aristotle provides a focus on the practice of moral action, Aquinas suggests why the need to act morally arises in the first instance.

The client is operating under a distorted law of reason (paranoia). She is using disturbed logic to make sense of her environment. So, without aid, she probably cannot do virtuous things or act in her own best interest. This obviates the need to incorporate the particulars of the case into the guiding principles.

Consequentialism argues that actions are morally good or bad depending on their consequences. The preferred form of it is Utilitarianism. The theory provides a possible solution to the urgency of scarce resources. Distributive justice suggests we allocate resources in a way that does the most good for the majority of members of society. What are the cost-benefits of the theory? Justice and fairness are at play. While the principle of justice recognizes everyone's rights to the good life, the stark reality is that the system is not always fair since the rights of some clients are traded against a benefit for the majority. But society must make an effort for its weak and poor members, if it is to remain just. P-M's environmental arm can meet this challenge since it expresses justice at the macro level and fairness at the micro level. Where else can we turn?

Deontological ethics are duty-based ethics. The focus is on carrying out duties without regard for personal desires. The deontological imperative to aim for universalized action offers a fresh alternative to cultural relativism, but at what cost-benefit? The cost is that justice cannot ignore the consequences of action, but the benefit is that fairness enshrines the noble principle that some truths are worth dying for. The claim appeals to the Socratic vision in us (our tendency towards good?) of writing an ethically based treatment plan. Deontological claims can be worked out on P-M's social arm, a place that celebrates empowering others even at the risk of personal injury. Deontological ethics entreats us to treat others as ends in themselves, with dignity and respect, irrespective of consequences. The client's gains are obvious, but can we ignore the costs? It seems not. There are times when consequences matter. In public health matters the common good trumps individual good. We cannot always treat clients as an end in self. For instance, a violent client has to be restrained, physically or mentally, if she becomes a physical threat to others. The arms of P-M obviate the balance between cost and benefit.

In summary, each ethical claim has some merit as well as a dark side. Once guiding

principles descend to meet the particulars of experience they get written as process rather than event. Two movements feed P-M with associations, one universal the other particular. The rights of clients descend to meet the particulars of a case, while the particulars rise to fetter rights. The associations are then expressed on the arms of psyche, other people, and the environment. P-M provides a trans-cultural vision of life rooted in the particulars of the day. The process of becoming human is scripted in the fleeting sands of relativity, but the fact that these associations make us more personal is objective. Applied ethics strikes a balance between universalism and relativism. It forages competing ethical claims to meet the actual needs of at-risk clients, discards what doesn't work and keeps what does.

Panel Three: Law

In a moral universe, ethics trumps law. If the client is at-risk in her family of origin she will be moved, not because the law says so, but because it would be unethical to leave her in such an environment. In a moral universe, law is based on ethics rather than ethics on law. However, ethics and law meet in the relationships of primary care.

The strategic agenda of the Law Commission of Canada recognizes this guiding principle since it advocates basing law on relationships. The Commission thereby places the centrality of relationships at the core of ethics as well as law. The Commission identifies four broad types of relationships, namely, "personal relationships, social relationships, economic relationships, and governance relationships"[7] Law is the means for channeling ethical responsibilities towards clients.

We begin with an assessment of quality of life. The client's social frame is poor. Staffs need to talk with the client's mother and father before adjusting that frame. Staffs make judgments about a client's quality life in order to plan management. But the care plan is enacted in accordance with Provincial standards. These (ethical and legal) standards are fettered by the particulars of the case, namely, the client's health, age, religious beliefs, family situation, and the availability of resources. Once the case is put in context, the expectation of services is discussed with the client's mother and father before changes can be made to the social frame. This process assures us of the best possible fit between the needs of the client and the particulars of the case. The level of care is expressed in a P-M chart. The associations are governed by contract, but they are seen to be ethical as well as legal. The associations are seen to maximize return on investment as scarce resources, Provincial standards, ethics, and law meet in the expression of a realistic social frame for the client. The client's psychological and environmental frames are instituted and varied in accordance with a similar "push pull" process.

Panel Five: Disciplinary Perspective

The examination of client rights is a multidisciplinary activity, but the paper limits itself to psychology. The client expresses psychological issues. Behavior therapists focus on learning principles in light of a client's problems and the circumstances that surround it. They ignore causes. Basically they alter the circumstances and see if the behavior changes. To illustrate the process, let me review a basic principle known to every first year psychology student. The Russian physiologist Ivan P. Pavlov expressed the belief that behavior can be controlled. He trained dogs to salivate when a circle was projected on a screen and not to salivate when an ellipse was shown. Of course, his dogs quickly learned to associate the circle with food and

would salivate upon seeing it, even in the absence of food. The next step was to blur the distinction between the circle and the ellipse, so that they became almost indistinguishable. At that point the animal did not know what to do and became agitated. This is an experimentally induced neurosis. The same principle applies to humans. Staffs can unknowingly introduce mixed messages into a client's life. A restless client could be receiving conflicting signals from others (new staff, other clients), the environment (rearranging a client's room without prior warning), or even from her own brain (changes in medication, diet). Staffs can check to ensure that the care they offer clients is consistent. The view of the individual as becoming a person offers more promise than the view of the individual as being human since it is more transparent.

A central trait of interpersonal relationships with clients of vocational centers and residential units is genuineness. Carl Rogers emphasizes the importance of being genuine. He describes the social frame as the client's reciprocation of the therapist's attitudes. If staff bring an attitude of acceptance to the social frame, clients are more likely to feel comfortable. If clients are not allowed the opportunity to input into the treatment plan, they are less likely to be at peace. The panel objective is to be integrative and constructivist; to view the problem from the perspective of relevant disciplines, and from the client's point of view, respectively.

Panel Six: Particulars of the Case

This paper could have opened with panel six. After all, the "push" of the deductive panels meets the "pull" of the inductive panel at the same place, namely in the P-M propositions of practice. The particulars of the case can be identified by asking eight or nine key questions (1) What are staffs concerns? What are the issues and how can fresh relations be struck to meet those concerns? For instance, will moving the client from a vocational center to a residential unit meet some of these concerns? (2) What are the effects of each alternative? (3) Who are the people involved (include a list of family, other clients, staff, and other professionals)? (4) How is the treatment decision being made (what medical model is used i.e. paternalism, collegial, engineering, or contractual)? Is everyone that is being affected by the decision consulted (in a democracy, everyone that is affected by a decision should be consulted)? How does staff express the client's best interest? (5) Why are the client's rights at-risk (why is this issue problematic)? Does the decision-making-process safeguard the client's rights? (6) When is the client at risk? Note the time and circumstances that accompany a client's disruptive behavior. Does she become agitated before meals, before medication is given, at bedtime, etc? (7) Where does the behavioral problem occur? The resident's total environment is a critical component of the P-M process. (8) Do staffs have access to required resources? Since treatment is labor intensive, the resource category includes the availability of staff. This is a budget issue. (9) Ask a co-worker to confirm your observations.

Panel Four: Practice

A method to arrive at practice is now at hand. Once the associations between client rights and particulars are expressed on the arms of P-M, we can begin the task of instituting new relations or varying old ones. Since staff focus is on non-aversive (non punishing) behavior change, clients learn to modify their behavior through the positive consequences of doing so rather than out of the negative consequences of not doing so. The goal is to establish positive associations

that allow clients an opportunity to behave responsibly (valuing autonomy and informed consent). Thus, staff focus is on teaching the consequences of behavior. Punishment is rarely effective since it enlists a confrontational attitude between individuals. It sends a signal of being out of control (in sharp contrast to the loving, nurturing environment we expect will arise out of healthy associations). The focus shifts from passive learning (operant conditioning) to active learning (trial and error) as P-M developments progress.

In the psychological frame, we find that the associations that accompany the client's condition of paranoid schizophrenia blur the distinction between real and imagined experiences. Her belief of being vilified by a resident is real to her, even if imagined. It is met by enlisting more input on the particulars surrounding the event. The what, when, where, and such of the incident provide an opportunity to vary that relationship. If, for instance, the client is allegedly victimized at a certain time of day, then, a shift in the timing of the event can result in a changed outcome. The focus on psyche includes the client's religious life. Although the case study does not provide details here, staffs should make the appropriate inquiries to determine if their client's spiritual and religious needs are being met. A client's spiritual or religious experience is an integral component of holistic health. Is the client generally unhappy? What else can staffs do to help? What can the client do for herself? The therapeutic value of play is well known. The client's focus on self can properly be directed outward through play, constructive recreation, dancing, working with clay, painting. Such activities have a potential to unleash healing, spiritual energies of the psyche. This energy is creative, restorative. So it is important to access it and find some way to allow it to do its healing work.

The essential characteristic of the social frame is that we need others to become more truly personal. However, relations with others can become askew and destroy a healthy concept of self. The client is experiencing real problems in her relations with mother, father, and other clients. The first consideration is for the welfare of the client. If she is at-risk in her present social frame, then, that association must be changed, and the client integrated into new associations. The client's mother is controlling (she uses medication and the daughter's father to control her daughter). Staffs need to meet with the mother to understand her motivation. Does the mother distrusts staff; if so, why? The contractual model suggests that mother, daughter, and staff are entitled to an opportunity to settle their differences. The daughter should only be removed from the family of origin, if she is at risk. Still, with consent from all parties the client might move from a vocational center to a group home. The relationship with the father also needs mending.

Staffs might agree to the use of a 12-Step approach to address the client's paranoia. In this event, feelings trump reason. The equality of participants is critical to the success of such groups. In the early stages, a staff member can choose to lead a group, but gradually move away as such groups are not led by anyone. They acquire a life of their own. Group work takes place in a nurturing setting where the focus is placed on feelings, emotions, and the equality of the participants. Group autonomy is valued. Resonance and identification provide an opportunity for individuals from different walks of life to speak in single voice. The client's opportunity to voice her concerns over the name calling in this kind of a social setting will help other clients understand what she is going through. They will reach out to her as they become more able to identify with her and connect their own feelings of being victimized with her struggle for self-respect. The client's rights can then be expressed through new associations. For instance, can she be put back on regular (common) schedule of activities?

The environmental frame encompasses everything else about the P-M process of becoming more personal. We begin, as usual, by cataloguing the particulars of the case. When

does the disruptive, destructive behavior emerge? Does it appear before meals or at other times? Is the environment the problem? Can it be modified; what about seating arrangements at the table? Could it be diet? How is the treatment decision being made? What are the alternatives? Would moving the client out of her mother's home into a group home be beneficial to the client? Have any changes been made in the client's room, resources. Etc. Always co-opt the resident's input before initiating any change in the environment, including the introduction of new staff (staff can be classed as environment as well as social frame). This is especially important during Summer months when regular staffs go on vacation. The role of environment in the definition of self should not be under described! The body receives clues from the environment before the 'brain' does.[8] Changes in a client's environment could have a negative outcome on a client's rights. What counts is that the environmental connection be made clear so that no one is caught off guard.

Conclusion

The development of a treatment plan for this client is successful because it views her as being the product of relations. Rather than wander in search of an elusive subject of experiences, those relations provide staffs a place to fix problems. This might be the sort of thing psychiatry has in mind when it focuses on relational disorders. Over the past few years, I have used the model in a dozen workshops with staffs of Vocational Centers and Residential Units in the Cape Breton area, and it works. Hopefully additional research will confirm this belief.

ENDNOTES

1. Thanks to Debra MacLean, Director, North Side Adult Services Center, for providing the particulars of the case.

2. See the *Human Rights Act of Nova Scotia*, chapter 214, amended 1991. Section 24, number b. p. 11.

3. Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans: http://www.nserc.ca/programs/ethics/english/policy.htm
21 Nov. 2000.

4. The term *standing* means that the individual –or court appointed guardian–has the right to initiate legal action if a client's best interest is threatened. The rights of society at large take precedence over the rights of individuals. For instance, in the case of communicable disease, citizen's rights to be protected from harm trumps the individual's right to privacy.

5. The sentence appears in the second line of the third paragraph: "When making clinical judgments, nurses base their decisions on consideration of consequences and of universal principles…"

6. *Summa Theologica* 1-11 q. 91 a.2.

7. Di Palma, Annie <adipalma@LCC.GC.CA> "Law Commission of Canada/Commission du Droit du Canada" 19 Nov. 2001. Distribution List.

8. A study by Siegel, S. Hinson, R. Krank, M. and McCully, J. (1982) "The Mystery of Heroin Overdose" In William A. McKim, *Drugs and Behavior*. 3rd Edition, makes the environmental connection clear in a case of tolerance to heroin; " Siegel reasoned that the tolerance to heroin was partly conditioned by the environment where the drug was normally administered. If the drug was consumed in a new setting, much of the conditioned tolerance will disappear, and the addict will be more likely to overdose" (p.45).