THE RESPONSE OF COMMUNITY MENTAL-HEALTH PROFESSIONALS TO CLIENTS' RIGHTS: A REVIEW AND SUGGESTIONS

LESLIE M. TUTTY
The University of Calgary

ABSTRACT

Clients' rights is an issue which resurfaces periodically in professional journals, but which is ever-present in the minds of consumers of mental-health facilities. While some of the most striking pleas for adherence to rights have centred in the past on inpatient mental-health facilities, similar issues related to client treatment continue to exist in community mental-health centres. This paper reviews the literature on outpatient clients' rights from the perspective of both clients and professionals. The paper provides suggestions for mental-health professionals to more adequately address the rights of their clients in terms of the workplace, the organization of their agencies, and through legal/legislated means.

In the past decade clients have become increasingly vocal regarding their dissatisfaction with the available information and procedures in mental-health facilities. The consumer rights movement in psychiatry, originally created by psychiatric patients who had been institutionalized, identified such serious, life-threatening violations of human rights as the lack of choice to refuse harmful treatments and inhumane living conditions in psychiatric hospitals. In the United States many of these concerns resulted in successful lawsuits which subsequently provided some measure of protection against the most damaging infringements of rights (Ziegenfuss, 1983). In Canada, the implications of the Canadian Charter of Rights and Freedoms on issues such as involuntary admission and informed consent are still being debated (Gordon & Verdun-Jones, 1986; Keyserlingk, 1985; Newman, 1985; Schafer, 1985; Verdun-Jones, 1988).

While mental-health professionals, especially those who deal routinely with institutionalized patients, have become sensitized to these extreme issues (e.g., see Florez, 1988), it is the author's contention that parallel violations of clients' rights occur in the context of outpatient community mental-health facilities. The issues are often similar but subtle infringements of rights, including matters such as access to information and choice of therapist and treatment.

This paper will describe consumer impressions of community mental-health services which suggest the need for further attention to clients' rights. Basic outpatient clients' rights will be briefly reviewed and documentation provided regarding what procedures may be currently in place which address these rights,

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especially in the Canadian context. The resistance of practitioners to broadening the extent to which they inform and treat clients as partners in treatment will be examined. Finally, further mechanisms at the worker, organizational, and legal/legislative levels which might be instituted in the future to respond to the broader spectrum of consumer rights will be described.

CLIENTS' IMPRESSIONS OF MENTAL-HEALTH SERVICES

Several studies by mental-health professionals (Hatfield, 1983; Holden & Lewine, 1982) have assessed client satisfaction with services offered in mental-health centres. Holden and Lewine (1982) found 38% of the families surveyed, all of whom had a family member with a psychiatric history either living with them, in independent housing, or hospitalized, found professionals frustrating. Another 33% described professionals as not helpful, while only 26% were very or generally satisfied with their service. Over half the clients complained professionals had not involved them in the therapy. Other problems identified included lack of information about diagnosis, treatment and medication, lack of support during the transition back to the community, lack of help in connecting with community resources and in dealing with difficult behaviour on the patient's part. Hatfield (1983) found there was "no significant relationship between the families' priorities for help and the focus of their family therapy." Not one of the needs identified by the families had been addressed by the professionals during treatment.

A recent Canadian study (Gregory, 1989) identified almost identical concerns in families from Toronto with a psychiatrically diagnosed member living at home. The families expressed significant needs in the areas of crisis management, information and education, in-home support, and respite care.

A further contribution to the general awareness that accepted modes of treatment are not necessarily helpful to clients has been expressed by a growing number of consumer groups in psychiatry (Canadian groups include branches of Friends of Schizophrenia, Recovery, Inc., and the Manic Depressive Association). Such coalitions of patients and their families have complained about the stigmatization, lack of resources, and shortage of helpful interventions on the part of mental-health professionals (Bernheim & Lehman, 1985; Chamberlin, Rogers, & Sneed, 1989; Dearth, Labenski, Mott, & Pellegrini, 1986). Individuals have utilized their own experiences while receiving in-hospital treatment (Francis, 1985; Levine, 1982) to illustrate "negative attitudes and prejudices held by some of the helping professionals and the consequences for the patients in their care" (Francis, 1985, p. 2).

On Our Own, a Toronto-based self-help group, has taken a more extreme stance, describing themselves as "ex-inmates" of psychiatric institutions and taking a strong anti-establishment position toward mental-health services. In a *Declaration of Principles* (Tenth Annual International Conference on Human Rights and Psychiatric Oppression, 1983) they stated their opposition to psychiatric procedures in general and called for the abolition of the psychiatric system.

Some community psychologists (Morgan, 1983; Walsh, 1988) have acknowledged consumer concerns and have expressed the need to protect clients from iatrogenic side-effects of therapy. They cite research which has demonstrated that some forms of treatment are worse than no treatment at all. For example, Billings, as reported by Frey (1983), found suicidal patients in day treatment had a higher death rate (13.4%) than patients who had not been seen in treatment (10.4%).

Professionals do not typically receive feedback on how their services are received. Spaniol, Jung, Zipple, and Fitzgerald (1987), for example, surveyed both mental-health professionals and families with a psychiatric disability and compared satisfaction levels. Eighty-two percent of professionals believed the families were generally satisfied with the services being offered, but almost half of the families expressed moderate to significant dissatisfaction with overall services. There was clearly a lack of professional awareness about concerns regarding the provision of treatment.

The consequences of professionals' disregard for the opinions of their clients may be serious. At the very least, clients who are dissatisfied with treatment drop out prematurely (Romney, 1986). Investigating this phenomenon, Romney found the most likely reasons for dropping out were not liking the therapist or the treatment offered. Unfortunately, rather than asking for a change in therapist or treatment modality, in most cases clients simply stopped attending sessions. They often did not seek further help, assuming their negative experience could be generalized to all agencies and counsellors.

Clients' rights, in the context of community services, address some of these issues by acknowledging that consumers of mental-health facilities should have more input into choices about their own treatment.

CLIENTS' RIGHTS

There is no one universally agreed-upon set of clients' rights. The majority of suggested inventories focus primarily on problems related to inpatient facilities (e.g., Berman, 1982; Farrell, 1982). Atkinson, Madill, Solberg, and Turner's (1985) listing of three categories of patients' rights illustrates the overlapping nature of inpatient as compared to outpatient clients' rights. The three categories are: quality of life (social rights within institutions), quality of care (which relate to the therapeutic relationship), and self-determination (issues involving legal rights). While the first category relates solely to inpatient concerns, the last two categories are applicable to both inpatient and non-institutionalized clients.

Few authors have suggested codes of clients' rights specifically for community mental-health facilities (Eberlein, 1977; Hare-Mustin, Marecek, Kaplan, & Liss-Levinson, 1979; On Our Own, 1985; Pettifor, 1985). Of these, Pettifor provides the clearest, most comprehensive list. It is not the intention of this paper to examine the complexities of the issues related to clients' rights in detail, but to remind professionals that clients' rights issues extend into the community. These rights include:

- The right to informed consent (*), if considered competent.
- The right to refuse treatment (*), if considered competent.

- The right to access to treatment.
- The right to the least intrusive, least restrictive intervention.
- The right to confidentiality.
- The right to allow or to refuse release of information (*).
- The right to peruse personal records (*), if considered competent.
- The right to be treated with dignity and respect.
- The right to non-discrimination (*).

Some of these rights are supported legally (*) (Atkinson et al., 1985; Berman, 1982), while others are enshrined in the codes of ethics of the Canadian Medical, Nursing, Social Work, and Psychological Associations.

Consent to treatment is one of the cornerstones of client rights. Three issues are central to consent being considered legally binding: it must be voluntary, it must be made by a person who is considered competent, and it must be informed—that is, the person must understand why the treatment is necessary, both potentially positive and negative effects of the treatment, possible alternative treatments, and common side-effects (Keyserlingk, 1985; McKague, 1983).

A person may be judged competent in different areas. For example, under the Mental Health Act of Ontario (1980), a doctor may decide a person is incompetent to manage one's finances but competent to consent to treatment (Berman, 1982). Nevertheless, patients not considered competent can be treated with the consent of either a relative or a review board (Community Legal Education Ontario, 1985).

Because most outpatient clients are assumed to be competent and voluntary, the main concern regarding these consumers is informed consent. This concept was initially borrowed from the medical system where diagnosis and treatment are usually more straightforward than in the psychotherapeutic realm. The first problem for mental-health clients is the varying views of different practitioners regarding the cause of an emotional problem. A condition such as anorexia nervosa may be variously viewed as being caused by an intrapsychic wish to avoid growing up (Bruch, 1978), a control mechanism in a dysfunctional family system (Haley, 1980), or an indicator of possible incestuous activity (Sloan & Leichner, 1986). The form of treatment proposed will thus depend entirely on the practitioner's view of the etiology of the problem.

Rozovsky (cited in Reamer, 1987) suggested six standards which must be met for informed consent to be considered valid: there must be an absence of coercion and undue influence, the client must be competent, the consent must relate to specific procedures, the forms of consent must be valid, there must be provisions to refuse and to withdraw from treatment, and the decisions must be based on adequate information.

In the medical system doctors have discretion regarding how much information is conveyed. While they are expected to discuss side-effects of the proposed treatment, for example, they need only describe common, serious side-effects (McKague, 1983). The mental-health system is less able to make conclusive judgements about outpatient treatment, and so practitioners can rarely provide definitive opinions regarding diagnosis, alternate forms of therapy, or possible iatrogenic effects of the proposed therapy (Sue, 1977). This makes it difficult at times to fully adhere to the right of informed consent, however practitioners

would be wise to become aware of any negative implications or alternatives to the treatment which they are offering (Hare-Mustin et al., 1979).

The *right to refuse treatment* and the *right to the least restrictive, least intrusive intervention* stem from legal and moral battles against such damaging treatments as lobotomy and electroconvulsive treatment. Although clients in the community can simply stop receiving treatment which they find unpleasant or objectionable, some authors argue that outpatient mental-health clients should have more opportunities to choose their treatment modality (Manthei, 1983). This is difficult, however, when consumers are faced with a confusing range of professional caregivers and forms of treatment. Some styles of psychotherapy would be considered restrictive and/or intrusive by some clients (Miller, 1982), whereas others would find the same treatment valuable. The difficulty is fitting the concern with the appropriate treatment modality.

A logical first step to facilitate choice in treatment issues is to provide the consumer with information about the general counselling process and variations in professionals' training and focus in treatment (Reamer, 1987) (e.g., see Mishara & Patterson, 1977). An important aspect of this orientation would be the clarification of a client's right to ask questions of the therapist and to refuse interventions. Some advocates of client choice in treatment go so far as to suggest consumers should be allowed to choose their own therapist rather than being assigned to a counsellor as is the case in most community mental-health facilities (Manthei, 1988).

It has been claimed that the emphasis on the right to refuse treatment has overshadowed the right to treatment. Norton (1985) noted, for example, that of 647 clients in 1984 who took concerns to the Windsor Ombudsman program, the majority described problems regarding access to treatment rather than the right to refuse it. This issue has been exemplified in such controversial areas as unsuccessful attempts to hospitalize individuals who have subsequently harmed themselves or others. A less dramatic example is the many potential consumers who do not know what services are available in their community or how to connect with these agencies.

Confidentiality is both a legal and a professional issue. While most clients assume confidentiality of counselling sessions, courts can subpoena agency files. As such, confidentiality in legal terms does not really exist for mental-health clients. Clients need to be advised at the outset of what issues may be kept confidential and what issues must be reported to authorities by law, such as child abuse.

Release of information is handled in most provinces by forms which must be signed by clients before an agency may release information to another agency. This important procedure protects the client from illegitimate dissemination of information. Ironically, however, many clients are merely provided with a verbal report of what information will be discussed. It is entirely up to the discretion of the professional whether clients are given a copy of the report. Professionals excuse this oversight by describing incidents where clients misused or misunderstood information (Pettifor, 1985). Unfortunately, most reports are written for other professionals and are often difficult for members of the general public to understand. Standard practice should include the automatic provision

of copies of reports written in jargon-free language. In addition, clients should be given the opportunity to discuss the report in detail and an invitation to return for clarification if necessary.

Similarly, *access to personal files* is often not available despite the Kreever Commission's recommendation for qualified access (Beatty, 1981). Medical records are restricted by law unless one is suing the doctor or hospital (Community Legal Education Ontario, 1985), however, non-medical records kept in community mental-health facilities may be viewed upon request. Most consumers are not informed of this option. Concerns include the fact that information regarding one family member may be inappropriate or present ethical dilemmas if known by other family members (Beatty, 1981).

In regard to the issue of access to files, Pettifor (1985) stated, "Probably most professionals believe that patients have a right to see their own records, but in practice they prefer that this right not be exercised" (p. 23). In a British study (Doel & Lawson, 1986), social workers opened their case records to clients in a collaborative manner, rather than simply in response to requests exercised as a client "right." The research concluded that "a focus on shared recording can promote a partnership between the worker and the client" (p. 407). This cooperative model may be appropriate for Canadian community mental-health services.

The right to be treated with dignity and respect is implied in many treatment modalities and is addressed in most professional codes of ethics. Infractions of these rights may be subtle and subjective to the point where consumers may not feel they have the right to complain. One common example is that when clients come into treatment with clear ideas about the form of therapy they are seeking, they are often regarded with suspicion by therapists. A common pattern is exemplified by one case where a family with an 8-year-old son sought help with disciplinary problems. The family approached an agency in the hope of receiving individual play therapy for their son. They were offered family therapy, the immediate focus of which became the marital relationship. Despite the accuracy of the therapists' perception that the marital dyad was dysfunctional, the parents felt their wishes were being ignored. They subsequently left treatment after only two sessions. This is an example where, had the therapists respected the initial focus which the parents had requested—on their son—therapeutic changes would likely have occurred.

As outlined earlier, each of the professional groups which provide mental-health services have ethical codes which describe the responsibilities of professions to provide high quality services with the well-being of the client as a major consideration. Respect for the individual rights and the dignity of clients without discrimination are explicitly stated (Pettifor, 1985). Several authors, however, are of the opinion that ethical codes were mainly established to protect the professions from outside regulation while allowing for the censure of clearly unacceptable behaviour on the part of individual members (Hare-Mustin et al., 1979; Van Hoose & Kotler, 1977). Hare-Mustin and colleagues claim clients' rights are essentially of secondary importance and "statements of ethical standards represent more of a 'salute to the flag' for therapists than a bill of rights for clients" (1979, p. 3).

Despite the value of providing information to clients on the mechanisms used to lodge a complaint with an ethical review board regarding violations of rights, many infractions may be subtle and difficult to prove when it is the professional's word against the client's (Pettifor, 1985).

Violations of the *right to non-discrimination* should technically be addressed through provincial human-rights legislation. Again, however, issues may be subtle enough that most clients would not consider taking direct action, especially since they may feel powerless already. It is the women, the poor, the physically disabled, native and ethnic groups who are most vulnerable to such discrimination (Pettifor, 1985). An example is provided in a 1981 study (Dinges, Trimble, Mason, & Pasquale, 1981) which discovered that relatively few native Indians utilize mental-health services and those who do rarely return for a second interview. The issue was not necessarily overt discrimination, but a lack of cultural sensitivity on the part of professionals, a fine distinction.

One further issue which deserves mention but is too broad to cover in its entirety is the rights of children as clients in community mental-health agencies. The clients' rights mentioned previously apply to adults and, in most cases, the child's parents are assumed to act in the child's best interests. However, professionals who work directly with children have acknowledged that the children themselves deserve access to similar rights, including the right to be told the truth, to be taken seriously, to confidentiality, to respect, and to participate in decision making (Koocher, 1976). This is especially important because in cases such as child custody or intrafamilial sexual abuse it cannot be assumed that parents are behaving to protect their children (Dorros & Dorsey, 1989; Hart & Brassard, 1987) or that the treatment modalities will address safety issues for the child (Valentic & Anderson, in press).

In the United States, Ziegenfuss (1986) suggested that over the past 20 years there have been three common professional responses to the rights of inpatients (a) ignoring rights issues, (b) supporting litigation to resolve rights complaints and (c) helping to advocate the development of rights protection programs. He believes ignoring inpatient rights is no longer an option, and litigation has ultimately not been helpful. An advocacy approach is suggested as most beneficial to preserve the relationship between patient and professional.

There may be a parallel evolution in the case of outpatient clients' rights. While these are currently nominally addressed in outpatient mental-health facilities, it is my impression that professional compliance with the procedures is more often passive than active. If consumers do not ask, they are rarely provided with information about their rights or options. The advocates in Atkinson et al.'s (1985) article found "persons working in the mental health field are often not aware of rights and obligations that flow from the Mental Health Act" (p. 6). Others, who may be aware of clients' rights, are not supportive because they see the rights as interfering with their position as "expert" and with the process of therapy itself. They may work from a position of mystification (Sue, 1977) which they believe is necessary to countervene the client's "inherent resistance to change." They may not believe that clients with severe psychiatric disabilities are capable of setting reasonable goals in therapy (Anthony, Cohen, Farkas, & Cohen, 1988). Others fear increased client access to information regarding rights.

may lead to increases in litigation, a not unreasonable fear given the experience with some advocacy programs in the U.S. (Applebaum, 1986; Lamb, 1981; Ziegenfuss, 1986). Finally, some feel blamed by the rhetoric surrounding clients' rights: It is yet another idealistic standard against which few of us could comfortably measure ourselves. The intent of this paper is to bring these issues to the awareness of colleagues, not to provoke a fit of mass guilt for past indiscretions, an exercise in which the author would be forced to join.

It is, however, my contention that mental-health professionals would ultimately lose little by actively supporting clients' rights. Client self-determination is a concept which has been embraced theoretically by the helping professions for decades. In social work, for example, the concept is considered one of the foundations of casework (Richmond, 1922) and has been a common theme in the profession's literature since that time. Biestek, for example, described the client's right to be free in making decisions and choices in a 1957 article.

Hare-Mustin and colleagues (1979) believe some treatment models fit more easily with clients' rights issues, especially those which contain a high degree of client participation. While such modalities obviously have the leading edge in integrating rights into therapy, the issue is, I believe, more one of therapist stance than type of therapy. Even in models of treatment where therapists assume a clear leadership position, such as strategic family therapy, one can potentially offer consumers general information about the treatment process, permission to refuse interventions, and information about their rights without interfering in the treatment process whatsoever. In fact "difficult" clients may be more easily helped with assurances that they are in control of many of the choices in treatment.

A more complete integration of clients' rights into mental-health treatment is long overdue. The next section contains suggestions of procedures which mental-health professionals could utilize toward fulfilling this end.

MECHANISMS TO ADDRESS CLIENT RIGHTS

Further strategies to address the rights of clients can be considered in three areas: worker-centred, organizational, and legal/legislated. The following discussion will present examples of mechanisms which could enhance clients' rights falling within each of these areas, and will identify the clients' rights which they address.

Worker-Centred Mechanisms

1. Teach clients' rights to students in the helping professions. As mentioned earlier, the inclusion of the concept of client self-determination in theories of helping is over a half-century old. Nevertheless many training programs do not explicitly teach clients' rights. Such an addition to curricula would obviously broaden awareness of the issues.

2. Therapist-client contracts. Therapeutic contracts have been suggested (Anderson & Stewart, 1983; Hare-Mustin et al., 1979; Morrison, 1979) as a beneficial method of including the consumer in choices about treatment. Contracts take many forms, the most basic being a verbal agreement to participate in

treatment. More elaborate contracts may be written which specify the goals, process, techniques, and the length of treatment as well as practical issues including fees, frequency of sessions, and provisions for the renegotiation or cancellation of the contract (Hare-Mustin et al., 1979).

Rothery (1980) referred to another form of therapeutic contract which is developmental in nature, in that as clients make changes and progress in therapy they may also change their contract. Other practitioners similarly set aside five to 10 minutes in each session to talk about how treatment is proceeding. Aside from being advantageous in reinforcing consumer participation, this strategy encourages clients to recontract if they so desire. Contracts encourage specificity in many aspects of the counselling process as well as introducing a collaborative atmosphere. Contracts therefore address several clients' rights, the most basic of which are the right of consent to treatment, the right to refuse treatment, and the right to respect.

3. Training opportunities to experience treatment. It is difficult for some professionals to understand what it is like to be in the "client" role and how to address clients' rights if they have not experienced "helping" first hand. A recent study discovered professionals who have undergone therapy themselves are most successful in keeping their clients in treatment (Greenspan & Kulish, 1985). Such therapists were more able to meet the needs of their clients because they had experienced what it felt like to be a client. Consequently, perhaps the simplest method of helping professionals to become more responsive to clients' rights and to understand for themselves the importance of consumer issues would be to provide opportunities for students in the helping professions to undergo their own therapy.

4. Keeping a current knowledge base on the efficacy of various treatment modalities. Clinicians may have favourite modes of treatment which they believe can be utilized for virtually every problem. They would, however, be well advised to evaluate their own skills in treating different presenting problems, and to be willing to screen clients and to refer to other professionals (Winborn, 1977).

It is important to provide the most effective treatment available. This entails professionals keeping current on the research on treatment effectiveness for their particular client populations. There is, I believe, a general reluctance to make across-method comparisons between competing modes of treatment. One current example of the appropriate contrast of different treatments is in family therapy with schizophrenia. Traditional family therapy has not been proven to be effective with families with schizophrenic members, and the implication in the family model that parents are responsible for the "craziness" of their offspring has caused great distress (Grunebaum, 1984; Terkelsen, 1983). On the other hand, the newly-developed psychoeducational model, which provides information to the entire family about the disorder, and works with the family to practice problem-solving skills, has prevented the rehospitalization of a significantly large group of former patients (Falloon & Liberman, 1983; Hogarty et al., 1986). Spaniol et al. (1987) speculate that professionals are not aware of the recent literature on families of the mentally ill. It behooves professional helpers to remain current in their treatment areas and to steer clients toward the most effective treatment available.

5. The support and development of mutual-aid and self-help groups. Hare-Mustin et al. (1979) suggest that in order to address the right of consent to treatment, professionals should describe other treatment modalities which may be available. Among some of the most potent therapeutic interventions are self-help groups such as Alcoholics Anonymous and Parents Anonymous. The support of discussing issues with others who have experienced the same problem is generally acknowledged as helpful (Chamberlin et al., 1989), especially since other group members may be well aware of and more effective in confronting ways that individuals rationalize their problem behaviour. Self-help groups may also be considered as an adjunct to other forms of professionally-offered treatment.

Professionals can be instrumental in the development and support of self-help groups. McFarlane (1983) describes the development of a support group of families with a schizophrenic member. The groups began at the instigation of a professional leader who initially took an active role both to help group members feel comfortable and to model effective group leadership and support. Over a two- to three-year period the leader gradually took an increasingly less active role until eventually her/his presence became mostly honorary and the group process was managed by members.

Organizational Mechanisms

Ziegenfuss (1986) argues that the organizational system is an appropriate forum for addressing conflict between clients' rights and clients' need. The following are suggestions for organizational change which would deal with clients' rights issues.

1. Quality assurance programs. Quality-assurance programs "consist of various procedures designed to increase the probability that the services received by clients will be adequate and appropriate and that they will be delivered in sufficient quality" (Coulton, 1982, p. 398). Unfortunately, quality-assurance programs may be seen as more aligned with the protection of the worker from client protests than as an effort to protect clients. Some quality-assurance programs concentrate solely on the presence or absence of reports and process recordings, with no corresponding discussions as to when or if clients viewed their files. The emphasis therefore remains essentially on the completion of paperwork.

Program evaluation can be an important component of quality assurance programs, and the use of client feedback in such evaluations (Warfel, Maloney, & Blase, 1981) raises the hope that violations of clients' rights may be brought to light and procedures to prevent such violations put into place. This would occur more easily if clients were also involved in the design of the evaluation, had access to the results, and had a place in the decision-making process at the completion of the research (Kopolow, 1981; Trembley, 1977; Walsh, 1988). The addition of such a program-evaluation component could render quality-assurance programs more beneficial to consumers rather than merely providing worker protection.

2. Consumer information. Counselling is a novel activity for most consumers of mental-health facilities. Many clients have difficulty gaining access to the mental-health system. Once involved, they often do not understand the roles of different mental-health professionals, they have no clear expectations of what will happen in treatment, nor of their rights as clients. Andreae (1987) has sug-

gested that the responsibility for this dilemma rests with mental-health professionals. Published information about mental-health services, however, is rarely available (Callahan & Martin, 1981), and when available tends to be written at a level incomprehensible to much of the general public.

Brochures on clients' rights and expectations for therapy may be one of the simplest, yet most effective means of addressing clients' rights issues (see Appendix A for a sample brochure). The entire spectrum of rights may be described in such publications. Also included could be instructions for dealing with breakdowns in the system, and in which order to proceed. Thus, if a client was unhappy with some aspect of treatment, the first logical person to approach may be the therapist especially if most other aspects of treatment were going well. In other cases where the therapeutic relationship is too damaged to salvage, approaching the supervisor or agency director would be more appropriate. If satisfaction was not available through this route, one could approach an advocate in the agency or in the community if available. Alternatively, if further action was needed, consumers could be given the address of the relevant professional association and information regarding how to file a complaint. Pursuing these steps could in fact encourage independence and assertiveness for many clients for whom these may have initially been treatment goals.

3. Case managers. An organizational mechanism which can be effective in safeguarding the rights of clients is the identification of a case manager (Anthony et al., 1988; Johnson & Rubin, 1983). In large mental-health systems, particularly when more than one professional group is working with a client, the overall needs of that client are often misplaced, with each profession working with their "piece" of the client. Case managers can work within one agency or may coordinate treatments from a variety of professionals from different agencies. The use of a case manager, often in an ombudsperson-like role (Blazyk, Crawford, & Wimberley, 1987), can therefore be a vital component of treatment. The ability to enhance the provision of clients' rights, however, presupposes that the case-manager allow access to treatment information, consistent with the rights to consent and to refuse treatment.

4. Consumer/agency coalitions. Trembley (1977) recommended that counsellors and consumers form coalitions to support each other for the "perpetuation of counselling services that are determined by the expressed needs of the consumer" (p. 212). This idea acknowledges the mutual need of both professionals and consumers: two obviously interdependent groups. This could be accomplished by designating consumer seats on agency boards of directors or less formally, counsellors could facilitate consumers addressing agency representatives about relevant issues as they arise. Such coalitions could potentially short-circuit the need for adversarial approaches to problems, and give credence to the genuinely positive feelings most practitioners have toward clients and vice versa. The opportunity to work together on an equal footing in planning the provision of services would give both groups a chance to see the other as people rather than in their roles as professional and client.

Legal/Legislated Mechanisms

1. Patient's advocacy programs. In a recent evaluation of an Ontario psychiatric patient advocacy office, an in-hospital program (Lord, 1987), a recommendation was made to extend such services into the community. Among other goals, it was suggested the advocate could educate the public and agency service providers about client rights. Some of the problems with the in-hospital program as discussed in Lord's evaluation merit mention. Patients were generally pleased with the program; however, staff had several concerns. One theme discussed was the staff's perception that the advocates emphasized rights to the detriment of treatment. Thus the mechanism of pointing out the client's right to refuse treatment, as one example, was taken as advice to do so by some patients. Staff complained that this created a lack of balance between the right to refuse and the right to receive treatment. Another relevant concern was that the role of advocate was perceived as adversarial to staff rather than providing mediation.

The major concern of patients regarding the program was that, because funding was provided by the Ministry of Health which also funds the hospitals, the advocacy function was perceived as compromised and not truly independent (Capponi, 1986). These issues deserve consideration if a similar patient advocate program is to be extended to the community.

An Ombudsman program operated by the Canadian Mental Health Association in the community of Windsor, Ontario has offered advocacy services since 1984 (Norton, 1985). The policy of CMHA staff has been to take as much of a balanced view as possible regarding right and access to treatment, particularly since its experience has been that, with deinstitutionalization, the right to treatment is a more salient issue in the community at this time than the right to refuse treatment. This agency has therefore managed to avoid becoming unduly adversarial, a problem which has plagued community advocacy programs in the U.S. (Applebaum, 1986; Lamb, 1981).

Willetts (1980) added an interesting perspective to advocacy for patients of mental-health facilities, when she described a new development in the patients' rights movement. Although advocates are traditionally seen as speaking for disadvantaged groups, Willetts describes the growing realization that many mental-health patients are capable of speaking on their own behalf. The advocate can thus facilitate rather than take over for such patients, encouraging them to pursue their rights by providing the guidance needed to negotiate the system.

2. Government legislation. In the United States, Michigan became the first state to legally guarantee the rights of recipients of mental-health services (Raider, 1982). Agencies which fall under Michigan state management must formally advise clients of their rights verbatim from a government-prepared pamphlet and must have internal client complaint mechanisms in place. Simply legislating rights is no guarantee that professionals will comply, as was discovered in a U.S. study on the impact of clients' rights on psychiatric hospitals and mental-health centres (Swan & Dipert, 1979). Nevertheless, legislation at least makes concrete the intention to address client issues and compliance can be subsequently addressed.

In summary, the utilization of a number of these procedures at the worker, organizational, and legal/governmental levels would appreciably enhance the provision of clients' rights.

CONCLUSION

It is difficult to present a balanced position on clients' rights, one which does not antagonize professionals on the one hand nor dilute the essential human rights entailed in clients' rights on the other. Clients' rights are a "motherhood" issue: Who could disagree with the idea in principle? There is no reason to assume most professionals do not follow the legislated procedures currently in place, although Canadian research on this topic would be helpful. But encouraging practitioners to widen the extent to which they provide more than lip service to these and other non-legislated rights, such as respect and choices in treatment, is not an easy task. Writers in this field have described hostile reactions from their colleagues when the topic of consumer rights was broached (Arbuckle, 1977; Hare-Mustin et al., 1979).

A final suggestion which may add balance to the issue is to acknowledge that having rights entails using those rights responsibly. Hare-Mustin and colleagues (1979) discuss client rights and *professional* responsibilities, an important theme. But, equally as important, Arbuckle (1977) suggests *clients* have corresponding responsibilities as well, such as making use of information provided, assuming control of their participation in therapy, and not making false accusations. Professionals may be more amenable to broadening their acceptance of clients' rights if they do not feel totally responsible for ensuring not only that treatment proceeds well, but that clients feel their rights have been respected. It is hoped that the ideas provided in this paper can be utilized to balance rights and responsibilities on both sides of the helping dyad.

RESUME

La question des droits de la clientèle refait périodiquement surface dans les journaux professionnels. Pour les usagers des services en santé mentale, elle demeure toujours d'actualité. Dans le passé, les allégations les plus fortes d'atteinte aux droits ont mis en cause les services internes de santé mentale. Pourtant, les mêmes questions se posent quand le traitement a cours dans des centres de santé mentale communautaire. Cet article fait état de la littérature sur les droits des patients traités en externe, du point de vue des clients et des professionnels. On y apporte aussi des suggestions pour que les professionnels de la santé mentale considèrent de façon plus adéquate les droits de leurs clients, à partir de leur milieu de travail, de l'organisation de leur agence, et des moyens légaux et/ou législatifs.

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APPENDIX A

CLIENTS' RIGHTS

You have the right to information about:

- your worker's qualifications to work with you.
- how the worker sees your problem. The diagnosis and treatment of people's emotional concerns may take longer than a doctor would need to diagnose a health problem. However it is fair for you to ask your worker about her/his present thoughts about the cause and treatment of your concerns.
- what type of treatment could help. Your worker should be able to tell you why the suggested form of treatment is the best for your problem, and whether there may be any potential side effects from the treatment. There may be other forms of treatment available from your own worker, from different workers in the agency, from different agencies or workers in private practice, or from self-help groups in the community.
- how long treatment will last. Many workers offer treatment on a "contract" basis: they specify that they will work with you for a certain length of time. At the end of that time treatment may be finished, or you may wish to make a new contract.

Remember that change does not always happen quickly. If you are not happy with how long therapy is taking talk to your therapist.

IF YOUR THERAPIST DOES NOT PROVIDE INFORMATION ABOUT THESE AREAS: ASK

In treatment you have the right to be:

- treated with respect and dignity.
- given enough information to decide whether you want to do as your worker suggests.
- free to ask for changes in therapy if you are not happy.
- free to ask for a second opinion.
- free from sexual harassment or discrimination.
- able to have copies of written reports about you or your family.
- able to ask to see the agency file on you except where this violates the right to privacy of another member of your family.
- free to discuss issues with your worker under rules of confidentiality except where disclosure of information is required of your worker by law.

IF YOU ARE NOT HAPPY WITH TREATMENT YOU CAN:

- speak to your worker and ask for the change you want. This is likely the best step if you are generally pleased with your worker and do not want to change therapists. You may, however, ask for a second opinion or for a change of worker.

- if you wish to change workers or if you have significant concerns about the treatment that you received then ask to speak to your worker's supervisor.
- there may be an ombudsperson or an advocate in the agency or in your community who can help you deal with your concerns.
- if you have significant concerns about the treatment you received or the way the agency handled your case, you can ask to speak to the director of the agency.
- if you have significant concerns which you feel were not being addressed by the agency, you may contact your worker's professional association to make a complaint.