Four players In an Ongoing Saga of Service Provision

The “system” rarely questioned itself when plans and processes didn’t work out well. The usual scapegoats were "the patients.” They were an easy target for blame since they were not equipped to fight back. When they did, their approach was primitive and was seen as proof that they had no credibility. This lack of credibility became convenient for policy makers and politicians who were unwilling to admit their approach to community treatment was seriously flawed. Some academic researchers even supported the claim that many “seriously and persistently ill” people, particularly those diagnosed with schizophrenia, showed little initiative in seeking psychiatric services. The “seriously and persistently ill” were difficult to engage in community treatment. The system seemed oblivious to the fact that the programs and services were dull, irrelevant, and unresponsive to the concerns and conditions faced by people who at some level knew they had the potential to recover.

Take Dawna. Her story presents us with a good example of how the person in need of help is often blamed for the shortcomings of the system. Dawna was a smart woman who survived a tough life. Her survival skills left others aggravated and unmotivated to work with her. She knew how to find a person's “buttons” and could strategically push them when she didn’t get what she needed. Her case was shuttled between angry case managers who swore they’d never work with her again. The notes in her case file described her as “a hopeless borderline with a poor prognosis for improvement.” I was once given this diagnosis when I aggravated people who thought they should “manage” me. Some of my best friends have experienced the same treatment. So I kept an open mind about Dawna when I heard the stories about her, and there were a lot of stories.

Due to her ability to win most power struggles, Dawna soon gained a reputation across several agencies. Most of them did as little as possible to help her recover. They wanted to get the hell away from her before she could win another argument—a win that left them frustrated and humiliated.

Dawna called “staffings” held on her behalf “stabbings.” I happened to be present at a staffing-stabbing session held on Dawna’s behalf, and I suggested that the staff take a new approach. After a few polite rejections fell on my deaf ears, the staff said, “If you question our consensus and want to do something different, you go see her and you’ll see what we mean.” I wrote down Dawna’s last known address and later in the day headed out to find her.

On the way I wondered if I'd made a mistake. What if the only thing I could do was confirm the negative consensus? I prayed I could find a way to be with her that would provide a hopeful path for the case managers to follow—after I'd paved the way by creating a relationship. I'd met Dawna once before and found her to be quite cordial. Staff said, "It usually starts that way. Then…."

Dawna was actually home, such as it was. According to her file, she trashed every place staff found for her. Now she lived in a scary part of town in a one- room storage shed with a tiny bathroom. There was a small bar sink that took up most of a dirty plastic counter. A three-legged toaster oven teetered on top of a microwave oven that took up the rest of the counter. Above this was a box cupboard with a variety of canned goods, a couple boxes of "mac 'n' cheese" and a few other out-of-the-ordinary food items. Snuffed out cigarette butts littered the concrete floor. A mattress on the floor had a scramble of dirty blankets on it. A single chair sat buried under a pile of dirty clothes. A television with no means of reception sat on the floor in front of a cabinet that housed a broken hot water heater. An unplugged ("made too much noise") refrigerator sat in a corner near the bathroom.

Dawna threw out the usual power struggle bait.

"So, you're here to help me? You look more like a bureaucrat than a case manager." But I wasn't tempted, so we quickly moved on to harmless chitchat.

She asked me if I wanted something to eat. I said that would be great. Surprised at my agreeable response, she started naming food options as she pulled cans out of a food box her case manager had left on her door step. She mumbled off the various possibilities through a half-smoked cigarette that dangled from her lips.

At first glance it looked like Dawna was equipped to feed herself. Her case managers probably convinced themselves about the viability of her living arrangements. As we considered the possibilities, however, it became clear that nothing would lead to a meal. She had several cans of food, but no can opener. The little microwave worked, but absent microwavable dishes—paper, plastic, or glass—there was no to way to use it. The toaster oven worked, but was missing a rack. Without pot- holders it would be risky to take out the hot food. No pan was big enough to cook the "mac 'n' cheese" regardless of which oven was used. The lack of hot water made it difficult to clean up.

Dawna's confusion grew as we continued to discover unworkable aspects of her living plan. Not realizing that it didn't make sense, she assumed it was more

evidence that she was inadequate and “crazy.” I began to realize that she covered up her fears about herself by deliberately aggravating the case managers.

At last we made a couple of sandwiches. We managed to whittle a few hunks off a brick of cheese with a series of plastic knives that kept breaking. We found stale bread and spread some mayonnaise on it to soften it up. We balanced the sandwiches on an aluminum pan in the warming toaster oven. When they were toasted we used the corner of one of the dirty blankets as a potholder to grab them. We sat on the bed and ate. We thought the cheese sandwiches were pretty good.

When I drove away that afternoon, I tried to convince myself that Dawna was an extreme case. I tried to convince myself that most other people on case management received more thoughtful attention and assistance. This didn’t work. I wasn't able to convince myself. By the time I got home I was confident this situation of blaming the person for the flaws in our own work was pervasive. I had a list of suggestions for the case managers the next morning. Then I followed up to see if I had been taken seriously. My concerns seemed commensurate to a grain of sand on a big beach, but at least one grain was looking better. People like Dawna were harder to blame for the shortcomings of our work.

The set of assumptions in my experience with Dawna is not just a story about fixing lunch under difficult circumstances. It's about how people we are trying to help sometimes get blamed for the shortcomings of the system. It’s about the lack of integrity of “treatment planning,” also known as “service planning.” “Consumers” of case management are, in most cases, required to have a plan that describes and guides the services they use. This is a good idea. However, the way it’s carried out has become an immense waste of time for both the staff and the “consumer.” The fundamental problem with these plans is that they are medically driven and problem oriented. They focus almost entirely on what is wrong with the person instead of focusing on what is right— the person’s strengths. Expectations are generally set very low, and boring services are offered that don’t appeal to the “consumer.”

Worst of all, the plan is rarely the person’s plan. It is a plan that the case manager develops for the person. Yet the person is supposed to agree to the plan and to follow it. The strangest part of all? The person is often not present when the plan is conceived and rarely receives a copy of it. Furthermore, the plan does not include an exit strategy. “Consumers” are expected to stay on case management forever. So much for high expectations and recovery outcomes!