

## THE CHARG EXPERIENCE WITH CONSUMER-PROFESSIONAL PARTNERSHIP

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*Empowerment can be a challenge to translate into practice. In this article, four consumers and three professionals describe Denver's CHARG Resource Center, a partnership of two nonprofit corporations representing consumers and professionals respectively. The Center's model is rooted in empowerment theory and involves (1) a range of services, (2) consumer-centered focus and trust, (3) advocacy, (4) larger community connections and support, (5) a gathering place, and (6) opportunities for employment and volunteer work. Challenges to consumers and professionals, and the implications for larger mental health systems are also explored.*

The Capitol Hill Action and Recreation Group (CHARG) Resource Center is a unique mental health clinic and consumer-run drop-in center. At CHARG, a legal partnership between mental health consumers and professionals provides an innovative approach to governance. The CHARG model represents fundamental challenges to the status quo for mental health agencies and professionals. As befits the partnership concept, this article is a collaboration of four mental health consumers and three professionals, who together tell the story of CHARG and discuss the partnership model from different perspectives.

The concept of empowerment is not new. Creative programs across the country seek innovative ways to approach this goal. Empowerment is often enacted where professionals are largely absent from agency or program

management. However, there is growing recognition that there is a role for professionals to play in consumer-run programs. Some programs take advantage of professional advisors, who provide behind-the-scenes guidance to consumer-run efforts; other consumer-run programs are enclaves within a mental health agency that is provider driven, with professional control of policy and budget decisions. Some agencies have consumers as representatives on governing boards.

CHARG Resource Center is founded on the assumption that both consumer and professional contributions are important, brought forward through partnership. This assumption is reflected in the governing structure. The structure provides for two equal nonprofit boards, representing both consumers and the

larger community. This joint legal governance may be unique in the country.

The partnership model is an innovative treatment approach that extends the efficacy of psychosocial rehabilitation interventions and strengths-based case management. The traditional system, with an unequal distribution of power, can create a “we-they” mentality that pits consumers, family members, and providers against each other. The partnership model stresses collaboration and a united effort through shared power.

This article describes the partnership, its development and value, the importance of preserving an independent board of consumers, and the challenges encountered in the implementation of such a model.

### **CHARG Resource Center**

CHARG Resource Center is a multi-faceted agency that consists of a mental health clinic (Heartland Clinic) and a consumer-run drop-in center. In addition, there are formal associations with the federally funded Project to Assist in the Transition from Homelessness (PATH), and the Coalition for the Advancement of Rights in Treatment (CART), an advocacy organization for persons with mental illness (Figure 1). Heartland Clinic is a comprehensive mental health clinic that serves 40 clients, with a multi-disciplinary staff including a part-time psychiatrist, a social worker, two psychiatric nurses, a recreation therapist, a licensed counselor/substance abuse specialist, and various students.

The drop-in center, operated by consumers, is located a few blocks from the clinic in a local church basement. The center is open Monday through Friday from noon to 4:30 p.m. Staffing includes a drop-in director, assistant director, and a telephone receptionist position shared by several consumers. The drop-in center is a gathering place for any interest-

ed consumer and serves as the setting for a number of more structured opportunities, such as a life skills group, assistance with budgeting and shopping, groups addressing depression and schizophrenia, and a variety of recreational activities. Last, but not least having fun is encouraged. There were over 500 unduplicated contacts last year. Free space is provided to the Bipolar Support Group of Denver and a peer specialist training program from a behavioral care agency.

The PATH program is the result of a partnership with the Colorado Coalition for the Homeless. One professional and two consumer employees supervised by CHARG provide outreach and assistance to homeless persons with mental illness. In addition, staff from PATH “hang out” at the drop-in center to assist homeless consumers attending programs there. CART is a coalition of consumers and advocates in the community that promotes the rights of people with mental illness. Many of the staff and consumers at CHARG are active in this association.

### **Empowerment Literature**

The partnership model of CHARG is based on empowerment principles and philosophy. Empowerment, as an intervention concept and as a philosophy, has become an important focal point for the transformation of mental health services. Examples of models that incorporate empowerment include self-help programs, clubhouse programs, consumer-run models, advocacy/empowerment models and strengths-based case management approaches (Deegan, 1992; Chamberlain, 1990; Rapp, 1998; Rappaport, Reischl, & Zimmerman, 1992; Silverman, 1992; Rose, 1992; Segal, & Anello, 1992).

The term empowerment appears in many different fields and has been applied rather loosely in the mental health service system. For purposes of this article, the definition of empower-

ment is derived from mental health consumer perceptions in a research study on empowerment (Manning, Zibalese-Crawford, & Downey, 1994). Empowerment is the ability of individuals with serious psychiatric disability to make choices that give them control over their lives. Empowerment includes

- feeling respected by having a voice, and being listened to
- managing one’s own mental disability
- finding and using financial resources, employment, recreational facilities, creative outlets, health resources, and social friendships necessary for quality of life
- belonging to a natural community through developing relationships with others
- contributing to the well-being of others
- “coming out” about psychiatric disability.

Empowerment is multidimensional. Through empowerment, individuals have the ability to be more self-determined in personal, interpersonal, and social-political arenas. These dimensions result in changes in attitudes such as self-efficacy and self-control, the acquisition of knowledge and skills to cope with problems and challenges, and increased participation in community/group actions to improve quality of life (Gutiérrez, Parsons, & Cox, 1998; Manning, 1998). Empowerment is a developmental process and happens in relation to taking action and making decisions. Kieffer (1984) found a substantial relationship between the developed attitudes of self-efficacy and self-worth, and the individual and group actions taken to resolve issues and challenges by individuals.

Professionals must confront traditional attitudes and beliefs when working with

consumers using an empowerment model. Shera (1994) developed some principles for working with people with serious mental disability that are congruent with the partnership model. They include

- (1) People are treated as subjects rather than objects; the service recipient is a person first, before diagnosis and psychiatric symptoms are considered.
- (2) The focus of interventions is on strengths rather than pathology or deficits: consumers actively participate throughout the helping process—in treatment planning, program development, staffing, and evaluation.
- (3) Resources are viewed as the total community, rather than formal mental health services.
- (4) Emphasis in the helping relationship is on the creation or rejuvenation of informal social networks.
- (5) Evaluation and advocacy are accomplished in a collaborative manner.

These principles provide the foundation for collaborative relationships between consumers and providers. The distribution of power becomes one of partnership, rather than “power-over.”

There is increasing empirical evidence that empowerment philosophy and interventions result in positive outcomes for consumers in increased social skills and improved quality of life (Manning, et al., 1994; Paulson, 1991; Rappaport, et al., 1992). The integration of an empowerment model with the collaborative and power-sharing aspects of a partnership provides the innovative and effective approach incorporated in CHARG.

## HISTORY

CHARG was formed in 1980 as a non-profit 501(c)(3) corporation, with the help of a VISTA volunteer. CHARG represented consumers who were receiving public mental health services in the Capitol Hill neighborhood of Denver through a model community support program called the Boardwalk Community. Lynn Jones, an author on the partnership model (see Jones, 1984, 1992) was our staff advisor. We had some challenges getting ourselves established; for example, in our early meetings some people fell asleep, and Lynn said to herself, “What did I ever get myself into?” But we always had a quorum, which is a good sign.

The year of 1989 was one of change for Denver’s mental health system, with the creation of a new entity called the Mental Health Corporation of Denver (MHCD) to provide all public mental health services. A small group of professionals saw this as an opportunity to try a new approach, working with mental health consumers independently of the public system. They formed HEART of Boardwalk as a new 501(c)(3) organization affiliated with CHARG. The two organizations became CHARG Resource Center, a nonprofit joint venture.

CHARG Resource Center opened in August of 1989 as a drop-in center for any interested mental health consumers. We started out with \$5,000. One of the former Boardwalk Community staff served as our drop-in director. The current executive director was hired in January of 1990. In February, the idea of having our own mental health clinic was brought up by the CHARG board, approved by the HEART (Healing, Empowerment, & Advocacy for a Richer Tomorrow) board, and implemented. We hired a part-time psychiatrist and a psychiatric nurse and began offering comprehensive mental health treatment.

As far as we know, *this clinic is unique in the country in that it is the only psychiatric clinic directly answerable to an all-consumer board*. After the clinic was underway, we got help from all sorts of organizations and individuals, but money was still tight. One month we were short \$400 of making the payroll. Sister Maureen, one of our staff, prayed, and the very day that we were supposed to make the payroll, she received a check for \$400 in the mail. This was perhaps the most dramatic of many small miracles which helped us to survive in those early years.

Shortly after the center opened, a consumer advocate in the early years had a woman come in who was living in her car. Winter was near, and the advocate was on the phone for an hour and a half before she finally found a place for the woman to call home for a while, so she could get off the streets. We tried to help everyone who came to us, whether they were in crisis or simply looking for a community to belong to.

In 1992, Barbara Quarton became the first consumer director of the drop-in center. A van was donated and has since been used for consumer transportation and activities. In December we partnered with the Colorado Coalition for the Homeless to begin a federally funded project to assist in the transition from homelessness. The CHARG Schizophrenia Peer Support Group (all consumers, no professionals) also started the same year.

In February of 1993, we held our first annual conference, with the theme “Sharing power in the mental health community.” We have held a conference every year since, to foster dialogue among consumers, professionals, family members, and other interested persons on issues relating to empowerment. The formation of CART (Coalition for the Advancement of Rights in Treatment), began in 1993 under the auspices of

CHARG. This coalition of mental health consumers and advocates in the community successfully fought to overturn the state of Colorado's plan to house civilly committed and criminally committed patients in the same state hospital unit. CART has been active ever since, and was instrumental in fighting a recent legislative effort to remove from state law a person's right to treatment for severe and persistent mental illness.

The Junior League of Denver provided major funding in 1993 to enable CHARG to purchase its own building. That site has become headquarters for our clinic, administrative offices, and two apartments rented to consumers through the HUD Section 8 program. We also continue to maintain our drop-in center at Our Savior's Church in the Capitol Hill neighborhood of Denver.

The history of CHARG represents the incremental development of a vision between consumers and professionals. Each added component and formal relationship with other agencies represented an enactment of that vision of shared power and collaboration. The values of empowerment are brought forward through action, advocacy, and the dissemination of knowledge. These same values must be represented through the structures and process of the agency.

## METHOD

### The Partnership Model: Important Components

The following components have been identified by the authors as critical to the success of a partnership model. They are described through the experience of the CHARG Resource Center. However, we believe that they represent areas which should be addressed by any program seeking to implement a partnership model.

“REDISTRIBUTING THE DECISION-MAKING POWER TO AN AUTONOMOUS CONSUMER BOARD ENHANCES THE SELF-DETERMINATION ASPECT OF THE EXPERIENCE OF EMPOWERMENT.”

### The Importance of Structure

To accomplish a partnership, structures must be in place that initiate a redistribution of power. These structures must insure open communication and opportunity for dialogue. The structures at CHARG, for example, help people—consumers, family members, providers, board members—talk together about what is going on in the drop-in center, the clinic, and the community. This dialogue sets the stage for decision-making in those areas.

In order to redistribute power, the *opportunities* to make decisions and the *obligation to take responsibility* for those decisions must also be redistributed. Traditionally, these opportunities and responsibilities have been removed from consumers, creating a “learned helplessness.” (Deegan, 1992). Redistributing the decision-making power to an autonomous consumer board enhances the self-determination aspect of the experience of empowerment discussed earlier.

A power-sharing structure redistributes respect, responsibility, and reciprocity. Working together as partners promotes a level of involvement that is different than in traditional mental health settings. This helps to eliminate the stigma and objectification that develop through use of diagnostic labels or through rigid professional roles, and enables people to see each other as unique individuals, thus promoting the person-to-person relationship mentioned by Shera (1994).

**Description of structures.** CHARG Resource Center is a partnership of two nonprofit corporations, both of which have 501(c)(3) status with the Internal Revenue Service. The CHARG board is made up of elected consumers, while the HEART of Boardwalk board consists of lay citizens drawn from the community. The two boards share hiring and firing authority over the executive director and overall responsibility for accomplishing the mission of the agency. Each board must approve any policy decision, and CHARG board members are usually part of hiring decisions. The executive director attends both board meetings and meets with the board presidents and the clinic's medical director on a regular basis. An affiliation agreement reinforces the partnership.

This structure is different than consumer representation through consumer membership on the community board. Consumers in a token position on a board are isolated from peers and lack the political power to effect change. Also, because of previous socialization in the mental health system, consumers have learned to adapt or depend on professionals to decide for them. The structure at CHARG requires the consumer board to have *equal* decision-making power with the HEART board. This ensures an independent policy-making role for consumers in the organization—critical in order to share power.

Two policymaking boards may appear cumbersome, with the potential for creating conflict. However, conflict has been almost nonexistent because the boards cooperate well, operating with a high degree of trust and a sense of a shared mission. Should the boards disagree, procedures for conflict resolution are part of the governing policies.

In practice, much of the day-to-day operation of the organization is overseen by the CHARG consumer board, which meets once a week at the CHARG drop-in center. The HEART board meets once a month, and tends to look more at long-term goals, fundraising and financial matters. However, as noted above, any policy which is initiated by one board will be presented to the other for approval, before going into effect. The boards meet together at the end of the fiscal year to review the accomplishments of the previous year, to revisit the vision, and to develop strategies and goals for the coming year. These meetings are also an opportunity for socializing and celebration, and they help to create a sense of working, reviewing, and moving forward together.

All meetings of both boards are open. Consumers spontaneously join a discussion in a HEART board meeting. Similarly, the CHARG board (which meets at the drop-in center), has consumers, providers, and community members who observe and/or join in. This creates an invitation for involvement. Having examined this participatory governance system, we now turn to the type and range of services that are integral to the success of an empowerment model.

### **Type and Scope of Service**

It is important to decide at the outset the range of services that should be provided within the partnership structure, with careful attention to the funding sources available to support specific services. CHARG began as a drop-in cen-

ter, with the commitment to identify further areas of unmet needs, and to develop services to meet those needs. A strategic plan (including sources of financial support) was necessary to gradual service development. The following is a summary of important components that provide the base for services provided at the center.

***Consumer-centered and trust-promoting services.*** Critical to the success of a partnership is the trust between partners. CHARG Resource Center was fortunate to start with a key group of consumers and professionals who grew to trust and respect each other over a period of years. The philosophy of encouraging consumers to accept responsibility for their lives and the willingness to share power helped to develop trust. At CHARG, the professional staff has agreed that consumers have the right to make decisions concerning the running of the program, as well as having a say in their own treatment plans. They have been willing to teach consumers the necessary skills to work as partners in the program. This focus on consumer choice, decision-making, and skill development reinforces the essential elements of an empowerment model (Gutiérrez et al., 1998; Manning et al., 1994). Some consumers already had a number of valuable skills, and it was a natural progression for them to assume responsibility and become equal governing partners in this model. Thus, the ability to make a contribution and the opportunity to help others also reinforced the development of empowerment (Manning et al., 1994).

The spirit of trust and partnership extends into the arena of clinical treatment, sometimes the last bastion of traditionalism. In developing treatment plans, the individual consumer and his/her clinician will talk about what each one feels needs to be addressed; they will discuss what is most important to the consumer, and will work on those

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issues first. The CHARG consumer board added a new page to the end of each treatment plan, giving the consumer a chance to express any feedback he/she wishes, regarding the clinic's services. This feedback is summarized and reported back to both boards. In the past year, a Treatment Issues Group has also been established, consisting of one professional and four consumers. The group discusses what is important to consumers, decides if policy changes are needed in the clinic, and makes recommendations to the boards. The group also functions as an in-house informal complaint resolution system. These opportunities for feedback to the governance structures help to integrate the evaluation and advocacy components referred to by Shera (1994), presented earlier in the discussion.

A climate of trust also creates an atmosphere that can be noticed by a visitor to our center before a word is ever spoken. Visitors report that they often cannot tell who is a consumer and who is a professional—always a good sign that a program is on the right track! We strive to

create an inclusive, family feeling in which diversity is naturally accepted. One of the authors of this article, for example, is a blind, gay man. Heartland Clinic has helped him to feel more comfortable about himself. He particularly comments, "My sexuality wasn't what anyone was worried about. I didn't get the usual attitude about this issue as I have in other situations."

**Advocacy and community connections.** We believe that a truly empowering program must include an advocacy component, which enables consumers to address larger issues regarding the system and to take their rightful place at the table when decisions are made. Advocacy relates to the political dimension of empowerment, where consumers develop the ability to impact their larger environment (Gutiérrez et al., 1998). CART has been an important avenue for CHARG members to join forces with numerous other like-minded individuals and organizations to bring about positive changes in the Colorado mental health system.

Individual CHARG members also spend some of their time pursuing advocacy and building community alliances. Executive Director David Burgess recently completed a term as the President of Community Shares of Colorado, an alternative workplace-giving federation that provides some funding to 95 small, grassroots agencies. Barbara Quarton is on the governor's Mental Health Planning and Advisory Council. Two of our consumer board members are on the board of the Mental Health Corporation of Denver, which remains the major mental health provider in Denver. Another board member is on the Advocacy Committee of Capitol Hill United Ministries, pursuing advocacy goals at the state legislative level. We also speak at churches, schools, hospitals, community groups, and conferences, to promote a wider understanding of the realities of mental

illness, the possibilities represented by our partnership model, and to combat stigma. These community connections are not a prerequisite for board involvement on the CHARG board. Instead, they are natural evolutions of individuals who pursue increasing leadership and advocacy based on the opportunity to be involved. The community connections and political advocacy serve to reduce the stigma of mental illness, as well as promote the self-efficacy and self-worth of individuals and the group (Kieffer, 1984).

A consumer-professional partnership will naturally want to seek out other partners in the larger community for financial, political, technical, and even moral support. Individuals, private foundations, and a variety of religious institutions have all provided CHARG with important assistance. The development of community support is attributed to the emphasis on relationship building and involvement with resources outside the agency, an example of Shera's (1994) principle on utilizing community resources.

**Socialization and recreation.** A healthy community needs a gathering place, and the drop-in center represents a crucial resource for socialization and recreation. Many of our consumers are isolated from family and friends, and CHARG functions as a primary support system for them—a beginning of their own community. Our location at Our Saviors Lutheran Church is particularly beneficial, as it is close to four boarding homes serving persons with mental illness, as well as being centrally located to city buses. Activities are developed according to the needs and desires of consumers, and therefore the activities are relevant to the consumers' quality of life. The drop-in center has a reputation for its "Tuesday lunch"—a nutritious meal in the company of others for 50 cents. The meal is planned, cooked, and

served by consumers with staff support. Holiday parties and rituals are held to help connect isolated individuals to a sense of community, an important source of empowerment. Activities such as shopping, joining a competitive athletic team, and camping trips create opportunities for the personal and interpersonal development of empowerment. Consumer involvement in the planning and implementation of activities provides the opportunity for decisions, responsibility, skill building, leadership and contribution—all mentioned in the empowerment literature as important to empowerment.

### **Contribution: Employment and Volunteerism**

A central aspect of the partnership philosophy at CHARG is to utilize the skills of our own consumers in as many aspects of our program as possible. All of our consumer positions offer skills that can be taken and used elsewhere in the workplace. Positions now filled by consumers include receptionist at the clinic and drop-in center, clerical staff, consumer advocate, a van maintenance person and driver, the drop-in center director, and director of administrative services. In addition, volunteers are involved in every part of the drop-in operation from leading groups to organizing activities. Two consumers have been recognized for their contributions in volunteerism to the community through the Community Volunteer award from the Denver Foundation. Most recently, six consumers were hired as consultants to give training in empowerment at a local mental health center and to introduce the partnership model as part of a federal grant. The consumers, in collaboration with the executive director and the facilitator of the grant, developed a talk show format to disseminate the conceptual information. Opportunities for employment and volunteerism place the consumer in the decision-making role and increase consumers' impact on the

organization and the community. This impact is an example of the political dimension of empowerment (Gutiérrez et al., 1998).

The above components by themselves cannot begin to capture the process of empowerment. Perhaps the best presentation of an empowerment model in action is through a consumer's story.

### **A Story of Partnership in Action**

A key aspect of CHARG's partnership/empowerment model is the growth of consumers' independence and self-esteem. We would like to give an example of how this philosophy works in practice by sharing with the reader the following "tee shirt story":

The teams for volleyball and softball needed sports tee shirts with our logo on them. First we needed to find a place that would do these tee shirts for us within the range of money we had to spend. Before we could get a bid, we had to have a logo made up. Margie, our Program Director, thought she could bribe someone to do it with a free lunch. Edith said, "Leah (a consumer) is sitting in a basement apartment with a four thousand dollar computer, and she is capable of doing the logo." Leah did the logo. But then the decision became more complicated because Leah also wanted to do the tee shirts with the logo and make the transparencies. So then we had a problem. Do we go to the professionals or to Leah? Can Leah do the job? The CHARG consumer board spent much discussion time, for the decision rested heavily on our shoulders. We finally decided that we could not pay Leah adequately and to go with the professionals, as they could do the job for less money.

Leah went to war. She said, "I will match their price. I want to do these shirts." So we had her put the logo on a shirt, and we ran it through a washer and dryer six times to find out if it would fade. When it didn't, we knew that this was possible. We

gave Leah the bid, only to find out that she was not going to provide the tee shirts. So we went into the tee shirt business. We got three different samples at department stores, and we had to decide which to use. This took a while. The extra large and medium necks didn't match, so we knew the end result would look a little scrappy. We persevered anyway and bought the tee shirts, the price of which had to be taken off Leah's bid amount. We finally ended up with 75 tee shirts; we gave them to Leah, and she put the logo on each one by hand with her iron. She also added a small logo to each sleeve, which was a nice extra touch. We were the only team with consumer-made tee shirts, and our teams wore them with pride.

This is the process that goes on with most of our decisions. From this story you can see that we used a common bond of trust. To paraphrase our friend Dr. Ed Knight, we used the mutual process of helping oneself and helping other people. It was voluntary; it was not mandated for us, or charity. It was trusting, open, and supportive. It was an experience of learning and reaching out. We learned a lot about tee shirts. There was no dichotomy between the person giving or receiving help. Margie, our Program Director, and David, our Executive Director, have no vote on our board, and they rode it out.

We got a tremendous amount of self-esteem out of walking out onto the field in our consumer-made tee shirts. I like to think that we act as "stigma busters"—in our actions, our decisions, and by being examples to others.

### **Challenges of the Partnership Model**

The idea of partnership is attractive, but implementation poses a number of challenges for professionals and consumers alike, as we strive to move beyond our old habits of interacting.

**Giving up power.** Professionals are trained to develop and apply their skills to problem situations, to have something tangible to offer. For many, this is central to their identity and their feeling of job satisfaction. Empowerment requires a fundamental shift for professionals to leave a problem alone, so that clients/consumers can address it themselves, in their own way. Professionals are still needed to help define the problem, sort out options, etc., but must resist the impulse to become too assertive in their suggestions. This is especially challenging when the professional is fairly certain that consumers are making a mistake. By letting things proceed without becoming actively involved in directing the decision-making, the professional allows for the possibility of one of two possible outcomes, both potentially beneficial:

- (1) The decision may turn out to be a good one after all, despite the professional's misgivings.
- (2) The decision may in fact be a mistake, but it is important for consumers, like everybody, to be able to learn from their mistakes. In other words, empowerment means the freedom to choose, without conditions; otherwise, power is really not being shared.

The partnership model, however, does not imply that all power is transferred from professionals to consumers. There may be situations in which imminent harm would result from a course of action, and the professional may need to intervene. In a partnership, there are understandings about various decision-making arenas appropriate for consumers and others appropriate for professionals. Thus, consumers must be involved in all policy and program decisions. Professionals have more discretion in clinical areas that relate to professional standards. For example, the psychiatrist would not be expected to

prescribe a medication that would not be clinically indicated, even at a consumer's request. A certain amount of trust, flexibility, and dialogue is called for here; but an important step for the professional is to go through the attitude shift described above.

Another more basic obstacle to empowerment of consumers is that professionals enjoy exerting power. It feels good to take positive action, to feel responsible for creating something of value, and we all need to feel that our talents are engaged. The challenge is to engage those talents in letting go of power, and to feel good about doing that. This requires a shift in perspective for most professionals in terms of the basic sources of our job satisfaction.

**Accepting power.** For the consumer, taking a share of the power means shouldering increased responsibility, and many may be uncomfortable with this role. This has been our experience at times with CHARG and its board. Consumers also may be comfortable with certain behavioral patterns, and are used to having professionals make certain types of decisions for them. Many professionals face the challenge of helping their clients to build personal skills such as time management, budgeting, food preparation, apartment living, etc., in order to enhance self-determination. In this partnership program, a new challenge is added: helping consumers build the necessary skills to plan budgets, and to do program oversight, fundraising, long-range projections, etc. Many consumers view such tasks as the job of the professional. Since these are not always easy tasks, some may shy away from taking them on. It may be particularly stressful to contemplate budget shortfalls, program cutbacks and the like; however, an equal governing partner must also take on these responsibilities. Skills training and leadership development are critical to the success of this effort.

**Trust.** Attention given to assessing the existing degree of trust between mental health professionals and consumers is ongoing. Trust can vary considerably, depending on the past history of coop-

  
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eration and respect. Also, consumers are a diverse group with different viewpoints regarding the value of professional assistance, medications, and the idea of partnership. Consumers also have varying levels of impairment. CHARG consumers are individuals with severe and persistent mental illness, with significant impairment in their ability to be productive. The process of developing a group identity for consumers, and between consumers and professionals, and respect for the developmental nature of empowerment, become important factors in identification of goals and likelihood of success.

**Role issues.** The collaborative model creates many different and complex patterns in terms of roles and responsibilities. Consumers experience multiple roles that can cause complex dilemmas. They may receive services from the clinic and also volunteer to help run a group. They may be on the CHARG board as well. HEART board members

may be volunteers in some clinical part of the program. To clarify this, a policy was developed that ensures that a person at any given time can only be in one role. For example, if a consumer from the CHARG board is volunteering in the clinical program and his/her job performance leads to a complaint, he/she cannot function as a board member and rule on the complaint. Sometimes consumers feel confused about where one role stops and another starts. A consumer board member may make decisions about policy, and then have a hard time with feedback from his/her clinician about behavioral problems. Staff may have a difficult time making the transition from traditional role behaviors. They are used to “just deciding” and now have to refer to the CHARG board for issues such as policies about disruptive behavior.

Blurred roles also create opportunities and benefits. Board members speak on particular topics at the drop-in center. Consumers help teach classes on mental health at the university where a board member teaches. Consumers have helped to conduct research studies on empowerment, and have at other times been research subjects, contributing their own perceptions of empowerment. Despite some challenges, the overall effect of multiple roles has been liberating. Consumers develop new skills. Leadership roles change their self-perception and how they are viewed by others. Board members and staff experience involvement that is emotionally satisfying. Stigma at all levels is impacted in a positive way.

DISCUSSION

**Implications for Larger, More Traditional Systems in Public Mental Health**

CHARG is a relatively small agency with a small client-to-staff ratio, which affords a personal and interactive approach. This environment enhances the practice of partnership. Larger mental health centers typically have larger caseloads and a more impersonal, provider-driven environment. The philosophy in most traditional settings is the medical model, in which the treatment provider is the expert and determines the best course of treatment for the client. The client's role is essentially passive; he/she is expected to follow treatment recommendations. A system change requires adoption of an explicit philosophy of empowerment. The entire system is affected, since treatment involves a continuum of care. During the treatment

process, consumers are often involved in different programs with different providers.

In the partnership model, professionals are recognized as having clinical expertise and knowledge; clients are viewed as having experiential knowledge—knowing what they need to enhance their recovery. The consumers' role in a partnership model is active in developing the course of treatment and in the evolution of treatment. Resulting changes in the nature of the relationship require important attitude and value shifts on the part of providers and consumers.

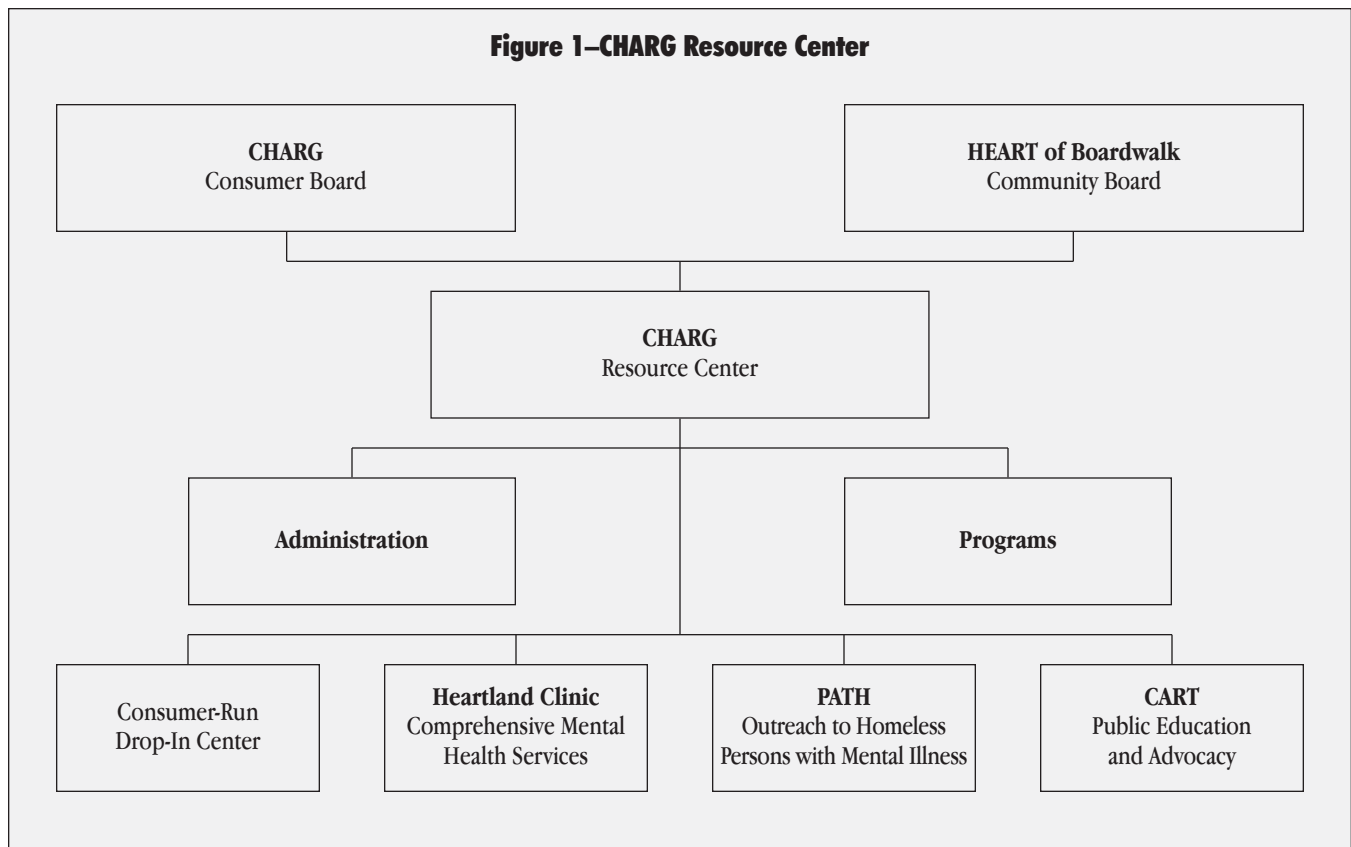
Implementation requires adequate training for administrators, professionals, consumers and family members. A "consciousness-raising" is necessary for all groups. The importance of shared power at all levels of the hierarchy must be understood conceptually, and structures provided that initiate the sharing of power. The organization may need to

address caseload size to determine adequacy for this more intensive, interactive model of treatment. Resistance to change by all groups is a normal part of the process. Questions of consumer involvement in budget, policy approval and strategic planning may well prove to be more difficult than consumer empowerment in clinical treatment services.

In the clinical arena, there may be a self-selection of consumers and professionals that are attracted to the empowerment/partnership model. More investment of time by providers may initially be necessary to ensure that the process is going well.

The culture of the system must reflect openness to feedback by consumers, with attention to making the system consumer-friendly and respectful. Structures for consumers and providers to give feedback on how the process is working are critical to develop, and feedback must be effectively utilized to

**Figure 1—CHARG Resource Center**



ensure services are delivered in a manner compatible with empowerment/partnership principles.

## GENERAL IMPLICATIONS AND CONCLUSIONS

The practical and realistic nature of CHARG Resource Center's partnership model is perhaps best illustrated by the fact that the Center celebrated its tenth anniversary of successful operations in August of 1999. Of course, no program has all the answers, and we at CHARG continue to learn from our mistakes. Other programs interested in partnership will be subject to their own realities—political, administrative or financial—as well as differences in the pre-existing level of trust between the partners. Some may envision a more central role for AMI's or other family-member organizations.

We believe that the most important lesson of CHARG's partnership experience for professionals is to learn to let go of power gracefully, and thereby to surrender exclusive rights to the very design or vision of what their program is to become. Within larger mental-health systems, professionals must seek ways to create smaller communities in partnership with their consumers—settings which allow for empowerment to be exercised on a human scale. Consumers must learn to handle power and its associated headaches, and to be realistic about their need for professional and other types of assistance from their friends who are not mentally ill. This assistance can be acquired without giving up decision-making power or independence, and that is perhaps the ultimate lesson learned at CHARG Resource Center.

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