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Frontstage and Backstage Ethics in Mental Health: A Qualitative Case Study

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Abstract

This qualitative study attempted to examine the ethical principles of autonomy and confidentiality and their applications among the daily work activities of mental health case managers. The philosophical concepts of Utilitarianism and Deontology were also examined as justifications for the case managers' applications of treatment. For the purpose of this study, a qualitative interview was conducted with three, mental health, intensive case managers to ascertain their individual perceptions and applications of autonomy and confidentiality. Observations of case manager team meetings and reviews of several agency policies were also conducted. All data were then analyzed for thematic content. The emerging themes consisted of: daily havoc, confidentiality is contextual, autonomy is relative and is manipulated, and protection. These themes suggest that the application of autonomy and confidentiality are directly influenced by contexts, policies, values, and behaviors. This study should be beneficial to health care practitioners for the purpose of recognizing the dynamic role of context and its' influence on client health care and therapeutic management.

Overview

Ethical principles are perhaps the most salient representations of human thought and action embraced by individuals, societal institutions, and communities. Despite their traditional acceptance, these principles can, and often do possess various meanings that are either directly or indirectly influenced by the cultural context in which one interacts. The controversy that comprises ethical decisions and their applications is derived from the nature of ethics itself. The role of ethics becomes apparent only as one considers his actions in response to another. Therefore, human interaction is but one prerequisite of ethical application; context furnishes the remaining attributes. It is the human component however that appears to provide the dilemma that characterizes ethical applications. For instance, human interaction is diversified and characterized by multiple perceptions, beliefs, and attitudes. Although many theorists argue that human interaction is comprised of entirely observable behaviors (Skinner, 1971), its diversity poses difficulty for measurement and predictability. In essence, humanity is the gray between the black and white that comprises our societal rules and regulations.

Ethical principles assume primary salience within a mental health setting predominantly because of the multitude of individualities and the civil eases with which the mental health practitioner can assume a paternalistic role with a client that is experiencing personal distress Thus, both context and human interaction encompass the bureaucratically established mental health system. In essence, it is almost paradoxical to analyze the colorful role of ethics within a monochromatic bureaucracy.

Throughout history, ethical principles and their applications have consisted of both analysis and controversy. Traditionally, philosophers have been designated as those who are associated with the study of ethics. However, as health care reform has become a reality, many health care associations have begun to examine the role of ethics as it applies to the treatment of its societal members. Despite the enactment of ethical codes for various disciplines such as those established by the American Psychological Association, the American Medical Association, and

the American Bar Association, controversy is most evident in the application of ethics to the mental health client (Bersoff, 1994). Salience within a mental health setting arises from the controversial and transitory mental status of the mental health client. Although, it is a logical assumption that a mental health client is experiencing difficulty in exercising judgment (with respect to his daily activities), it is not a logical assumption that the client is incapable of exercising coherence in thought or decision. Kitchner (1984) has identified five ethical principles that pertain to the treatment of mental health clients: autonomy, beneficence, justice, fidelity, and nonmaleficence. These principles are not only based upon specific rules and principles, but upon the basic foundations of morality.

Although little research has examined the role of ethics in health related fields, Kugelman (1992) analyzed the function of the National Association of Social Work Code of Ethics in regard to contextual and organizational variables. Social work participants were presented with pre-established vignettes that posed ethical dilemmas. The dilemmas required that the participants provide a course of action in which either personal and/or organizational power could result in direct conflict with the organizational code. Kugelman (1992) concluded that as the scenarios oscillated (in content) between the number of ethical considerations and the number of organizational demands, the participants' responses varied accordingly. Therefore, in light of this disparity, Kugelman (1992) advocated for the continuance of ethical education. She extended this assertion by citing apathy and routine decision making as primary concerns that face health care disciplines who do not ensure adequate ethical preparation.

Although Kugelman (1992) provided an original account of the role of ethical principles in health care disciplines, the use of prepared vignettes may have indirectly influenced the participants' responses. Since, as asserted by Kitchner (1984), ethical principles are a combination of conventional standards and character morality, author-created dilemmas may serve as a reflection of the author's ethical standards rather than the perceptions of the participants. Despite, the transition in discipline, Hasselkus (1991) attempted to gain an understanding of ethical applications as they related to the practice of occupational therapy. In addition, Hasselkus (1991) examined the roles of what Kitchner (1984) proposed as the five basic ethical principles. For the purpose of this study, the author interviewed sixty care givers in regard to their daily routine. Specific questions that referred directly to the ethical principles were avoided, but were deduced from the participants' responses. Hasselkus (1991) found that a significant disparity exists between a care-giver's "personal code of ethics" and that of the occupational therapists. Specific differences were noted between family perception of autonomy and beneficence and that of the occupational therapists. As a result, Hasselkus (1991) asserted that therapists should examine the personal ethics of the family prior to dictating a course a course of action for the care- giver to follow.

Thus, Hasselkus (1991) provided evidence for the diversity found between ethical perception and ethical application. Her purpose, was however to provide credibility for the use of qualitative measures as a means to assure equality between the ethical perceptions of care-givers and the actual therapeutic practices delivered by occupational therapists. Despite the diversity in academic discipline, Hasselkus' (1991) methodology possesses significant implications for this study. Specifically, authenticity increases as one enables the participant to "tell" the story and relate their individual perceptions.

There is heuristic value in examining Kitchner's (1984) ethical principles, for it enables the researcher to consider the fundamental ethical principles within a pristine view, as well as within a socially constructed formal code of ethics. Furthermore, support for the theoretical position of Utilitarianism can be derived from both Kitchner's (1984) and Kugelman's (1992) studies which suggest that contextual variables directly influence the application of ethical principles.

For the purpose of my analysis, I had chosen to examine the role of autonomy in the treatment of mental health clients. Autonomy can be analyzed from generally two perspectives. However, autonomy is primarily viewed as an individual's right to choose their course of action and to make

their own decisions without justification. I will refer to this definition when discussing autonomy. The dilemma thus arises when one must consider another's level of competency. In addition, issues of confidentiality are also inherent within the concept of autonomy. Confidentiality (with respect to its' definition), extends the concept of ethical responsibility, as well as exerts legal prominence within a mental health setting.

Historically, Plato in his documentation of Socrates' discussions, was perhaps the first to provide an analysis of ethics as it relates to the mental health client. Socrates discussed the course of insanity as it related to the responsibility of society (Ozmon & Craver,1995). Inspired by Socrates' discussions, philosophers have scrutinized the application of ethics from two dominant perspectives, Utilitarianism and Deontology. Utilitarianism adheres to the role of context in the application of ethics, whereas as Deontology maintains an absoluteness of ethics regardless of the context (Fine & Ulrich, 1988). In accordance with the scrutiny of ethics, I chose to examine the ethical perceptions and applications of mental health case managers. The philosophical concepts of Utilitarianism and Deontology were also examined as justifications for the case managers applications of treatment.

My interest in the application of ethical principles within a mental health setting stems from my clinical involvement with mental health clients. My early role within the mental health field was limited to predominantly concrete variables. For instance, as an evaluating school psychologist, I assessed clients for potential mental health status and service appropriateness. Therefore, my involvement was limited to measurable assessments; decisions that render and monitor services are made by a team designated as "utilization and review". However, despite my limited involvement, specific mental health practitioners, such as case managers, maintain daily contact with clients. It appears that during this intense involvement (between client and case manager), the case manager assumes several roles: that of friend, advocate, and monitor. In consideration of these roles, I became interested in the perceptions and applications of autonomy and confidentiality that are manifested in the social work and psychologist Codes of Ethics.

Methods

My analysis of case manger ethics began in March of 2006. I selected a local mental health agency, which I will call "Linkages" as the source for my data collection and consequent analysis. Linkages was established in 1980 as a focal point for the county mental health system. "We are the gatekeepers of services", was the description that a case manager provided. At Linkages potential consumers are informed about services and are evaluated according to their individual needs. In addition, Linkages provides case management services to those individuals who are considered to possess chronic symptoms, such as those that are routinely hospitalized for psychiatric behaviors (suicide, depression, schizophrenia, anxiety, self mutilation, injurious conduct, etc.). I limited my subsequent analysis to three case managers, (Linda, Alan, and Sue) so that I could obtain an in-depth account of their ethical perceptions and applications. I obtained permission to conduct this analysis from the Executive Director of the agency, as well as from the individual participants, who then introduced me to the case management supervisor. I then explained my study to the supervisor, who facilitated the selection process by introducing the topic at a team meeting and enlisted the aid of three volunteers (Linda, Sue, and Alan).

Case Managers

To reiterate, Linda, Sue, and Alan volunteered to serve as my participants within the study. Each was employed as an intensive case manager at Linkages, and each possessed bachelor degrees in health related fields, such as psychology, counseling and social work. Although the participants varied slightly in age, (Linda-30, Sue-27, Alan-41), they possessed similar employment histories, as well as comparable years of employment at Linkages (4.5 years).

In regard to work related experience, Linda was previously employed for three years with a Children and Youth Services Organization. She described this job as ". . . very stressful and

heart wrenching". Linda's demeanor can be described as "up front". She appears to be a person "who tells it like it is". Linda attributed her decision to leave Children and Youth to the birth of her daughter.

> I'm a single mother, and I couldn't stand to see the day to day abuse and the number of mothers who would give up their kids so that they could go and party.

Sue, like Linda, had also worked with a child/adolescent population prior to her employment at Linkages. However, in contrast to Linda, Sue's primary role was directed toward the therapeutic preservation of the family. Sue stated that she aspired to work in the mental health field primarily because of personal reasons.

> . . . because I was an adolescent involved in the system. I couldn't cope with my parent's divorce and I started to act out a lot, so I was sent to PHASE [an adolescent partial hospitalization program] so that I could work on school and me and my family could work on issues together.

In contrast to both Sue and Linda, Alan began his educational career later in life at the age of thirty-three. However, despite his initial lack of formal educational training, he was employed as a supervising house resident within several community mental health/mental retardation facilities. His involvement within the residential programs initially arose from his personal struggle to find housing for his mentally retarded brother and emotional stability for himself.

> It was hard to find a home for Ben. After all he was in an institution for twenty-three years of his life. Community help was sparse and Ben was reluctant to participate in the community. I had to literally, work day in and day out with him so that he could handle everyday things, like saying "Hello" to people instead of staring at them. So when I saw an ad asking for a live-in aide to care for the mentally challenged, I applied for the job and applied for a place for Ben to live too. See, I was homeless for nine years, so I know what these people go through, and when I found out that Ben needed help, it was a turning point in my life. I got my act together.

To ascertain sample interpretations of the ethical principles, I observed Linda, Alan, and Sue during their scheduled team meetings, interviewed each individually, and examined their individual case notes. Specifically, I accumulated thirty-three hours in data collection during a three week period. In addition to these rich data sources, I also examined several agency policies that pertained to the maintenance of confidentiality and autonomy such as those that involved home visits, informed consent, and release of records. In support of multiple data sources, Glesne and Peshkin (1992) assert that various data sources facilitate the authenticity of the analysis; multiple data sources provide an inherent check for consistency and verification. Thus, from this array of data, I was able to substantiate my qualitative inferences by coding each data source, placing similar codes into summative categories of description, and then deducing the categories into overall encompassing themes. Therefore, each theme was substantiated by its respective data sources.

Daily Havoc

Although I did not attempt to examine the case manager's perceptions of their work environment, I did gain a legitimate understanding of their daily routines. Within this context, havoc appears to characterize the manager's typical day. "I never know what to expect," was a description offered by one case manager, Sue. Linda further substantiated this theme stating, " I don't think any day is typical". This lack of standardization is also reflected in the case manager's work hours. A case manager works according to what Alan called," . . . a flex schedule". The manager's schedule is arranged essentially by their caseload and then followed by approval from their

immediate supervisor. Although a typical work week consists of 37 1/2 hours, as stated in the agency policy, the managers possess relative freedom in the construction of their schedule, which does not preclude client weekend visitations or emergencies. This apparent freedom (to construct one's own schedule) is however deceptive, for the clients' needs appear to supersede, if not nullify, the schedule. Linda described this process as "biting into a piece of salty candy". Hence, although opportunity to construct their own schedules appeared as a reward, several limitations and constraints were inherent within its construction. The daily variations in scheduling can be attributed to a general lack of predictability for human behavior. " You can just leave a client in great shape, and the next day hear that they tried to commit suicide or something", according to Alan. Diversity in diagnosis also appears to add to the instability, for as reported by Sue, "it depends on the severity of the diagnosis and its characteristics. I mean if you have a borderline client, your schedule will be crazy; they can change like that" (she snaps her fingers). The agency policy that addresses schedule factors does not however provide a description of the circumstances under which a practitioner's schedule fluctuates. In addition, although procedural steps are listed for the formation of a schedule, the policy reads as if the schedule is incapable of multiple variations. For instance, the policy states, " white-out can not be used to make changes, a case manager's initials must be placed at the side of a change and a single line must be drawn through the incorrect information". Consequently, the appearance of the schedule at the end of a work week can be characterized as chaotic. "They're often a mess and hard to follow, but they do represent our craziness", as reported by Alan. Thus, these initial descriptions of a "typical day" serve as a prelude for the variance with which mental health case managers apply the ethical principles of confidentiality and autonomy.

Confidentiality is contextual

An emergent theme that I found throughout the various data sources was that of inconsistency in which the ethical principle of confidentiality was applied. For instance, although Linkages' policy in regard to confidentiality states " . . . only the consumer can consent to the release of information in their medical record", several limitations exist in reference to this statement. The first limitation was found in the agency policy that defined the course of action for the attainment of informed consent. Specifically, the policy states that,

> Clients may have access to their records if not subject to specific contradictions by the therapist, psychiatrist, or legality governing minors and those adjudicated as incompetent.

Furthermore, the agency policy defines "access" as ". . . physical examination, not including physical possession or a copy". Thus, it appears that the maintenance of absolute confidentiality is extended to the client himself. Discrepancy also exists in regard to the process of informed consent. Although the policy clearly indicates that the health care provider must obtain the client's signature prior to the initiation of record release, Alan stated, " there has been some confusion with one of the governing bodies because they are saying that we [Linkages] do not need a release to talk to them [the governing body], since they are the governing body". Linda substantiated this assertion of governing power in relation to confidentiality stating,

> some agencies think that you can fax releases, some don't. I don't think you should. There are small differences, C&Y won't worry about a release if it is something they need to you to do.

Sue acknowledged the difficulty in maintaining interagency confidentiality with this statement, " . . . I think that with a multitude of services that the systems are so inner connected that it can be breached so much easier because you are not referring to one specific entity all the time." Agency interconnection and the consequent ease with which information is exchanged is evident throughout my observations of the manager's team meetings. Linda, for instance discussed the transference of client status with individuals designated as psychiatrists, therapists, and specialized school personnel. The prominence with which confidentiality is released among other health care providers was also verified in my observation of the supervisor's answer to Alan's

concern regarding a client with significant drug and alcohol issues. ". . . see if we can have a D&A rep at the staffing".

The policy further extends its confidentiality limitations with its statement that defines when informed is not necessary.

> Records concerning those receiving services or
> having received treatment shall be kept confidential and shall not be released without consent except
> for the following in which summaries will be released: those engaged in treating the individuals and state correctional institutions.

The policy however neglects to provide documentation of the conditions under which confidentiality must be legally breached, such as in the event of client disclosure of harm to others or suspected child abuse.

In regard to the maintenance of confidentiality within the community, the agency possesses policies for general interaction and work- related visitations. For instance, the policy specifically states, "do not engage in conversations about consumers and their families in public places" and "let the consumer approach you first in public and avoid discussion of treatment". In a description of school visitations, Alan stated, " the only way that you can communicate is if the child comes to you and acknowledges you. Then if someone asks who I am, I ask to be introduced as a friend". In addition to the difficulty that arises from the maintenance of anonymity within the schools, Alan described difficulty in the avocation of client needs within the community at large.

> Well I have this young lady who needs a place to live and she wants me to talk to her landlord. Well I don't have a release for the landlord, so I agree to talk to him by identifying myself as "friend".

In contrast to Alan, Sue described the assurance of confidentiality as problematic within the schools. ". . . because when you deal with a child, you are not dealing with just the child, you are dealing with the entire family and the teachers, and so the releases are not just signed by the parents, but by everyone involved". Linda concurred with Sue's perception of difficulty. She stated that ". . . confidentiality seems to have a wider range with children". "Even though they are small, they need to know what is happening, I've seen agencies talk to everyone else about the child, but the child". Therefore, confidentiality appears to be relative in accordance with the environmental context and in accordance with the source that defines professional interaction (i.e. policy, team meetings, health related professionals). Furthermore, although confidentiality (as reflected in the agency policy) is a principle that is to be maintained, it is paradoxical that it is the first principle that is often breached in the therapeutic relationship. For instance, Linda stated,

> I know that they don't want to tell me things, so I take them to the mall so they can relax and with their feet moving, their mouths spill things, that probably to them is not anything, but as you are putting together the pieces of the puzzle you are like yea, this is why it is so clear now.

Autonomy is relative and is manipulated

As with confidentiality, I recognized various instances in which the application of autonomy (the client's right to make decisions) varied. Although the principle of autonomy was afforded to the clients by the case managers, the degree to which it was accepted appeared to vary in accordance with the clients decisions. A relevant question of freedom surfaces in regard to an analysis of autonomy. For instance, is one literally able to decide their own course of action, or is this process merely masking another's intentions? Linkages' policy is limited in regard to both its establishment of rules for autonomy and in its application of autonomy. One specific example however states, " avoid sympathy unless the consumer requests it". Despite the lack of attention

provided by the agency policy, numerous examples that pertained to the application of autonomy were evident throughout the case-managers' interviews and discussions during my scheduled observations. For instance, Linda described autonomy in terms of her role as an advocate for client needs.

> I was taught by another, um man that supervised me from another agency along time ago that the squeaky wheel gets some oil, and I can squeak better than most.

This description was in reference to the willingness of the client to pursue services despite the unavailability of services due to monetary constraints and/or necessity of needs. In addition, autonomy was described as, " being willing to listen to the people's perceptions". Linda substantiated this claim with implications for the acceptance of cultural diversity. She stated, " I have a Cherokee Indian, um who only believes in bathing three times a week, because it has to do with your soul, and all that, or else I would probably be saying what the hell is he talking about". Alan concurred with Linda's statements and extended the role of autonomy to unconditional worth. ". . . now there is someone who is saying don't worry about that, it is totally ok and then just let them grow into that". At times however, respect for client autonomy can be in direct conflict of the safety of the consumer. ". . . this girl, probably the only one on my case load that will commit suicide. And I can see it, and I can smell it, but I can't stop it". Another case manager provided evidence for this frustration.

> Respecting a client's decision is difficult, if not insane, especially when you know that the family is the perp.

Thus, although autonomy is generally perceived as beneficial, the application of its principles can impose frustration and inquiry pertaining to one's right to life.

Although the case managers "surface" statements suggested that they respected client autonomy, I noted several discrepancies throughout their verbal descriptions and overt actions. The question to consider is whether autonomy is actually contrived or representative of another's values? One case manager equated the rights of mental health clients to the rights of a consumer in a department store.

> The consumer is always right in a store, and the consumer is always right on their likes, dislikes, and wants.

However, unlike the department store consumer, the mental health client is not always able to attend to the caveat because of a lack of information or competency. Sue, for instance related that

> . . . they come in with a specific idea of what they want or what they need. If you can't sell the other product to them, then they are going to go in and get the treatment that they wanted, but that is sometimes not filling the gaps that they need.

Alan, in his description of autonomy, described difficulty in providing services to clients. He,however rectified this difficulty, stating, " If they don't want services, I go back and on several occasions say "I know there is a problem here and you know that there is a problem here, we need to be able to have the resources you need". This directness of this tactic was evident in my observation of Sue's discussion of her suicidal client, T.C., who was abruptly released from a psychiatric ward by her father because of his disagreement with the facility psychiatrist. " I told her dad, you know me, that the responsibility is on him, it was his decision and he needs to get T.C. services".

Manipulation was another strategy for client concurrent that was apparent in the case manager's descriptions.

> . . . and you know as a case manager that this is what they need but that they are just not recognizing it, so you try to manipulate them to signing a release; you do a song and dance with them.

The use of manipulation was poignantly substantiated in another case manager's descriptions of initial client resistance.

> I suck them in. I suck them in. I go to their house, I become a fixture on their table, they get really comfortable with me, and I slowly point out [what needs to be changed].

Application of crisis management also appeared to possess elements of emotional influence. In his discussion of the relative meaning of crisis, Alan stated . . . " you have to contact them and get as much out of them that you can so that they can convert some of their anger and then to them it doesn't seem to be as urgent as it was a few hours ago". Manipulation was also evident in the case manager's use of rewards for appropriate behavior. " And you can use those wants and needs to your advantage; you know you can use them as goals or as a reward system for appropriate behaviors". Another case manager revealed that jokes and story telling can serve as additional tactics to facilitate the modification of client behavior.

> Um, I like to joke around a lot, joking around lets them feel open to recognize their craziness. Sometimes I will make-up stories that have never happened that I think are close to what is going on in the family so they think that others have done this stuff and then changed.

In addition to manipulation, one case manager rationalized her decisional dominance through the provision of education and logical consequences. For instance, Linda, in a description of what she termed "uncooperative clients" stated, " . . . I know that you really want to drink, but lets talk about what happens, you cannot take your meds and drink and have an even level that you won't cause harm to your self". Reference was then made to the enactment of logical consequences. " . . . then you let them make the choice. They might call me the next day and say, hey I'm really sick, and I say, hey we discussed this and you chose to drink, and honey I'm sorry ". The use of logical consequences as a representation of the rationalization that the case managers' dominance was further substantiated in Alan's discussion of a abrupt client.

> When he explodes in public, ranting and raving, I tell him, see everyone sees you and creates opinions, but if you were to remain calm, no one would talk about you.

Therefore, a summative question is whether autonomy can be maintained when a case manager's role is to modify or change a client's present behavior.

Protection

In accordance with their definitions, both confidentiality and autonomy provide for the protection of an individual. Protection is maintained by either the selective release of information or by the established rules of anonymity. Within a mental health setting, anonymity and censorship of information are crucial to both the maintenance of an individual's well being and to the attraction of future consumers. The agency's Client Information Policy clearly specifies that "the client is entitled to the protection of his record(s)". It further specifies that ". . . the information gathered and recorded is limited to client care". The protection of the client appears to be a paramount concern of the case manager's and is reflected throughout their statements. However, despite the centralized theme of protection, the case managers identified several different rationales for their incorporation of protection. For instance, Alan's statements suggested his concern for anonymity. " If a case manager goes to school, you have to be careful cause other kids are going to see them with you". Concerns for the maintenance of anonymity were also discussed within a context of community animosity and stigma effects.

> Without confidentiality it would create ah, there would be a lot of animosity between the community and the consumer that we work with, because a lot of consumers can not be readily identified as mental health clients, they could be very sick, and if they see people going in to them, they would have a tendency to shy away from services, I believe because of the stigma of needing someone to help them.

Sue concurred that anonymity is essential to lessen the constraints of future stigmas while facilitating the therapeutic relationship.

> They need confidentiality especially you know that I see it from my own point, later in life, that these children have some issues now, but protecting them and their future there is still a stigma about being a mental health client and people always think that you are crazy, and confidentiality ables them to open up and essentially let's them know that they are protected.

Aside from reducing the constraints imposed by labeling practices, the case managers explained that confidentiality is essential for the emotional well being of the client. "I think that all MH/MR clients have these self esteem issues and it is harder because they have been stigmatized with a diagnosis, but confidentiality enabled them to melt into the background". Linda further substantiated this statement.

> When they need help, they call us. That way we don't just show up in our little cars and cause a scene, and make them embarrassed and feel like shit.

In addition to the case managers' concerns for client anonymity and emotional safeguards, the case managers also provided evidence for the protection of their own personal safety, safety of the agency, and safety of others. During a scheduled observation Sue expressed difficulty in the acceptance of a particular client on her case load. "Could I switch referrals with Alice cause P.N. only lives one house down from my family and then he would know where I live and he would know that my family knows who he is". This concern for personal protection was also reflected in Alan's reference to his employment status.

> . . . if you are talking with anyone in the field, and ah,some asks how well do you know so and so, I say I never heard of them if I don't have a release. And there are a lot of agencies and staff that fish for information.

In addition, Alan suggested that a confidentiality policy also protects him from his own personal character flaws. For instance, he stated, "I love to talk, and I am a very verbal person, so I am forced to keep my mouth closed".

To reiterate, although Linkages' policy did not designate the conditions under which confidentiality can be breached, the managers clearly specified these conditions and cited community protection as their rationale. "Everything is kept confidential except when it pertains to the welfare of the community, and that is a fine line, except in cases of child abuse and murder." Linda substantiated this theme, as see made reference to the establishment of therapeutic rapport.

> Of course they understand that as a mandated reporter there are certain things that I have to report, and I make it clear from the get go. For instance, I say when it comes to hurting yourself or threatening to hurt someone else and having the means to carry it through, then that is it. I have to keep safety as an issue for you, your family, and whoever else.

Despite the agency's failure to list specifications for the abandonment of confidentiality within its policies, my review of Linkages' documents appeared to suggest their concern for internal protection. After a review of three policies pertaining to confidentiality and record release, I noted that significant legal discourse was present following each agency policy. For instance, the informed consent document that was listed as an example for client encounters, had several lines following the confidentiality statement in which a signature from the consumer, the case manager, and a witness were required. In addition, the policy concerning the release of information, specifically outlined the procedures for the receipt of a subpoena. "#1. Locate the CEO, #2. Do not sign anything unless your name appears on the subpoena." Furthermore, the Home Visit Policy required that the employee sign their name following this statement, " failure to comply with this regulation will result in suspension or immediate separation from this agency". Thus, although confidentiality is generally perceived as a means by which to protect the consumer, its application appears to possess significant bureaucratic corollaries for the internal protection of an agency.

Conclusion/Discussion

B.F. Skinner (1971), in a discussion of human behavior, negated the proposition that one's behavior is free of manipulative constraints. His discussion appears to coincide with my analysis of the case manager's application of confidentiality and autonomy. To reiterate, the application of absolute autonomy and confidentiality, as proposed by the Deontological Perspective, is contradictory, at least, when applied to a mental health setting. For instance, when a client seeks treatment, he is in essence asked to disclose his personal self to another, thereby relinquishing his right to confidentiality. Furthermore, the client, in order to discontinue services and/or to receive a positive treatment review, must change his behavior, thereby yielding his right of autonomous behavior to another. Therefore, unadulterated autonomy and confidentiality are contrived concepts within a mental health setting.

In accordance with the facade imposed by confidentiality and autonomy, manipulation appears to be a primary tactic that is utilized for the maintenance of the facade; it is inherent within the role of the mental health case manager. Although it may be either directly contrived or innocently enacted, the case manager's role is to " . . . facilitate positive human growth and development" as stated in Linkages' brochure. Thus, manipulation appears to be the means by which one employs his value system or the value system of the community. The presence of a value system was substantiated in Alan's concern for his client's anonymity within the community as a function of client's maintenance of discrete behavior. Although manipulation appears to contain negative connotations, its practice was primarily defined (by the case managers) " . . . as necessary to the health of the client". Hence, manipulation of a client's thoughts or behavior is an essential strategy to employ in reference to clients who experience suicidal ideations or actively engage in destructive behaviors (i.e. alcohol or drug abuse, non-compliance with medication, harm to others, etc.).

In contrast to the Utilitarianism perspective (that appears to define the role of the case manager), the Deontological Perspective, or the absolute application of ethical principles, is evident in the agency's written policies. This is substantiated by the discrepancies that were noted between the agency's policies and the case managers' descriptions of their daily experiences. Thus, it appears that the agency's policies reflect "black and white" conditions, whereas the actual application of ethical principles is analogous to the painter who mixes the colors black and white to create the color gray. Agency policy, however, may be a direct result of bureaucratic influence, that is typically unable to accurately account for the diversity of context and human interaction.
In conclusion, it appears that the application of autonomy and confidentiality are directly influenced by contexts, policies, values, and behaviors. Furthermore, through this analysis of their applications, I discovered that their definitions are aspirational and their applications are inconsistent. Although it appears that the assurance of "absolute" confidentiality and autonomy are in direct conflict with the role of a mental health practitioner, it is paramount that the limitations of the principles be discussed with the client and/or his advocate.

To conclude, the controversy that encompasses the application of ethical principles appears to be fed by the abstractness of their definitions. Ironically, it is the very abstractness of their definitions that affords one with the most freedom. Hence, it is important that future research not only draw upon a more diverse array of subjects but also expand upon the number of subjects to enhance the validity of the findings, as this study is limited by its case study analysis and qualitative nature.

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