Working With Families in Assertive Community Treatment (ACT): The Case Manager’s Perspective

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In response to research findings of insufficient family involvement in mental health services for people with severe mental illness, this grounded theory study examines case managers’ interactions with families of clients in Assertive Community Treatment (ACT). Findings suggest that case managers conceptualize families as sources of social connections, rather than sources of care, for clients. This conceptualization is influenced by case managers’ goals, which also guide their assessments of families for involvement in treatment in terms of the extent to which families help attain treatment goals. In developing strategies to work with families, case managers engage in ongoing assessments and consider client permission for family involvement in treatment, family availability to clients, and family wishes for involvement in treatment. Three case examples illustrate the relationships among case managers’ goals, assessments of families, and selections of work strategies. The potential role of the ACT model in shaping this particular view on families is also discussed.

Keywords: mental illness, family-provider interactions, family caregiving, Assertive Community Treatment, grounded theory study

Previous research has found that family involvement in psychiatric treatment is beneficial to both the client and the family member (Dixon, Lucksted, Stewart, & Delahanty, 2000; Greenberg, Greenley, & Brown, 1997; Reinhard, 1994) and mental health guidelines and policies have highlighted such involvement (Lehman et al., 2004; Weiden, Scheisler, McEvoy, Frances, & Ross, 1999). However, family members still express an unmet need for more communication with mental health providers (Greenberg, Greenley, & Kim, 1995; Hall & Purdy, 2000) and for improved quality of existing interactions (Biegel, Song, & Milligan, 1995; Wasow, 1994). These findings suggest a gap between the guidelines and practice among providers working with people with severe mental illness and their families.

Some scholars cite a lack of providers’ competency in working effectively with families (Biegel et al., 1995; Wasow, 1994). Others attribute unsatisfactory interactions to providers’ beliefs about the etiology of the illness (Lefley, 1994; Rubin, Cardenas, Warren, Pike, & Wambach, 1998). They point out that traditional psychoanalytic theories and expressed emotion theory are most influential to providers’ interactions with families. These scholars argue that many providers continue to ascribe to outdated, traditional psychoanalytic theories, which attribute mental illness to problematic family dynamics. They reason that providers believe that mental health treatment should exclude families, who, according to those theories, are the cause of the psychiatric problems (Fromm-Reichmann, 1948). Similarly, expressed emotion theory, despite its move away from familial etiology, links psychiatric relapse to families’ high levels of criticism, emotional involvement, and hostility (Brown, Birley, & Wing, 1972). Critics argue that providers who ascribe to expressed emotion theory tend to involve families to change family behavior, not to collaborate with families on mental health treatment (Hatfield, 1990; Lefley, 1992).

Despite these critiques of mental health providers’ lack of collaborative interactions with families, little is known of providers’ perspectives and practices on family involvement. What research has found is that providers spend little time on, and have a low frequency of, family contact and that providers work with the families of only a small percentage of their caseloads (Bernheim & Switalski, 1988; Dixon et al., 2000; Marshall & Solomon, 2004). Research on the process of family-provider interactions is needed to better understand how providers actually work with families, how they regard family involvement, and what working theories guide their practices. These insights may help improve policies and practices concerning mental health treatment. The understandings may also enhance the well-being of persons with severe mental illness and their families and facilitate their pathways to recovery (Schauer, Everett, del Vecchio, & Anderson, 2007).

I address these knowledge gaps herein by exploring case managers’ practices with families in Assertive Community Treatment (ACT) programs. ACT is a comprehensive program that aims to assist adults with the most severe psychiatric conditions to con-
tinue to reside in their communities. From its inception, ACT has identified both clients’ freedom from pathological dependence on family or institutions and support and education of involved members in the community, including family, as essential elements to the ACT model (Stein & Test, 1980). In a more recent review, Phillips and colleagues (2001) reiterated education and support to families and other informal supports for clients as a focal service domain and an indicator of ACT fidelity. Nonetheless, research has not taken a further step to explore how ACT case managers work with families. This particular study focuses on (a) case managers’ conceptualization of “family involvement” in relation to their work with clients and (b) the conditions that influence case managers’ interactions with families.

Method

I used grounded theory methodology to explore how case managers conceptualize family involvement and their work with families. Following the tradition of symbolic interactionism (Blumer, 1969), the current study employed a constructivist approach of grounded theory (Charmaz, 2006). The method is designed to elicit study participants’ perspectives and to explore how they construct a particular phenomenon, in this case, ACT case managers’ work with client families, without imposing a priori theories or assumptions.

The process of grounded theory research can be conceptualized as a helix insofar as cycles of sampling, data collection, and analysis are intertwined and proceed in an iterative manner. That is, analysis of each interview guides the next sampling target and is used to generate new questions for subsequent interviews. The helical process permits researchers to incorporate new relevant data into building theory as the study progresses. For the purpose of clarity, I will describe each aspect of the research process separately.

Recruitment and Sampling

The study is set in the state of Wisconsin, where ACT is known as community support programs (CSPs). I recruited study participants by contacting individual case managers to whom third parties introduced me and by posting advertisements of the study at local CSPs. Twenty-four case managers participated in the study and they represented 10 CSPs over seven counties in southern Wisconsin (see Table 1).

Sampling decisions were guided by theoretical sampling (Charmaz, 2006; Glaser & Strauss, 1967). Rather than sampling on a predetermined theoretical framework, theoretical sampling in grounded theory involves a type of purposive sampling to collect the most relevant data to establish a conceptual representation of a particular perspective. What to sample is intricately tied to and guided by the ongoing analysis and is determined in response to the developing conceptual model. Sampling targets in a grounded theory study are not limited to individuals. In this study, the sampling targets were practice situations. Although case managers were a convenience sample, their work experiences were “theoretically” sampled based on client permission and family availability in practice situations, the two determinants derived from the ongoing analysis that I will describe in greater detail in the Analysis section.

| Table 1 |
| Participant Profile (N = 24) |
| Characteristics | Freq. (%) | Mean (SD) | Range |
| Age (years) | 41.75 (8.52) | 26–57 |
| Gender | | |
| Female | 15 (62.5%) | | |
| Male | 9 (37.5%) | | |
| Race | | |
| White | 22 (91.7%) | | |
| Black | 2 (8.3%) | | |
| Educational degree | | |
| Bachelor of social work | 5 (20.8%) | | |
| Master of social work | 13 (54.2%) | | |
| Others | 6 (25.0%) | | |
| Experiences in mental health (years) | 14.33 (7.82) | 2.17–30 |
| Experiences at the current position (years) | 6.67 (5.69) | .67–20 |

Data Collection

I collected data through semistructured, one-on-one interviews, varying in duration from 40 to 80 minutes. Interview questions evolved throughout the course of the study, which involved three phases (see Figure 1).

In the initial phase, which included five interviews, I explored the conceptual categories that the participants raised and sought to maximize variation in these categories. Thus, I asked case managers broad, open-ended questions, such as: “Tell me about your work,” and “Give me examples of how you work with families.” I also asked probing questions to gain more detail and to begin to develop a working theory of their experiences. For example, a case manager mentioned initial assessments in response to a general question regarding their work. I then asked for the content of initial assessments and how this information was used in practice. I identified six primary conceptual categories from the initial interviews.

In the middle phase, which comprised the next 12 interviews, I sought a more complex understanding of the conceptual categories derived in the first phase of the study and their relationships. For example, in the initial interviews, family availability to clients seemed to influence case managers’ practices with families. To explore the relationship between the two, I generated questions such as “When families are involved in treatment, how are they helpful or unhelpful, and how do you work with them?” and “Would it be easier or more difficult to help clients to be independent when families are not available to them?” Using the data elicited from these questions, I confirmed that family availability and, if family were available, their wishes for involvement influenced how case managers worked with them. Case managers’ strategies for working with families also varied under different situations.

In the final phase, which consisted of the last seven interviews, I focused on verifying and integrating the conceptual categories. Thus far, the analysis demonstrated two primary factors that altered how case managers worked with families. One was client permission for family involvement when clients made their own legal decisions. The other was family availability and wishes for
involvement. I generated further questions to solicit examples of various situations concerning these two factors. Using these examples, I refined the relationships among the case managers’ goals, family assessment, and work strategies according to situations created by the combinations of client permission and family availability and established a conceptual model of how case managers calibrate their work with families in ACT.

Throughout the study, I used the principles of constant comparative analysis to generate interview questions (Glaser & Strauss, 1967). Constant comparative analysis establishes and integrates conceptual categories and helps to delimit the conceptual model. For example, while I was establishing the conceptual category of client permission, the use of constant comparative analysis resulted in the question of when client permission would not matter. I discovered that guardianship assigned to a family member created a situation where the case manager and the family might interact very differently. Although not pursued in this study because of time constraints, the discovery of guardianship set the boundary of my study findings and pointed to an underexplored territory in family involvement in treatment.

Analysis

I transcribed all interviews verbatim for analysis. My data analysis strategy was dimensional analysis (Schatzman, 1991). Although an analytical model of its own right, dimensional analysis is “generally informed by the core ideas and practices of grounded theory” (Schatzman, 1991, p. 303). The current study was conducted from a constructivist perspective and dimensional analysis “offers an elaboration of how situations are defined and demonstrates the process by which perspective and context are integrated into the definition of the situation” (Caron & Bowers, 1993, p. 288). Thus, dimensional analysis is particular suitable for this study exploring the ACT case managers’ view on their interactions with client families. Moreover, from a constructivist perspective, researchers “are part of the world we study and the data we collect” (Charmaz, 2006, p. 10). Using dimensional analysis allowed me to show how I was engaged in the ongoing analysis (how I understood the data, how I selected primary dimensions, etc.) and eventually how the conceptual framework was constructed.

Dimensional analysis is an approach to explicate the process of how people select and organize the concepts that form their particular perspectives. For example, medication monitoring can be dimensionalized into who does it and how it is done. A client might perceive his or her family member’s persistent monitoring as irritating but might see a case manager who does it in the same fashion as responsible. Relationship, in this case, alters the perception.

I applied dimensional analysis both in interviews on the participants’ immediate responses and in line-by-line coding processes of transcripts (Bowers, 1988; Caron & Bowers, 1993). At the initial phase, I identified and dimensionalized salient conceptual categories across interviews. Later, I focused on conceptual categories related to the developing theory and strengthened them by exploring their dimensions and the relations among them.

Through analyses, I identified two sets of key factors that were most influential in altering how case managers work with families: (a) clients’ legal decision-making status and clients’ wishes for family involvement; and (b) the availability of families and families’ wishes to be involved in treatment. These factors also form the basis for theoretical sampling. I then explored how case managers’ specific experiences varied along the spectrum of each factor. For example, regarding clients’ wishes for family involvement, I asked case managers to talk about how they work with families when clients allowed or objected to family involvement.
My analysis provisionally reached data saturation on the dimensions of the key factors after 24 interviews. For instance, by this time I had identified three types of client permission for family involvement, including present, absent, and variable (clients permit family involvement only in selected areas or inconsistently allow for family involvement), and I found no new type of client permission from the data collected by the end of the 24th interview.

_Credibility of the Study_

Credibility addresses how accurately analyses reflect participants' viewpoints in qualitative research (Lincoln & Guba, 1985). I enhanced the credibility of the study by conducting analysis in a grounded theory methodology group, whose members examined the assumptions and biases that I might have imposed on the analysis. For instance, a case manager described, "She [the client] doesn't like it [the visit to her sister] because the sister pokes fun..." While I interpreted "poking fun" as malicious, perhaps owing to my own cultural background where people tend not to tease or joke, another group member pointed out to me that American siblings commonly poke fun at each other without negative intentions. If I had not gained this cultural insight from the group member, I might have interpreted the client's reaction, avoiding malicious remarks, as ordinary and ignored the influence of the client's perception in deciding how to understand other people's remarks, as malicious or friendly, and to react accordingly. Moreover, I adopted member checking, an approach to verify findings by members of the target population (in this case, ACT case managers). I invited the last seven participants to review an outline of my developing analysis. Each of them agreed with my findings.

_Restults_

Figure 2 shows the final conceptual model of ACT case managers' work with families of individuals with severe mental illness. Analysis showed that case managers' goal and objectives informed how they perceived families and how they worked with families in terms of assessment and strategy development. When assessing families, case managers focused on how well families function as sources of social connections, information, and support relative to case managers' goal and objectives. Case managers developed strategies on the basis of those goals and family assessments. Two elements of these assessments, one client-related and the other family related, contribute, in turn, to strategy selection: (a) client legal decision-making status and client permission for family

![Diagram of working with families](image-url)

*Figure 2.* Conceptual framework of case managers' practice with families in assertive community treatment.
involvement in treatment; and (b) family availability to clients and family wishes for involvement in treatment.

Conceptualizing Families in Relation to Treatment Goals

Most case managers referred to clients’ relatives by blood or marriage as family. One case manager extended the definition of family to friends who were closely involved in care and support for a client on a daily basis. Case managers’ conceptualization of families in their practices was greatly influenced by their perceptions of the goals and objectives of treatment with clients. Case managers identified their ultimate goal as helping clients to achieve the best possible quality of life. To attain the ultimate goal, they referred repeatedly to three objectives that guide their work: (a) stabilizing clients’ mental illness; (b) promoting client independence; and (c) helping client develop social connections. Case managers perceived that families were ideally sources of social connections for clients. In general, case managers hoped that families could just be “family” to these adults—a source of support, care, and connection—and not a caregiver for clients to perform instrumental tasks.

You know, natural supports are very important, but I think sometimes the good things in family get really difficult if the family is doing all the nitty-gritty stuff with the person, like . . . clean their toilet everyday . . . then they don’t get as much of a chance to be a “family” and do quality family things together maybe. So, like, when we [say] . . . “Okay, we will clean this toilet. You guys go to the park.”

Families might be involved in working toward the three objectives, that is, to stabilize clients’ mental illness, promote client independence, and develop other types of social connections. When this type of involvement was in effect, case managers hoped that families were supportive of client goal attainment and that families’ actions indeed helped clients grow. Otherwise, family involvement might not be perceived as helpful. Specifically, case managers considered families to be most helpful if they could be a source of client-related information for case managers and a source of support for clients. For example, families could provide the case manager with information about a client’s illness history to fill in gaps in the client’s report. Moreover, family could be a support for enriching a client’s life experiences by helping the client develop social connections through recreational activities or employment that met the client’s interests.

In fact, most case managers made a distinction between family involvement in the client’s life and family involvement in treatment. Family involvement as a social connection was generally considered by case managers to be involvement in life, not in treatment. Case managers perceived that family was naturally a source of social support for a client, while involvement in treatment was not expected of a family. According to case managers, families were involved in treatment when families participated in clients’ attainment of other objectives, such as monitoring clients’ symptoms and medication compliance to help stabilize mental illness. As illustrated in the following quote, the case manager emphasized the importance of a family’s being “family” in the client’s life—loving and caring about the client on various aspects of life, while treatment-related activities are to be performed by case managers.

[ Families should be ] support, be involved, but let us deal with the crisis. Let us deal with the medication monitoring. Let us deal with the treatment . . . love and support from the family members is not to sit and talk about their mental illness . . . If you got a two-hr visit . . . Spend the two hours talking about things that they do well, things they are working on, other than the illness.

Case managers might blur the line of the distinction, because there were multiple objectives they hope to achieve. For example, while case managers strive to achieve the objective of client independence, they strived also to help clients develop social connections with families. Therefore, if families perceived their involvement in some of the treatment tasks as a way to connect with clients, case managers might alter their perception of the involvement. However, case managers perceived attaining independence and social connectedness as a balancing act. Case managers believed that families, although a natural source of social connections, were not always helpful for client independence, especially when families took care of everything for clients. Thus, case managers aimed to enhance family involvement in client life rather than in treatment.

Assessments of Families

Case managers assessed families on an ongoing basis not only in formal meetings designated for family assessments but also, informally. Their conceptualizations of families as sources of social connection, information, and support influenced how they focused their assessments on families. That is, they assessed families according to the extent to which families fulfill those functions and, therefore, facilitate or impede the attainment of goals. For example, to assess families as a source of information, case managers focused on the family’s level of knowledge about the client’s mental illness. To assess family involvement in client independence, case managers tended to focus on the client-family relationships and on families’ attitudes about client independence.

Key Factors Influencing Case Managers’ Work With Families

Case managers constantly referred to two sets of factors, one client-related and the other family-related, when developing and applying strategies to work with families. The first set of factors that affects case managers’ work with families was determined by the client’s legal decision-making status. When the legal system judges a client to be unfit to make decisions and when the system assigns the guardianship to a family member, the family member is automatically involved in treatment. The study did not examine this exceptional situation to client permission because of time constraints.

If the client was legally able to make decisions, case managers commonly agreed that family involvement in treatment was subject to client permission, which was exemplified by one case manager’s remark, “It’s [family involvement in treatment is] mostly in the hands of the client.” Clients formalized their permission by signing a release of information.

In general, even when a signed release of information was on file, rather than actively approach the client’s family, case managers commonly followed the client’s lead on whether or not—and if yes, which family member and to what extent—the family was
to be involved in treatment. Moreover, although a case manager might, to a limited extent, suggest to a client that there could be increased family involvement or make recommendations on strategies for solving family problems, case managers tended not to push clients on those issues.

Nevertheless, case managers were less concerned about client permission in crisis situations. They might contact families to alert them about a client’s family related comments. Some case managers might ask for family input or collaboration when the client was experiencing rapid decompensation.

The second set of factors involved family availability to clients, and if available, family wish for involvement in treatment. Case managers reported a wide range of family involvement in clients’ lives. Most case managers commented that a large number of clients did not have any family involvement and that families were generally less involved in clients’ lives if the mental illness was more severe, if geographic distance was substantial, if treatment had come late in the course of mental illness, if onset of mental illness had happened decades earlier, and/or if families had limited care capacity.

Consistent with respecting client permission, case managers relied primarily on clients’ reports regarding family involvement in clients’ lives. If clients did not identify anyone, case managers generally would not search for families, even if there was documented information about families in old records. Moreover, case managers usually would not initiate changes in family involvement in the clients’ lives unless the clients expressed an interest in making changes. Case managers expressed concerns about traumatic experiences or negative family relationships that clients might have had with the family and that might still pose difficulties for clients. In these instances, case managers did not take the initiative but instead waited for clients to exercise self-determination through a request.

The case managers reported that, of the families involved in clients’ lives, families’ own willingness to be involved in clients’ treatment spanned a wide range. In general, while some families had been devoted to caring for a client since the onset of the illness and were willing to continue to be involved in treatment, other families might wish to relinquish responsibility of care to the program. As family involvement in treatment was not expected of families, case managers generally respected families’ wishes and adjusted their work, including assessments and work strategies, accordingly.

A combination of client and family related factors generated various situations. For example, when the family was available, the client might permit family involvement in treatment, varied his or her permission from time to time, or did not permit family involvement. When the family was unavailable, the client either might have no wish him- or herself to contact the family or might wish to reconnect with the family. These different situations influenced how case managers employed different strategies to work with families.

Work Strategies

Three cases are used to demonstrate how case managers select different work strategies. In the first two cases, clients permitted family involvement and families were available and willing to be involved. However, work strategies varied on the basis of case managers’ family assessment as being possibly disruptive (Case 1) or possibly supportive (Case 2) of goal attainment. The third case illustrates the work strategies adopted when the family expressed the wish for a lower level of involvement in treatment.

Case 1: We had someone come in, and the mother was very, very involved in his life. And he wanted more independence and was really sort of rebelling against her. And she was the payee, his payee, and had all his money. And over time . . . I mean at first, we really wanted to be his payee, because we could work with him to be his own payee, and she was really nervous at first because she didn’t really know us, and trust us, and we just kept having conversations with her, with the consumer there, about the advantage of him being more independent.

And you try little things, like, you say, “Okay, Mom, we won’t be the payee right now, but let us take him grocery shopping.” And you do that for a little bit, and she can see that it goes well and that we are not going anywhere, and we are not kicking her son out. And then we will say, “How about we . . . you give us some money to pay these bills.” And then that goes well. And her son is not falling apart, because, you know, we are handling the money. And so it’s really a gradual process, and it can be hard.

In Case 1, the goal was to increase client independence through independent financial management. Usually, case managers assumed full responsibility for financial management, then gradually transferred the responsibility to the client by training him or her about financial management. However, the conditions in this case—both the client’s permission for the mother’s involvement and her involvement as his payee—necessitated different strategies. Through family assessments, the case manager found that the client-family relationship was quite intense. The mother was uncertain about the possibility of her son’s success in the program, and there had not been a trusting relationship between the mother and the program. The assessment revealed that if the situation remained unchanged, the goal of independent financial management would not likely be achieved. The case manager then applied multiple strategies to the situation: (a) mediating the client-family relationship by conducting open communications among the client, the mother, and the case manager; (b) building a trusting relationship with the mother by maintaining engagement with both the client and the mother; (c) educating the mother about mental illness by discussing advantages of client independence; and (d) reframing, through a “detour” approach, the client for the mother by building up her confidence in the client and the program over an accumulation of little successes.

Case 2: [H]is grandmother is the only one that’s really involved in his life right now . . . she is older, she and her husband are retired. . . . She is really happy to have us involved. She is someone who, you know, we [are] taking her to show her the apartment where he is going to live. We’ve asked her if she has anything she can donate to put in the apartment because, you know, he doesn’t have anything. So, we involved her in a lot of this stuff . . . He is gonna be moving into an apartment really for the first time . . . So, he is gonna be learning to be independent in this apartment . . . She [the grandmother] is gonna help get some stuff set up for his apartment . . . We are not sure what his cooking skills are . . . but she is willing to also, you know, kind of help out, showing him how to make something, giving him some recipes . . . and she said she is willing to come over and help him clean sometimes. You know, he will still be independent . . . She is willing to . . . show him how to do things like that, so . . . She is willing to help out with that.
In Case 2, the goal again was client independence. The client permitted the grandmother’s involvement in his treatment. By assessing the family, the case manager found that the client-family relationship was positive. The grandmother was the primary familial connection that the client had identified and the client was really happy about the grandmother’s visit during his hospital stay, which is not evident in the excerpt. The grandmother welcomed the program’s help, and was supportive of, and willing to assist with, the goal of client independence. The case manager used a set of strategies that was different from those in Case 1 to work with the grandmother, including: (a) involving the grandmother at every step, such as the apartment inspection; (b) soliciting resources, such as furniture and recipes, from the grandmother; and (c) collaborating with the grandmother, such as having her coach the client in independent skills for cooking, cleaning, and the like.

Following the common objectives as noted before, both case managers tried to strike a balance between promoting client independence and facilitating the client’s connection with the family by using different sets of strategies in accordance to their family assessments. In the first case, supporting client independence in turn helped to relieve the tension between the client and his mother and facilitated the transition of her role from a “caregiver” to a mother of an adult child. In the second case, while inviting the grandmother’s involvement in helping client independence, the case manager drew the line between the grandmother’s “coaching” the client’s living skills and doing the chores for him.

Case 3: [H]e is living in a group home now. . . He has got a lot of medical issues, and her [client mother’s] comments to me were, “Well, I hope he can stay in the group home for a long time,” because she has her own mental health issues too. But at the same time she is very grateful that he is where he is, and we can help him get to his appointments, keep his appointments, and . . . keep her up-to-date. Because before he was in CSP, she was doing a lot of that and that was very stressful to her.

In Case 3, the client aimed to live more independently, yet he still needed assistance. Although the client had relied on the mother’s care and permitted her continuous involvement, the mother was unable to be involved in his treatment as much as she had because of her conditions. In keeping with the assessment of the mother’s wish, the case manager took care to provide the support that the client needed without the mother’s involvement. However, the case manager continued to keep her informed about the client’s situations as that was so she wished.

Discussion

The case managers in this study generally believed that families should relate to clients as sources of social connections, not as caregivers to perform care tasks. In addition, case managers differentiated family involvement in client life from that in client treatment. Case managers hoped that, should families be involved in treatment, they can be sources of client-related information and support for clients and can, thus, help clients attain their goals.

Case managers’ working conceptualization of families differs from theory-based family conceptualizations in the literature. Case managers were aware of conceptualizations of families based on psychoanalytic theories, such as “schizophrenogenic mother” (Fromm-Reichmann, 1948), and expressed emotion theory (Brown et al., 1972), which some case managers mentioned during the interviews. However, most case managers attributed family behavior such as making critical comments to long-term caregiving burdens or to a stressful environment, instead of applying the psychoanalytic theories.

Case managers’ emphasis on families as sources of social connections also contrasts with the current dominant view of families as caregivers for individuals with mental illness. Since deinstitutionalization, caregiving for mentally ill individuals has become a prominent role for families. In part this is because of a fragmented, inadequate service system that has automatically positioned families in the caregiving role.

This special conceptualization about families in the ACT programs may indicate a promising alternative. I did not design the study to compare different program contexts in relation to practices with families. However, the core principle of ACT, and therefore its design, is to meet clients’ needs in one stop by providing most of the services in-house—a principle that allows case managers to reduce the reliance on families to provide care. Case managers constantly referred to the chance to prolong their engagement with clients and the teamwork approach of service provision as advantageous features of the program not only in facilitating goal attainment but also in reducing the necessity of family involvement in treatment. This study points to the possibility that in a comprehensive service system, as exemplified by the long-term, intensive, wrap-around service provided by ACT programs, families may be able to maintain their role as social support and need not compromise the role owing to the impact of mental illness.

The findings also seem to echo the original treatment philosophy of the ACT model. Although many viewed its philosophy as to promote constructive separation between the client and his or her family given its broad reference to the literature on familial pathologies in the 1950s (McFarlane, 2000), the ACT model aimed to create normalized lives for clients, including their relationships with families. In this study, case managers aimed to lessen families’ caregiving responsibilities so that the family and the client might develop normalized family relationships. Case managers also hoped that as social supports for clients, families might further help them attain other goals such as employment and independent living.

Moreover, when examining social cost as an aspect of effectiveness, Test and Stein (1980) addressed family burden and assessed the model’s effects on reducing disruption of mental illness in the household and in the caregiver’s physical health. In the current study, case managers believed that letting the family be “family” might lead to beneficial effects on families. In fact, case managers stressed that “giving families their lives back” would be a desirable by-product of their services to the client. That is, case managers hoped to see families be able to once again pursue their dreams, such as taking a vacation, without feeling worried or guilty. This conceptualization and the related work might inform research findings regarding families’ relatively high level of satisfaction with ACT programs (Audin, Marks, Lawrence, Connolly, & Watts, 1994; Houl, Reynolds, Charbonneau-Powis, Weekes, & Briggs, 1983; Muijen, Marks, Connolly, & Audin, 1992) and relatively fewer psychological burdens that families shoulder when their relatives are using ACT services (Essock, Frisman, & Kontos, 1998).
Implications for Research

The study uncovered two important factors that alter how case managers work with families: client permission for family involvement and family availability to clients. The results of this study highlight the point that client permission for family involvement is essential when case managers work with families. More specifically, case managers follow up on client wishes for family involvement rather than rely exclusively on the existence of a previously signed consent. That is, at times, clients might refuse contact between the case manager and the family, and case managers generally respect the client decision and void the previously signed consent. The findings on client permission and on its variability are of great significance because they help us to better understand the complex interactions between service providers and families. Most related studies have not factored in the effects of client permission when researching the family provider interactions (Bernheim & Switalski, 1988; Biegel et al., 1995; Marshall & Solomon, 2000) or have examined only generally providers' interactions with families—not specific situations (Dixon et al., 2000). Consequently, the results of these studies, such as frequency or amount of time that providers spent on family contact, do not sufficiently reflect the complexity in the context of interactions. Future research needs to incorporate the factor of client permission and to recognize that the interactions between service providers and families result from the integration of the triad relationships among the client, the service provider, and the family (Williams & Mfoafo-M'Carthy, 2006).

Case managers' experiences also reveal that family availability to the client varies. As observed by case managers, many unavailable or less available families are possibly vulnerable in terms of their well-being, their finances, and their relationships with the client—a spectrum of families that is currently understudied. Most existing studies have sampled families that exhibit homogeneous availability to clients. Some researchers (Biegel et al., 1995; Hatfield, Fierstein, & Johnson, 1982; Marshall & Solomon, 2000) recruited their participants entirely from family support groups—families that might be more willing and able to be involved in treatment. Other researchers applied recruitment criteria that inevitably limited the scope of families to those most involved. For example, families recruited were explicitly identified by clients as "most involved" (Reinhard, 1994) or as "having most contact with" clients (Greenberg et al., 1997). Although these studies have shed much light on families that have devoted themselves to care for their ill family members, the sampling approaches exclude families that are either not involved in, or not centrally involved in, clients' lives. Future research needs to better attend to the variability of families, especially those that have little or no availability to be involved in the clients' lives. Our understanding of these families' needs and strengths can inform us as to how the mental health service system may facilitate the promotion of the families' well-being and the families' roles in clients' well-being.

Studies are also needed to explore how guardianship of a family member changes the triad relationships. Finally, the exploration of the study at its current state was limited to the common conceptualization and practices across the case managers. Variations in practice among individual case managers, especially those regarding strategy selection, merits future research.

Implications for Practice

The study showed how significantly case managers' conceptualization of the appropriate roles of families influenced practice. These case managers practiced according to their perception that families ideally are social connections for clients and believed that families' caregiving for clients might hinder their role as a source of social connections. However, this perspective on family might not be in agreement with others'. Depending on cultural context, some families, for example, might perceive caregiving as a family obligation, that is, as part of "being family" (Kung, 2001; Park, 2007). Practitioners, thus, need to be aware of the potential discrepancy in perspectives, and be attentive to and communicative with all involved parties to ensure the effectiveness of services.

Moreover, this study also showed that assessment was an ongoing, dynamic process. In addition to their paper-and-pen assessments, case managers are constantly assessing clients and families in relation to the goals that they hope to achieve and are developing strategies accordingly. Oftentimes, these ongoing assessments provide more significant input to in vivo decision-making in practice than those assessments kept in file can provide. As service, by its nature, is complex and constantly changing, professional training and education need to expand practitioners' critical-thinking capacity to integrate multifaceted considerations into practice.

The case managers' goals and practices found in this study seem to correspond to the current trend of mental health recovery. Recovery is described as a fundamentally personal process that involves both confronting the reality of mental illness and finding a new sense of self and feeling of hope (Deegan, 2003). Not only is recovery an internal process, it also requires external conditions that facilitate a positive culture of healing (Jacobson & Greenley, 2001). The journey toward recovery is also important to the involved families, for they can be significant support in the process (Hall & Purdy, 2000). The findings showed a way of practice that facilitates recovery. Case managers support families to be the source of social connections to the client. Having meaningful family relationships enriches both the client's and the family's lives. To create a healing environment, more recovery oriented-practices need to be identified and developed.

Implications for Service Delivery

Although working with clients' support systems in the community is part of the ACT fidelity measures (Teague, Bond, & Drake, 1998), no further operational details are available. A practical framework of working with families has been developed through this study; however, when considering this framework for broader dissemination, one has to take into account the context of the study: ACT programs in southern Wisconsin.

Approximately 90% of the population of the state of Wisconsin is White. The dominant European American cultures that emphasize individualism and independence may shape the case managers' conceptualization of family. Although no specific guidelines are available, these case managers worked with families by following the socially desirable norms in the region, including viewing a client and his or her family as separate entities and privileging independence and productivity. These values, however, may not be relevant to populations with different cultural background.

Although fidelity measures may give ACT its skeleton, the operation of ACT can give it different faces. Particularly, working
with families needs to be situated in its local context. Service providers who engage in a different cultural group might view family differently (e.g., regarding the family as a unity rather than a gathering of individuals) and therefore use a different framework when working with families. Thus, this study does not intend to provide a model practice with families in ACT. Rather, it offers an example of practices with families and shows how a particular context influences its realization. Currently, ACT has been implemented nation-wide and internationally. The operationalization of working with clients' support systems may vary greatly. More research is necessary to understand how to incorporate flexibility in working with support systems while maintaining program fidelity to assess the cultural relevance of ACT as a community-based program.

Conclusion

Understanding practice issues usually requires the recognition of their complexity and the exploration of the various involved perspectives. This study discovered ACT case managers’ conceptualization of families as sources of social connections and two factors that are crucial in case managers’ practices with families: client permission for family involvement and the degree of family availability to clients. Given that neither of these factors has been sufficiently studied in previous research, these insights may contribute to ongoing dialogue on improving mental health service delivery that aims to enhance both the client’s and the family’s well-being.

References

Call for Papers: Special Section on Transforming Services to Support Low-Income Clients and Communities

Guest editors: Lisa Goodman, Ph.D., Boston College and Victoria Banyard, Ph.D., University of New Hampshire

We invite submissions for consideration for a special section of the American Journal of Orthopsychiatry.

This special section explores transformative practices/programs/ideas for supporting low-income individuals and families struggling simultaneously with poverty and emotional distress. Specifically, we are seeking manuscripts that describe:

1. evaluations of innovative practices and programs designed to support low-income individuals and families;
2. empirical explorations of poverty’s impact, with clear implications for transforming programs and practices; or
3. empirical explorations of how poverty intersects with other aspects of social context to shape peoples’ life experience and mental health, again with clear implications for transforming programs and practices.

We are particularly interested in research that challenges traditional conceptualizations of intervention and that addresses the unique circumstances of low-income individuals and families struggling with mental health issues. Example populations include but are not limited to single mothers, interpersonal violence survivors, or immigrants/refugees.

Manuscripts must be submitted no later than February 15, 2009. Manuscripts should follow guidelines for authors for the journal: http://www.apa.org/journals/authors/. Please send manuscripts to: Victoria Banyard, Ph.D. at Victoria.banyard@unh.edu