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Sharing Information with Families of Clients with Severe Mental Illness

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Abstract

Objective: Sharing information between families and mental health providers concerns a dilemma between clients' rights to confidentiality and families' needs to know. This study explores provider perspectives by examining how case managers in Assertive Community Treatment (ACT) share information with families of clients with severe mental illness. *Methods:* The study applies grounded theory methodology. Twenty-four ACT case managers in southern Wisconsin, U.S.A. participated in a one-on-one in-depth interview with the author. An interview was verbatim transcribed and analyzed before proceeding with another interview. Thus, interview questions evolved throughout the study. Data were analyzed by following a line-by-line coding procedure to identify and dimensionalize conceptual categories in the text. Client permission emerged from analysis as a key factor in determining how case managers share information with families, so sampling focused on examples of sharing information with families under various types of client permission. *Results:* Case managers generally consider families helpful in providing information about the client and assess families accordingly. When sharing information with families, case managers prioritize client permission to family demands. Three types of client permission – present, variable, and absent – influence the strategies that case managers employ to acquire and use the information from families, and to release client information to families. *Conclusions:* The study calls for examination on current policies and practice guidelines to address the client's rights to confidentiality and the family's needs to know, and to address the difficulties in balancing law compliance versus professional judgment on what is in the clients' best interests.

Information sharing between families and mental health providers may improve mental health consumers' outcomes (Anderson, Reiss, & Hogarty, 1986; Dyck, Hendryx, Short, Voss, & McFarlane, 2002), and may enhance families' well-being (Greenberg, Greenley, & Brown, 1997; Lukens & McFarlane, 2004; Reinhard, 1994). Research describes families' wishes to obtain information from providers (Bernheim & Switalski, 1988; Biegel, Song, & Milligan, 1995) and to be consulted about treatment (Goldman, 1996; Hatfield, 1997; Johnson, 1987; Wasow, 1994). Family satisfaction with providers is related to the receipt of provider-offered information (Holden & Lewine, 1982; Marshall & Solomon, 2000). Despite the apparent importance of information sharing, research suggests that providers give little information to families (Greenberg, Greenley, & Kim, 1995).

Conversely, little is known about providers' perspectives on sharing information with families (Bernheim & Switalski, 1988; Dixon, Lucksted, Stewart, & Delahanty, 2000). Instead, the more pronounced issue about information sharing in practice concerns client confidentiality. In the United States, confidentiality provisions generally privilege the client's right over the family's interest (DiRienzo-Callahan, 1998; Zipple, Langle, Spaniol, & Fisher, 1990).¹ Despite its principle importance, client confidentiality in care for mentally ill clients is usually viewed as a barrier to family-provider collaboration (Marsh, 1995; Marshall & Solomon, 2003).

Very few studies address the effect of client permission on information sharing between families and providers (Marshall & Solomon, 2000, 2003). What research 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). Little research explores how—given their legal

¹ Although there are federal standards to protect confidentiality, such as Health Insurance Portability and Accountability Act, confidentiality laws and their implementations vary locally (Bogart & Solomon, 1999).

obligation, professional ethics, and practical considerations—providers balance the client’s right to confidentiality and the family’s wish to know about the client’s status.

This study aims to examine the case manager’s perspective on information sharing with families in Assertive Community Treatment (ACT) programs. Using grounded theory methodology (Charmaz, 2006), the study explores how case managers: (1) conceptualize family in relation to their work; (2) assess regarding sharing information with families; and (3) alter information sharing strategies according to situations.

Methods

Participants and Recruitment

The study was conducted between August 2004 and November 2005 in the state of Wisconsin, where ACT is known as community support programs (CSPs).² The author recruited participants by contacting individual case managers and by posting study advertisements at local CSPs. The study was approved by the Institutional Review Board at the University of Wisconsin-Madison. After complete description of the study to the participants, written informed consent was obtained. Twenty-four case managers participated and represented ten CSPs over seven counties in southern Wisconsin (see Table 1).

Data Collection and Analysis

² In the state of Wisconsin, CSPs are equivalent only to ACTs. Outside the state of Wisconsin, the designation *CSP* refers broadly to service programs that, operated by both professionals and non-professionals, help mentally ill individuals to live in the community. According to the program guidelines, a case manager is a team member who coordinates individual clients’ treatment and referrals, who monitors symptom status, who organizes or provides psychotherapy and education, who advocates for needed services, and who educates and supports the clients’ families and the clients’ other major supports (Wisconsin Administrative Code, HSS63, Community Support Programs for Chronically Mentally Ill Persons, 1989).

The process of grounded theory studies resembles a helix where cycles of intertwined data collection, dimensional analysis, and theoretical sampling progress toward the construction of a theoretical framework (see Exhibit 1). Data were collected through semi-structured interviews, varying in duration from 40 to 80 minutes. An interview was verbatim transcribed and analyzed before proceeding with another interview. Interview questions evolved on the basis of ongoing analysis. Initially, questions were broad, such as “tell me about your work.” As the analysis went, an influential factor emerged in altering how case managers share information with families: client permission for family involvement when clients make their own legal decisions. Theoretical sampling then guided the purposive collection of data related to this key factor. That is, the author asked participants to provide information sharing examples under different types of client permission. Questions in later interviews thus became more specific, such as “how do you use the information volunteered by the family when the client clearly objects your contacts?”

Analyses were conducted in an interdisciplinary research group using dimensional analysis (Schatzman, 1991). Conceptual categories in text were identified and dimensionalized by following a line-by-line coding procedure (Bowers, 1988; Caron & Bowers, 1993). The helical research process allows collecting most relevant data for focused comparative analysis to further refine the relationships among conceptual categories. Data collection stopped at the 24th interview, when the analysis reached theoretical saturation: the author identified three types of client permission and could not find a fourth type of permission by the end of the 24th interview.

Credibility of the Study

Credibility, parallel to internal validity in quantitative studies, addresses how accurately analyses reflect participants' viewpoints in qualitative research (Lincoln & Guba, 1985). The study's credibility was enhanced by conducting analyses in the research group, whose members examined the assumptions and biases that the author alone might have imposed on the analysis. Moreover, the author invited the study's last seven participants to review an outline of her analysis. Each of them validated the findings. Finally, the author constantly explored exceptions to the known situations and modified the framework to incorporate new discoveries.

Results

Families and Case Managers' Goals in ACT

ACT case managers consistently identify stabilizing mental illness, promoting client independence, and developing social connections as the primary goals of their work. Case managers perceive families, in relation to these goals, ideally as sources of social connections for clients (Chen, 2006). To be helpful in other aspects of treatment, families can be sources of information. Although case managers may not always actively seek information from families, particularly when clients are able and willing to communicate their situations, case managers generally welcome information provided by families, especially when the information can facilitate goal attainment (see Table 2).

Foci of Assessments Regarding Information Sharing

Although information sharing involves two-way communications, case managers seem to focus on their receipt of family-proffered information for the benefit of goal attainment. When receiving information from families, case managers assess: (1) family knowledge of the client's

mental illness; (2) the consistency of a family as a source of dependable information; and (3) the relevance of information to the clients.

Nonetheless, results show that information sharing with families is subject to clients' permission, especially when case managers release information to families. Case managers emphasize the importance of assessing both a client's legal decision-making status and the client's permission for family involvement. When the legal system judges a client to be unfit to make legal decisions and when the system assigns the guardianship to a family member, case managers have to share information with that family member. The study does not examine this exceptional situation to client permission. If clients are able to make their own legal decisions, case managers generally agree that it is the client's decision that shall determine whether or to what extent the family can be involved in treatment, except crisis situations such as where the client might harm himself or herself or others.

Client permission refers to both the formal, signed "release of information forms" that confirm the family's access to information sharing and a client's general willingness to have the family involved in his or her treatment. A signed release of information facilitates case managers' initiative in contacting a family. However, in practice, a client's willingness to allow contact between the case manager and the family supersedes a previous signed consent form.

Findings show that client permission for family involvement is the most influential factor that alters how case managers share information with families. Analysis reveals three types of client permission: present, variable, and absent. The types of client permission guide how case managers assess and develop different working strategies to receive information from families, to use the information, and to release information to families (see Table 3).

Information sharing in the presence of client permission

When clients give their permission, case managers may actively elicit information from families or freely receive the information volunteered by families. To use the information, case managers generally consider the urgency of information. For example, case managers usually intervene immediately when families report signs of clients' deteriorating conditions. If the information regards only psychiatric history, case managers usually file the information in the charts for possible later use.

When considering how to disclose the family-proffered information, case managers assess the quality of the client-family relationship. If the relationship is positive, case managers tend to acknowledge family as the source of information. If the relationship is contentious, case managers use the "coming in the back door" strategy to avoid revealing the source, yet indirectly raise the issue with clients. Sometimes case managers view that families have to be involved in problem-solving to effect the information and assess families' willingness of involvement to decide whether to continue to receive the same type of information.

With client permission, case managers may release information to families. When releasing information, case managers examine the client's needs and the purpose of release. Case managers commonly report their general impressions of the client to the family or provide the family with general information about mental illnesses in response to what the family wishes to know. However, case managers might exercise their judgment and decide some types of information may be unnecessary for families to know, such as that related to clients' private life, that told to case managers confidentially, that which is possibly embarrassing to clients if released, and that which might be better released by clients themselves. Nevertheless, case managers are likely to divulge information to families if clients threaten their families.

Moreover, case managers consider living arrangement when releasing information. If clients live independently, case managers tend to consider it needless to share much detail about clients with families. Finally, case managers assess the effects of releasing information in terms of whether it helps or hinders the client-family relationship. Regarding this concern, case managers generally hope to release information to families in the presence of clients.

Information sharing when client permission is variable

There are two kinds of variable client permission, selective permission and on-and-off permission. Selective permission happens when clients generally agree to release information to families but make specific exceptions. For example, clients may allow the case manager to share with the family information about how they are doing except their residence. Case managers generally respect such request.

On-and-off permission regards situations where clients signed a release of information might, at times, object to contact between the case manager and the family. This scenario usually results from conflicts that happened in the client-family relationship, but the change of client wishes for family involvement is not always perceivable to case managers. Case managers may contact the family as usual but may become aware of the change of the client's mind when the client reacts negatively. Case managers then review the release of information procedure with the client and re-assess client permission. Case managers in this study agree that, when a client expresses his or her wish to withdraw the previously signed release, they have to respect the client's decision. Should the client again allow for case-manager-family contact, a new release would need to be signed.

After the release is revoked, case managers may receive the information, but they do not release information to the family. However, if the family has been a reliable source of information, especially regarding changes of symptoms, case managers usually assure the family of their acceptance of contact. This case is particularly pronounced when a client has been in the program for a long time.

To use the information provided by families when the client-family relationship turns adversarial, case managers depend on whether the family wishes to be revealed as the source of information. If the family does not give the case manager permission to do so, the case manager may employ the “coming in the back door” strategy. However, if simultaneously there is tension between the case manager and the family, the case manager tends to check with the client about the information when the family continues to contact the case manager after the client revoked the permission.

Information sharing in absence of client permission

Case managers commonly find it difficult to handle situations where the family, in the absence of client permission, desires to have contact with case managers. Such situations are usually emotionally charged. Case managers commonly agree that no release means no information sharing—neither information receiving nor information releasing—with families. Case managers feel challenged by the need to balance the client’s right to privacy and the family’s desire for communication. Moreover, case managers sometimes face the dilemma of respecting the client’s will and following their own professional judgment when they think family involvement can be helpful.

Case managers are concerned about both the legal and the professional consequences of their contact with families in the absence of client permission. Furthermore, case managers could lose the client's trust, especially when trust building is a difficult issue for the client.

Nevertheless, in order to navigate through the dilemma in practice, case managers strategically reinterpret the confidentiality guidelines to create some flexibility in relation to information received from families. The levels of flexibility vary among case managers. Usually, when families initiate and provide information, case managers will listen. If the information is helpful to the client, some case managers might encourage families to actively provide information. However, all the case managers stress the importance of not releasing client information.

Case managers recognize that by receiving information from families in the absence of client permission, they walk a fine line between compliance with and violation of confidentiality laws: after all, a case manager who listens to families acknowledges a client's presence in the program. Case managers justify this tactic by arguing that they reveal no information that is new to the family, especially regarding clients who have a long history in the program.

Degree of urgency influences case managers' use of information that they obtain without client permission. For other information, case managers use it depending on whether the family wishes to be revealed as the source of information. If the family does not wish to be revealed, case managers try either simultaneously to use the information and to ignore the source or to use the "coming in the back door" strategy. However, when case managers find it difficult to use the information without revealing the source, they try to explain the situation and to obtain permission from the family.

Discussion

Client Permission as Priority

The study demonstrates that information sharing with families is a strategy for case managers to facilitate goal attainment in clients' treatment. To effect the strategy, case managers try to balance among gaining useful information from families and responding to families' requests for information and to choose strategies to facilitate a positive client-family relationship so that families can maintain their role as a social support for clients.

Although case managers generally consider the information provided by the families helpful, they prioritize client permission over families' needs or demands. Moreover, given the variable nature of client permission, case managers concern most the client's wish at the moment and adjust their work accordingly. This finding thus provides insights into the predominant issue raised in the literature concerning the reluctance of providers to share information with families (Marsh, 1995). Recommendations on family involvement in treatment often overlook the fact that it is not the provider's decision alone to involve and to share information with families (Coursey et al., 2000a, 2000b). Although seemingly a dyadic interaction between the provider and the family, information sharing indeed involves triadic dynamics among the client, the provider, and the family.

Fine Line to Walk on Confidentiality

Even though case managers generally prioritize client permission and comply with confidentiality laws, the study discloses situations where case managers rather deviate from legal rules in order to follow the principles of their helping profession. Case managers thus walk a fine line between adherence to and violation of confidentiality laws or even risk going against the

client's wishes in order to receive family-offered information that might ultimately benefit the client.

Some scholars support the practical alternative that case managers employ to obtain useful information from families in the absence of client permission. These scholars argue that the primary purpose of confidentiality aims to protect clients from possible stigmatism if a stranger learns of their conditions. Family members, on the other hand, already know of their relatives' conditions (Lefley, 1999; Petrila & Sadoff, 1992). Other scholars have interpreted confidentiality laws as mechanisms for the regulation of information to, but not of information from, families (Marsh, 1995). Thus, unlike others, families should have a channel through which they can express their concerns and observations to providers.

Implications on Practice and Policies

While encouraged to involve families, providers do not have sufficient guidelines concerning confidentiality practices. Although professional ethics—such as the ethics for social workers (National Association of Social Workers, 1999)—covers confidentiality issues in counseling services for families (where the family as a unit is a client), providers in community-based services must generally contend by themselves with the competing demands from both the client and the family in variable situations. The findings show the importance for human service professions to review their guidelines.

Also, this study identifies the dilemma faced by case managers who are concerned about both compliance with confidentiality laws and actions that accord with clients' best interests. The finding reflects the urgency with re-examining the comparability of confidentiality laws and

professional ethics in practice. Moreover, it is important to clarify the proper approaches that providers in the field should take when attempting to balance the conflicting demands.

Limitations and Future Research

The scope of the current study is limited to clients who make their own legal decisions. Sharing information with the family who is the client's guardian merits future research regarding how this legal assignment to families might influence case managers' assessments and working strategies. The study is also limited to the exploration of client-centered information. The sharing of non client-related information, such as difficulties that families encountered in caregiving, also warrants further investigation. How case managers handle such sharing may affect the relationship between the case manager and the family, which may in turn influence the sharing of client-centered information.

Client permission needs to be incorporated in future studies examining the effects of information sharing or family-related practices. Moreover, rigorous explorations of the client's perspective on information sharing between service providers and their families may strengthen the adequacy of confidentiality policies and information sharing practices.

Conclusions

Case managers generally find information sharing with families helpful but also face the competing demands of client right to confidentiality. As the mental health system increasingly emphasizes community services for mental health clients and therefore contexts in which providers have more opportunities to work with client families, further examinations and discussions on the confidentiality guidelines, procedures, and effects of information sharing are

of great importance.

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Exhibit 1. Process of Grounded Theory Inquiry (An Example)

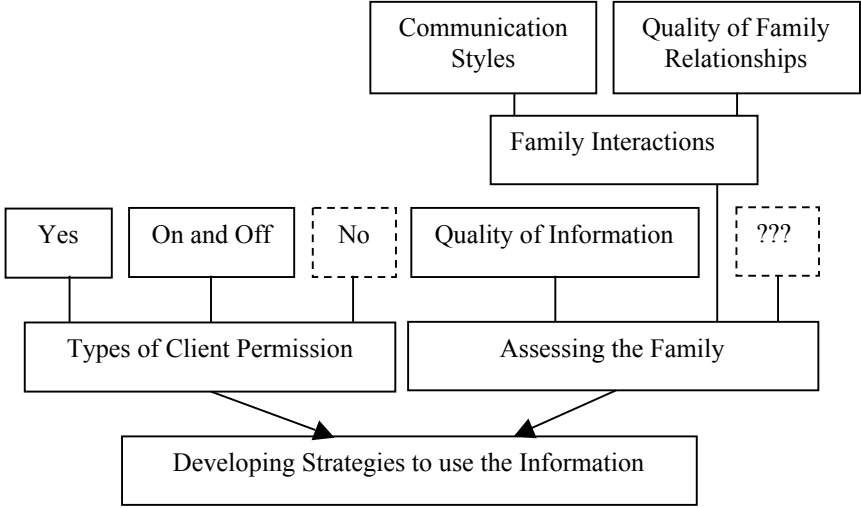
<p>In an early interview:</p> <p><i>Q: You mentioned that there is a wide variety of family situations. Could you give me some examples of how you work with different kinds of families?</i></p> <p>A: I have one client that I worked with who <u>on and off</u> doesn't want his family involved in his life . . . [the family members] often <u>have good feedback</u> about him . . . if they are worried about him, like his symptoms get worse . . . they will call me . . . then we had to sort of round about, like no telling him that we know about the symptoms . . . you have to <u>find a way to see that on yourselves.</u> (ID02L93-157)</p> <p>Coding: on-and-off client permission, assessing the family as a good source of information, developing strategies to use the information</p>	<p>The participant provided an example of receiving information from the family. Codes derived from the analysis of the concepts involved.</p>
<p>In a later interview:</p> <p><i>Q: How do you use that information when you hear parents call you up with some information about the client?</i></p> <p>A: It depends on the situation and the client, as far as <u>how open they are</u> with their parents or <u>how much they get along</u> with their parents. . . . I either come out and say, "Your parents called me and said they think you are feeling more depressed. How do you think you are feeling?" . . . Or if they don't really have an open relationship with their parents, . . . I would [ask], "What did you do this weekend? Did you have a good weekend? You don't look like you are feeling well" . . . try to have the client come out and tell me. (ID07L224-242)</p> <p>Coding: developing strategies to use the information based on assessments of family interactions (communication style/quality of family relationships)</p>	<p>The author followed up on information sharing in a later interview regarding a specific situation where client permission was present. She asked the participant questions about the use of the information. She then generated further codes.</p>
<p>Memoing in a diagram:</p>  <pre> graph TD CS[Communication Styles] --- FI[Family Interactions] QFR[Quality of Family Relationships] --- FI FI --- TCP[Types of Client Permission] FI --- AF[Assessing the Family] TCP --- Yes[Yes] TCP --- OAO[On and Off] TCP --- No[No] AF --- QI[Quality of Information] AF --- Q3[???] TCP --> DS[Developing Strategies to use the Information] AF --> DS </pre>	<p>The author drew a diagram to illustrate the relationships among the concepts, including those grounded in the data and those logically derived (shown in dashed boxes), awaiting further verification.</p> <p>Theoretical sampling in the subsequent interviews can focus on different types of client permission to shed light on how family assessments and strategy development vary in different situations.</p>

Table 1. Participant Profile (N = 24)

<u>Characteristics</u>	<u>Description</u>
Age (years)	41.75 (SD = 8.52)
Gender	
Female	15 (62.5%)
Male	9 (37.5%)
Race	
White	22 (91.7%)
Black	2 (8.3%)
Education	
BSW	5 (20.8%)
MSW	13 (54.2%)
Others	6 (25.0%)
Experiences in Mental Health (months)	172 (SD = 93.79)
Experiences at the Current Position (months)	80 (SD = 68.27)

Table 2. Family-Proffered Information and Goal Attainment

Goal	Examples of Helpful Family-offered Information
Stabilization of mental illness	<p data-bbox="516 268 902 300">Information on illness history:</p> <p data-bbox="516 306 1247 520"><i>Um... a lot of history, you know, psychosocial history. A lot of times, the consumer isn't the best self-reporter . . . because [of] . . . the degree of their illness, so, a lot of the stuff we try to get from the family. . . . What did they look like before they were ill . . . when they are doing well, when they are not doing well. (ID04L55-63)</i></p> <p data-bbox="516 562 1052 594">Observations on signs of decompensation:</p> <p data-bbox="516 600 1247 888"><i>The mother called me up . . . she tells me some of the things that are just benign . . . I checked out that, [and the client] was fine. Well, in a matter of days, [the client] was not fine. She was fully psychotic, and I was scrambling to try to get her help. So, that told me that, a lot of times, some things that are brought to my attention by family members, although they seemed insignificant to me, can be very important. (ID19L316-332)</i></p>
Development of social connections	<p data-bbox="516 930 1052 961">Information on client vocational interests:</p> <p data-bbox="516 968 1247 1178"><i>I found out through the family that he is mostly successful in employment that is usually landscaping kinds of things, and he can be working with another family member. . . . and he is better if it's part time. When he's tried to get jobs otherwise . . . usually it hasn't worked out very well. (ID21L631-639)</i></p>

Table 3. Types of Client Permission and Strategies of Sharing Information with Families

Client Permission	Situation	Example
Present	<u>Receiving information from families</u> Case managers may freely receive information volunteered by families	[Client] took a trip out to [place] that turned out to be real[ly] stressful. . . . So the sister called me just to let me know what's going on, that she was worried. . . . I guess just getting the perspective of the sister. That was good. (ID032L65-70)
	<u>Using the received information</u> depending on: (1) the urgency of the information	[Client] was having people over that were doing drugs or drinking alcohol. And that was quite early on, but the dad would call me up about those concerns. . . . [I] look into it right away. (ID032L365-381)
	(2) the quality of the client-family relationship	It depends on the situation and the client, as far as how open they are with their parents or how much they get along with their parents. . . . I either come out and say, "Your parent called me and said they think you are feeling more depressed. How do you think you are feeling?" . . . Or, if they don't really have an open relationship with their parents . . . I would [say], "What did you do this weekend? Did you have a good weekend? You don't look like you are feeling well" . . . try to have the client come out and tell me. (ID07L226-243)
	(3) the family's wish for involvement	And sometimes . . . [family members] said, "No, I won't come to the meeting." And you offer . . . some situations for a couple of years. At some point, you have to say that "I can't take this information anymore. . . . You won't come to the meeting. I don't know how I can help you to solve this kind of thing. So you have to be willing to do something or you can't keep putting me in the middle. You give me no options to change this." (ID16L136-144)
	<u>Releasing information to families</u> according to: (1) the type of information inquired by the family	They [client parents] want to know is their child safe, um . . . are they as happy as they can manage to be. . . . [Another example] Fatalism for those guys [client adult children] is a thing not to be as easy as to come by. . . . a daughter . . . raised the question, "Could this happen to me?" I believe it's not an unreasonable question. (ID13L244-258)
	(2) living arrangements between the client and the family (co-residing or living apart)	If the client lives independently, I shouldn't have to tell the parents how much he spends around. . . . Say he is having a hard time dealing with symptoms of delusions, we may talk about med adjustment for the client, but I don't think I will go over the specific delusions with this family. (ID222L60-70)
(3) effects of releasing the information	I had this experience that . . . the family uses the information against the client. . . . [Another example] some client says . . . "She [client mother] isn't doing anything for me. I hate her. I don't like talking to her." . . . If you talked to the mother and you told her exactly what the client said, is it gonna help, or is it gonna hinder? (ID222L30-40)	
Variable	<u>Receiving information from families</u> Case managers will not actively elicit information from a family in the absence of permission but will assure a family of their acceptance	He doesn't really want us talking to them [the family] . . . but we assure to giving them the permission to call, but we can't tell them any information about him . . . and they know that. But if they are worried about him, like his symptoms get worse, most often they see it first, and so they will call me. And, you know,

of information if provided	they know I can't say anything. I can just take in the information. (ID02L138-152)
<u>Using the received information</u> depending on:	
(1) family permission to reveal the family as the source	Sometimes the family has given us permission to say they called, but sometimes . . . the family called us and said he is a lot worse, and then you have to try to find a way to see that on yourselves. (ID02L153-156)
(2) the quality of the case-manager-family relationship	[When there is tension between the case manager and the family,] I would ask the client, you know, "This is what happened. I got this voicemail from so and so. That's what it said. I can't call them back. I can't disclose any information to them. What would you like me to do about it? Or is there any truth to it. (ID16L284-287)
<u>Releasing information to families</u>	
Case manager will not release information to families in the absence of client permission	We really have to say, "We don't have the release to talk to you." So, they [the family] may keep calling, they may continue to leave voicemails, and we can listen to it or not, but we can't call them back, or we can't share information with them. (ID16L279-281)
Absent	
<u>Receiving information from families</u>	
Case managers commonly agree that no release means no acquisition of information	[Without client consent,] we can do nothing, which is frustrating. They [families] are yelling at you. . . . It makes me mad . . . but . . . that's the person's right by law to determine whom and what they can talk to about. (ID22L331-335)
	The frustration is, the person doesn't want you to talk to a family member, but there are some times [when] talking to that family member gets all of us to truly help the situation—to, you know, really help the client. That's still the client's personal consent to do that, and you can't go against that. (ID22L337-341)
Situations where case managers might take a different measure:	
(1) When families initiate and provide information, case managers will listen	Nothing I can say. I can't tell you [the family] anything. I can listen, but that's it! (ID04L161)
	Our typical tagline is I can't reveal whether the person is with us or not, but if you would like to give me this information, that would be fine. So, that's the tagline. (ID21L172-174)
(2) When the information is helpful, case managers might encourage its release	What I will do is listening, and taking information, asking a lot of questions about it. Um . . . but let them [the families] know up front that without the release, I cannot say anything really about what's going on with this person [the client]. But I appreciate any information you [the family] give that might be helpful. (ID21L116-120)
(3) Case managers recognize that they are walking on a fine line	By answering the telephone, listening to the information, I am sort of acknowledging [the client's presence in the program] already, but most people have been in the program so long, it's already [known] . . . they already know. (ID21L114-116)
<u>Using the received information</u> depending on:	
(1) the urgency of the information	[When families contact the case manager without client permission,] this is usually if they think the person is having a lot more trouble and they tell me about that. . . . If it is

information that really has something to do with what's going on, that's important, and then I act on in whichever way I can. (ID21L124-131)

(2) family permission to reveal the family as the source

Sometimes a family says, "Don't tell him I said anything". . . . then I will say to the person that I understood from the sources in the community. I will leave it just like that. . . . And usually they will tell me if it is true. (ID21L132-135)

[When the family tells the case manager that the client was drinking and did not wish to be revealed,] I will say [to the client], "Have you been doing any drinking?" that kind thing, coming in the back door. (ID21L161-162)

Releasing information to families

Case managers will not release information to families in the absence of client permission

I've said nothing to them [the family], because I respect our client . . . obviously with this client, trust is a huge issue So the fact that she's learned to trust her treaters here . . . is huge, and if she knew that we were . . . having any communication with her family, I mean our trust with her would be blown. So, you know, both like legally and from a clinical perspective, that has to be respected. That's hard. (ID04L162-167)
