

FAMILY-FOCUSED CASE MANAGEMENT: A CASE STUDY OF AN INNOVATIVE DEMONSTRATION PROGRAM

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ABSTRACT

Using results from a formative evaluation, the paper describes family-focused case management (FFCM). FFCM is an innovative community mental health service designed to support both consumers/survivors and their families. The formative evaluation used a multi-informant, multi-method approach to describe FFCM services and assess their quality. Focus groups with program stakeholders produced a "program-logic model" and identified minimum standards for FFCM. Service activities and outcomes defined in the program-logic model were typical of those offered to consumers/survivors in intensive case management programs, but were supplemented with support being offered to their families. Monitoring of service activities showed that the case manager had regular contact with families and offered them a mix of direct and indirect services that corresponded, in most cases, to defined program standards. Interviews with 14 family members and 8 consumers/survivors receiving FFCM services revealed high levels of satisfaction with most aspects of the program. Overall, evaluation findings suggest that intensive case management can be expanded to include providing support to families. Future directions for developing FFCM are discussed.

INTRODUCTION

This paper presents the results of an evaluation of a family-focused case management (FFCM) demonstration program. FFCM is a model of case management that offers support to both consumers/survivors and their families. The literature review that follows provides the context for this new approach by briefly discussing the history of family interventions in community mental health, individual case management, and case management with a family component.

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History of Family Interventions in Community Mental Health

The importance of including families in an active manner in community support and rehabilitation efforts for persons with severe mental illness has been recognized only recently (Intagliata, Willer, & Egri, 1986; McFarlane, Stastny, & Deakins, 1992; Pyke & Apa, 1994; Whelton, Pawlick, & Cardamone, 1997). During much of the present century, families have been seen as more the cause of their members' mental health problems than as part of the solution. For example, etiological models of schizophrenia have included family factors such as the "schizophrenogenic mother," the presence of longstanding marital problems, deviance in family communication, and other problems in family relations (Beels & McFarlane, 1982; Lukoff, Snyder, Ventura, & Nuechterlein, 1984). In the context of these etiological models, it is not surprising that family interventions during the early years of deinstitutionalization (i.e., 1960s and 1970s) focused on addressing pathology in family members and in family dynamics (Beels & McFarlane, 1982). Consequently, families were forced to shoulder the double burden of being held responsible for their relatives' illness and of taking care of them in the community.

A crucial development in the 1980s that helped to shift the perception of families with a mentally ill relative was the ascension of the diathesis-stress model for explaining the development and course of mental illness, particularly schizophrenia (Lieberman, 1982; Zubin & Spring, 1977). In this model, persons with severe mental illness are posited as having a biological predisposition and vulnerabilities that, when combined with stress that exceeds a certain threshold, triggers mental illness or exacerbates an already-present condition. The adoption of this model led to the development of treatments designed to reduce environmental stresses, including interventions which focused on helping families to cope more effectively with the stressful consequences of having a member with severe mental illness (e.g., Hogarty et al., 1986; Falloon, Boyd, & McGill, 1982). In turn, more effective coping by families was expected to contribute to more stable functioning for family members with mental illness by lessening the stress in their lives.

These treatments are commonly known as family psychoeducational (FPE) interventions (Goldstein & Miklowitz, 1995). Core features of FPE interventions include educating families about the causes, course, and treatment of mental illness, assisting families to develop more effective coping abilities, and providing training in both communication and problem-solving related to the family in general and to the member with mental illness in particular. Empirical evidence on the effectiveness of FPE interventions demonstrates that they may reduce relapse rates for consumers/survivors with schizophrenia (Goldstein & Miklowitz, 1995).

Case Management

Separate from the development of family interventions in community mental health services over the past two decades, case management has emerged as one of the major approaches to supporting persons with severe mental illness who live in the community (Clarke Institute of Psychiatry, 1998). Case management has been defined as "a process or method for ensuring that consumers are provided needed services in a coordinated, effective, and efficient manner" (Baker & Intagliata, 1992, p. 215). Depending on the approach, the task of working with consumers/survivors to ensure that they receive the necessary services is assigned either to a multi-disciplinary team of case managers or to a single case manager.

Traditionally, case-management models have been open to, and have even promoted, working with families to assist the process of case management (Baker & Intagliata, 1992). In particular, it has been suggested that family members can contribute to all of the core activities of case management (including assessment, linking, monitoring, assistance in daily living, crisis intervention, and advocacy) as well as benefit from support being provided by case-management services (Intagliata, Willer, & Egri, 1986; Pyke & Apa, 1994). However, it appears that this openness to family involvement has not been translated, either systematically or formally, into case-management service activities.

Models of case management tend to emphasize individual-level interventions for the person with severe mental illness, while family interventions are secondary or not included (Baker & Intagliata, 1992; Solomon, 1992). Further, research on the effectiveness of case management has focused almost exclusively on outcomes associated with the person with mental illness and has not examined changes in family functioning (Baronet & Gerber, 1998; Clarke Institute of Psychiatry, 1998; Holloway, Oliver, Collins, & Carson, 1995).

Review of Studies on Case Management with a Family Component

Our review of the mental health research literature found only two published studies on case-management programs that actively integrated family members into service delivery (McFarlane et al., 1992; Whelton et al., 1997). McFarlane et al. (1992) describe an innovative case-management program which fuses "assertive community treatment" with FPE group interventions in an effort to help persons with schizophrenia live successfully in the community. The program is referred to as "Family-Aided Assertive Community Treatment" (FACT).

The case-management component of FACT was modelled closely on the Training for Community Living approach and its successor, Program of Assertive Community Treatment (PACT) (Olfson, 1990; Stein & Test, 1980). Using a team approach, the focus of PACT is to integrate persons with severe mental illness into the community by providing in-vivo teaching of coping skills, daily living skills, and crisis intervention. The FPE portion of FACT was developed from Anderson, Hogarty, and Reiss' (1986) family education program and from Falloon and Liberman's (1983) family problem-solving approach. These interventions focus on teaching families: (a) about mental illness, and (b) how to set and achieve goals with family members with mental illness.

Both PACT and FPE interventions have been shown to be effective (Goldstein & Miklowitz, 1995; Olfson, 1990). Based on the success of the PACT (individual) and FPE (family) interventions in isolation (Goldstein & Miklowitz, 1995; Olfson, 1990), McFarlane et al.'s (1992) FACT program was developed to integrate both components. An evaluation of FACT in comparison to PACT, with some limited family-based crisis intervention, found that those individuals whose families had participated in FACT had significantly fewer relapses and better vocational outcomes than those individuals receiving just PACT (McFarlane et al., 1992).

Whelton et al. (1997) reported on a program in Hamilton, Ontario that offered both case-management services to young adults with schizophrenia and support to their families by involving them in the rehabilitation process. The structure of the program and its services was generally consistent with PACT, with the exception that individual case managers had primary responsibility for a relatively small caseload of

clients and used a psychiatric rehabilitation approach in their work (Whelton et al., 1997). Moreover, family involvement and input about the rehabilitation issues (e.g., housing, vocational training, leisure activities) faced by clients was sought on a regular basis. Families were also encouraged to join a program-affiliated self-help group to share information and receive mutual support. Participating families were also referred to a psychoeducational program which focused on coping with having a member with schizophrenia. An evaluation of the program revealed high levels of family member satisfaction with the service. In particular, a significant number of family members perceived that the program had reduced their burden of supporting a member with a mental illness (Whelton et al., 1997).

Objective of the Paper

The objective of the present paper is to describe the demonstration phase of an innovative community mental health program which provides case-management services to families with a member with severe mental illness. In particular, the program integrates family support with traditional, intensive case management. Intensive case management is an approach characterized by frequent contact with clients, proactive outreach, community-based practice, and a small caseload of individuals who are followed on a long-term basis by a primary case manager (Clarke Institute of Psychiatry, 1998). The type of case management offered by the program was aptly termed "family-focused case management" (FFCM) because it involves providing support to family members and consumers/survivors.

To provide a detailed description of this program, this paper presents findings of a formative evaluation conducted during the program's first year of operation. Specifically, the paper describes a program-logic model for FFCM developed as part of the evaluation, identifies program standards and assesses the extent to which these were being met by the program, and provides the results of a survey of clients' and family members' satisfaction with program services.

METHOD

The evaluation methodology was modelled on the multi-informant, multi-method approach developed by Bryant and Bickman (1996) for evaluating case-management services.

Description of Program

FFCM is a demonstration program at the Royal Ottawa Hospital (ROH) which offers psychosocial rehabilitation and support services to consumers/survivors living in the community and their families. The program was initiated by the ROH in response to requests from families with a member who was receiving mental health services. The model for FFCM services was developed in close collaboration with these families, and was instituted on a pilot basis for one year starting in May 1997. When the evaluation commenced in January 1998, the program employed one case manager who carried a caseload of 15 clients and their families.

A distinguishing feature of FFCM is that families can initiate participation in the program without the expressed involvement of their family member with severe mental illness. This family member will have up to six months to decide whether or

not to access services for himself or herself from the program. If he or she decides not to become a client of the program, then services are discontinued to his or her family.

Clients participating in the FFCM program ranged in age from 22 to 57 years, with an average age of 34 years. Ten clients were men and five were women. None of the clients were currently married, although two female clients had been married previously and were divorced. Primary diagnoses of clients, as reported by clients themselves or by their families on admission to the program, included schizophrenia (73%) and schizoaffective disorder (27%). The average length of clients' psychiatric illness was 11 years, with a range of 2 to 25 years. One-third of clients (33%) lived at home with their parents. Other clients lived in the community in their own apartment or room (40%), or in a supported setting for persons with psychiatric disabilities (27%).

All family members participating in the FFCM program were parents. They ranged in age from 42 to 76 years, with an average age of 61 years. To qualify for FFCM, family members were required to identify themselves as the primary support for their family member with severe mental illness. In addition, families were required to have a desire to augment their current supports in relation to coping with their member's illness. All families indicated that their lifestyle had been restricted (e.g., isolation from other relatives and friends) as a result of their members' illness.

Study Participants

Hospital staff ($n=3$) who were directly involved in developing and implementing the program participated in the evaluation by attending two focus groups. Several other program stakeholders from the ROH were also members of the focus groups, including a psychiatrist, a social worker, a family member, and a consumer/survivor. The coordinator of the regional administrative group made up of programs from different agencies offering mental health case management in the Ottawa-Carleton region, including FFCM, also participated in the focus groups.

One family member for each client who was receiving services from the program was invited to participate in the evaluation by completing an interview about the program. Of the 15 families receiving services, 14 family members (93%) agreed to be interviewed. Ten of the family members who were interviewed were mothers, three were fathers, and one mother and father were interviewed together. In 13 of the 14 cases, family members who were interviewed identified themselves as the primary support provider for their relative with severe mental illness.

All clients receiving services from the program also were invited to participate in the evaluation. Their participation involved being interviewed and having their service records reviewed. Of the 15 clients receiving services, 8 (53%) agreed to participate in the evaluation.

The methodology followed standard ethical practice for conducting research with human participants. Participation in the research was voluntary and informed consent was obtained from participants. Anonymity and confidentiality were guaranteed to participants. A written summary of the findings was sent by mail to participating clients and family members. Program stakeholders participating in the evaluation also received a report of the findings.

Procedures and Measures

Program document review. Documents describing the program structure, practices and procedures, and the case manager's job were reviewed by the research team at the start of the evaluation. The purpose of this review was to become familiar with the program and to develop a draft of the program-logic model and a list of program standards.

Focus groups with program stakeholders. Two focus groups were held with program stakeholders. The purpose of these meetings was to revise and ratify the program-logic model (i.e., service activities, short-term and long-term outcomes) and program standards developed by the research team from program documents.

Recording of case manager's daily activities. A description of the services being delivered by the case manager was obtained using the Case Manager's Daily Activity Summary tool (Durbin, Goering, Wasylenko, & Roth, 1997). The tool is based on an earlier version of Brekke and Test's (1987) Contact Log. It provides a record of work activities, including the type of activity (e.g., direct contact with client, direct contact with family, working on behalf of clients or families, travel time), the primary focus of the activity (e.g., assisting with daily living activities, housing, crisis intervention), and the location of the activity (i.e., case manager's office, client's home, other community setting). Reliability has been shown to be high for this type of recording of work activities by a service provider (Brekke & Wolkon, 1988).

The case manager recorded all work activities that exceeded 15 minutes for the months of November 1997, January 1998, and February 1998. By November 1997, the case manager had a complete caseload of 15 clients and families. Thus, it was expected that the data gathered through the recording of work activities by the case manager would provide an accurate overview of the nature of services being provided in the program during its first year of operation.

Client interview. The client interview consisted of a semi-structured in-person interview modelled on the Client Satisfaction Interview (CSI) tool (Cullen, Waite, Oliver, Carson, & Holloway, 1997). The CSI asks clients to respond to forced-choice questions about their satisfaction with different aspects of services they receive, including the quality of the service, information, and advice provided, and attitudes and behaviours of service providers. Response alternatives on the CSI range from "dissatisfied" (0) to "very satisfied" (4). Cullen et al. (1997) reported a Cronbach's alpha of 0.89 for the CSI. The client-interview protocol also included several open-ended questions designed to assess clients' impressions of the program.

Family interview. Family members also participated in an in-person interview based on the Family Opinion Questionnaire (FOQ) (Whelton et al., 1997). The FOQ is a multi-item questionnaire containing 34 forced-choice and 6 open-ended questions designed to assess family members' satisfaction with services being received by a family member with a severe mental illness. Several items on the FOQ were derived from the Client Satisfaction Questionnaire (Larsen, Atkisson, Hargreaves, & Nguyen, 1979). Previous use with the FOQ has found the level of family satisfaction with rehabilitation services to vary with the type of living situation of their member with mental illness, and level of worry experienced by family members about their member (Whelton et al., 1997). For the current evaluation, several open-ended questions were added to the FOQ to assess family members' perceptions of program strengths and weaknesses.

Review of service plans and contact forms. Service plans and contact forms on clients and their families were reviewed by two independent raters for correspondence to program standards as defined by program documents and program stakeholders in the focus-group meetings. Discrepancies between the raters were discussed and resolved by raters conducting a second review of the file.

RESULTS AND DISCUSSION

Program-Logic Model for Family-Focused Case Management

The program-logic model for the FFCM program, developed through a review of program documents and focus groups with program stakeholders, is presented in Table 1. The program-logic model identifies service activities directed to clients which are typically found in traditional case management services, including outreach, assessment, planning, direct-service provision, linking to and co-ordination with other

TABLE 1
Program-Logic Model for the Family-Focused Case Management Program

Service Activities	→ Short-Term Outcomes	→ Long-Term Outcomes*
Client^b	Client	Client
Outreach and engagement	Improved relationship with service providers	Improved functioning
Individualized assessment of needs	Increased link with community resources	Improved quality of life in the community
Service planning	Increased participation in treatment decision-making	Improved satisfaction with family relationships
Direct service provision	Increased social support	Increased self-esteem and self-efficacy
– modifying behaviour	Increased knowledge about mental illness	Decreased hospitalization
– practical help	Improved well-being	
– emotional support	Decreased reliance on family	
– education	Satisfaction with case-management services	
– crisis intervention		
Linking and coordinating		
– individual advocacy		
– brokerage		
Monitoring and follow-up		
Family^c	Family	Family
Identification of expectations regarding client care	Increased informal support	Increased satisfaction with family relationships
Direct service provision	Increased link with community resources	Increased confidence in client's coping abilities
– practical help	Decreased family demands	Improved perception of client
– emotional support	Increased knowledge about mental illness	
– education	Satisfaction with case-management services	
Linking and coordinating		
– individual advocacy		
– brokerage		
Monitoring and follow-up		

* Those outcomes expected after receiving two years of service

^b The family member with severe mental illness

^c Members of the client's immediate family

services, and ongoing regular monitoring and follow-up at the client level (Baker & Intagliata, 1992).

Service activities falling under "family" in Table 1 represent innovative aspects of FFCM. The framework for these activities parallels those targeted to clients. In particular, expectations regarding client care initially are identified with families. Based on these expectations, service provided to families may include practical help, emotional support, and education about mental illness and available community resources.

In addition, according to the program-logic model, service activities of FFCM directed at families are expected to include assisting family members to find community resources and supports that will address their needs related to having a member with severe mental illness. Similar to providing case management to individual clients, FFCM includes ongoing monitoring and follow-up with families, reviewing their perceptions of the services received, and responding to changes in their needs.

Validity of Program-Logic Model

To assess the validity of the program-logic model, the outcomes specified are compared to the research literature on the effectiveness of case-management services and interventions targeted to families with a member suffering from severe mental illness. Given the unique nature of FFCM, the actual outcomes produced by the program can only be determined by an impact assessment. However, the review of the literature does enable an evaluation of the plausibility of the outcomes predicted in the program-logic model.

Overall, there is empirical evidence for many of the expected outcomes identified in the program-logic model for clients who receive case management. Outcomes shown to result from receiving case management include increased use of community services, reduced client symptomatology, improved functioning, reduced hospitalizations, increased social networks, enhanced quality of life, and greater satisfaction with case-management services compared to traditional services (Baronet & Gerber, 1998; Clarke Institute of Psychiatry, 1998; Holloway et al., 1995).

Currently, however, there is no evidence in the mental health literature of case management decreasing an individual's reliance on his or her family or improving an individual's relationship with his or her family. Nonetheless, a number of outcomes specified in the program-logic model under family have been achieved by FPE programs, including increased knowledge of family members about mental illness, decreased demands on the family, and improved family relations (Goldstein & Miklowitz, 1995).

Some family-level outcomes in the program-logic model (i.e., increased informal support for the family, increased link of the family with community resources, and improved perception of the family member with severe mental illness) are specific to FFCM. These outcomes have not been examined previously in studies on interventions to families with a member with severe mental illness. However, given the nature of the proposed services in FFCM, their hypothesized inclusion in the program-logic model seems reasonable.

Description of Program Services

Data collected on the Case Manager's Daily Activity Summary over a three-month period were summarized to present the amount of time spent by the program case manager in each service activity (i.e., type and primary focus).

Self-report data on the work activities of the case manager indicated 54% of her time being devoted to direct-service activities (i.e., in-person or telephone contact with family member with severe mental illness or other family members). The caseload of 15 clients and their families appears to present demands on the case manager that are manageable, at least when all of the clients are at an early stage of receiving services from the program.

The case manager spent almost three times more of her time in the company of clients (38%) as compared to family members (14%). This breakdown is reflective of the innovation of family support being implemented as a supplement to traditional case management. Interestingly, only 2% of the case manager's time involved having contact with clients and family members simultaneously, suggesting that client support and family support are being provided separately. This separation of services to clients and families is in line with the program-logic model for FFCM. Moreover, this separation also is reflected in services delivered by FPE interventions with the emphasis on increasing knowledge and bolstering support and coping skills of families (Goldstein & Milkowitz, 1995).

Ten percent of the case manager's time was spent in indirect services on behalf of clients and families (e.g., linking and co-ordinating) while 22% of her time involved work on behalf of the program or hospital. The remaining time was spent by the case manager in travel (10%) or was not specified in the recording of activities (4%). In terms of the location of service delivery, the case manager spent 65% of her time in the community (i.e., external to the hospital).

Direct services delivered to families. A breakdown of direct-service activities offered specifically to families revealed that the case manager devoted the greatest amount of time to providing families with emotional support and counselling (25%). Providing emotional support and counselling was defined as assisting with family relationships, especially those involving the member with severe mental illness, discussing and mediating family difficulties, and helping families to cope with stress. The activity to which the case manager devoted the second greatest amount of time was assisting families with mental health issues (21%). This activity referred to helping families communicate and negotiate with the mental health service providers of the member with severe mental illness.

Other areas of direct-service activities to families included providing information about the case manager's work with the family member with severe mental illness (9%), helping families with housing issues faced by the family member (6%), working with families to facilitate the engagement and receptivity of the family member to receiving FFCM (5%), and intervening in crisis situations (4%). The case manager spent minimal time helping families with issues related to daily activities, recreation, or the physical health of their member with severe mental illness.

Correspondence of Services Delivered to Families and Program Standards

Program standards were defined by the stakeholder group representatives participating in a focus group which worked from a draft of program standards that was developed by the research team from program documents. In line with the program-

logic model, program standards were categorized as being related to either clients or families. Program standards were intended to specify the characteristics of the minimum services that would be provided to clients and family members by the program (see Appendix for the list of program standards for the FFCM program).

Table 2 presents results on the assessment of the correspondence between services offered to families and program standards. Correspondence was assessed by examining two sources of information: (a) data from the monitoring of service activities by the case manager, and (b) contact notes in clients' service records describing services delivered.

As shown in Table 2, family expectations regarding care of the family member with mental illness were determined with all the families of clients whose service records were reviewed. Direct services being provided to family members showed some variability, although it appeared that the majority of families were benefiting from receiving different types of support from the program. At the same time, it appeared that some families were using the services in a less intensive manner than were other families.

In the majority of cases, the linking and coordinating of families with services and supports for themselves emerged as an important service element. Contact between families and the case manager was occurring on a regular basis for all but one family. In particular, the frequency of contact with families corresponded to the program standard of at least once per month.

TABLE 2
Correspondence of Services Offered to Families and Program Standards

Program Standards for Services Delivered to Families	Daily Activity Summary Data (<i>n</i> = 15) (% meeting stds.)	Review of Service Records (<i>n</i> = 8) (% meeting stds.)
1. Identification of expectations regarding client care		
a. expectations for client care will be identified	—	100
2. Direct service provision		
a. all families will receive practical help	80	50
b. all families will receive emotional support	80	66 ^a
c. all families will receive education	80	17 ^b
3. Linking and coordinating		
a. help link with services and supports as needed	100 ^c	63
4. Monitoring and follow-up		
a. contact with families at least once per month	91 ^d	86 ^e

^a Unable to judge in 2 cases (*n* = 6)

^b Unable to judge in 2 cases (*n* = 6)

^c Services on behalf of clients and/or families

^d Count of contact with 15 families at least once per month over 3-month period of service monitoring (*n* = 45)

^e Unable to judge in 1 case (*n* = 7)

Satisfaction with Services

Overall, family members and clients participating in the evaluation reported high levels of satisfaction with most aspects of the program. All family members who were interviewed ($n = 14$) reported that the program had met their needs. Moreover, they all reported feeling satisfied or very satisfied with the amount of contact they had with the case manager, rated their working relationship with her as positive, and perceived the case manager as understanding the problems they faced with their son/daughter.

A large majority of family members (85%) felt that case-management services had reduced their responsibilities and worries and helped their son/daughter deal more effectively with his/her everyday life. In response to being asked what he or she liked best about the program, one family member stated:

[Having] a shared burden . . . having someone to talk to who understands . . . for [the] family and [the] consumer . . . with less hospital care [available], having a case manager helps keep families healthier, physically and mentally . . . [it] preserves the health of caregivers . . . [the] case manager helps families so families can help consumers . . . families avoid burnout.

In discussing strengths of the program, several family members commented that they particularly appreciated the prompt access they had to the case manager when issues relating to their family member arose. They suggested that this access provided them with a sense of security. For example, one family member said:

She is more than case manager, she is a friend, she is caring . . . I have someone to talk to about all my concerns and needs and from whom I can get help . . . she understands my concerns . . . I know that if something drastic happens she would know what to do . . . she is reachable any time and she calls me back as soon as she can.

A number of family members also appreciated the fact that the case manager understood their unique circumstances and was able to respond to them. One family member made the following comments:

[I like] the individual attention . . . the individual attention and consideration . . . [the case manager] is a very good resource, she is a resource for resources . . . [she is] available to you on an individual basis . . . [she can] judge very well what is suitable for my son . . . the fact that this going to be permanent is super.

Despite these high levels of satisfaction related to different aspects of the program, a significant minority of family members (36%) reported that the program had not been successful in meeting the full range of their son/daughter's needs. Moreover, several family members expressed a desire to access more of the case manager's time, both for themselves and for their family members.

All of the clients ($n=8$) who were interviewed were very or mostly satisfied with the amount of help they were receiving from the program. As well, they were all satisfied with the extent that the program had helped them manage their illness better, set long-term goals, and improve their family relationships. Seven of the eight clients reported being satisfied with the kind and quality of the service that they had been receiving from the program.

All clients also perceived that the case manager had a good relationship with their family members. In response to an open-ended question about the handling of confidential matters by the program, all of the clients appeared satisfied that the case manager had not communicated to family members any personal information that they had shared with her. Given that the case manager often sees clients and family mem-

bers separately, this finding is noteworthy. Nonetheless, two clients did express some discomfort with the case manager having contact with their family as part of the service.

Similar to family members, a significant minority of clients (38%) did express some dissatisfaction with the extent to which the program was meeting their needs. As well, in response to an open-ended question about areas of the program needing improvement, four of the eight clients expressed the wish to have more time with the case manager. Specific unmet needs identified by clients included a desire for assistance with finances, housing, employment, and goal-setting.

CONCLUSION

The present evaluation suggests that intensive case management can be extended to include family support. The FFCM program examined joins only two other documented case-management programs which include family support (McFarlane et al., 1992; Whelton et al., 1997). Unique contributions of the present paper include the presentation of a program-logic model for FFCM, a description of the specific services delivered to families in FFCM, and a definition of minimum service standards for FFCM.

Our findings indicate that families receiving FFCM perceive it as helping them with the day-to-day demands of supporting a family member with severe mental illness living in the community. The high levels of satisfaction with FFCM reported by families are similar to those found by Whelton et al. (1997), which reflect the appreciation of families in being actively involved in the treatment and rehabilitation of their family members. Moreover, the majority of individuals with severe mental illness who participated in our evaluation were satisfied with the services they were receiving, including the involvement of the case manager with their families.

Our findings also highlight the needs of individuals and their families in facing the complexity and magnitude of dealing with the lifelong challenge of living with severe mental illness. Although clients and their families expressed high levels of satisfaction with FFCM, a significant minority of both groups reported that not all of clients' needs were being met by the program. In particular, many clients and family members expressed the wish to have more contact with the case manager. High levels of need and high expectations combined with the early stage of the program's operation may explain, at least in part, the perception of clients and families that client needs were not being fully met. It will be important in the future for the program to clarify expectations of clients and families regarding services and to negotiate with them about which needs reasonably can be addressed by this type of program.

Limitations and Future Directions

One limitation of the current evaluation of FFCM is that it was conducted at a very early stage in the program's development, when the case manager had just begun to provide services to a group of 15 clients and their families. Consequently, the findings can be considered as only a very preliminary perspective on this type of case management. It remains to be seen whether the program will be delivered in the same way if and when it expands to have a team of case managers serving a much larger group of clients over an extended period of time.

Another limitation of the evaluation is that a relatively small number of clients

were interviewed about their perceptions of the program. A likely factor contributing to the relatively low response rate is the early stage of engagement of clients in the program. In all cases where clients had refused to participate in the evaluation, families had initiated the request for FFCM and the clients were ambivalent about participating in the program. It is possible that those clients who were not interviewed had different views about the program than those who were interviewed. Unfortunately, the present paper does not include their perspective.

We hope that the present paper can provide an early blueprint for the development of FFCM. At this point, there are two avenues that could be pursued to further the evolution of this innovation. The first avenue would be to extend traditional intensive case management services to include family support. The nature of the program-logic model for the FFCM program evaluated in the present study allows for services to be expanded easily in this direction without losing the core services provided by traditional case management. The pursuit of this option is appealing in that it potentially lends itself to helping a large number of families living with severe mental illness without having to wait for the development of new services. A second advantage of extending existing services in this direction is that doing so may provide an opportunity for some individuals with severe mental illness to work on reconciling with estranged family members.

A second avenue would involve developing FFCM in the context of new services. In the future, case-management services can be expected to be one of the priority areas in the expansion of community mental health services across North America (e.g., Ontario Ministry of Health, 1993). New services provide an opportunity for implementing innovations such as FFCM. With its emphasis on the inclusion of families in service delivery, the advantage of pursuing this avenue as a way of advancing FFCM is that it would allow the case-management approach to be specialized and distinct from other types of case management. In this way, FFCM would be intended for individuals with severe mental illness whose families are the primary source of support in the community, and where both individuals and their families are interested in the approach.

The demonstration program evaluated in the present study was small and in its first year of operation. Consequently, it would have been premature to examine service outcomes. An important next step in the development of FFCM as it expands will involve conducting an outcome evaluation. The developed program-logic model can provide some direction for the outcomes to be examined in this type of evaluation, particularly as they relate to family relationships and family functioning. Ultimately, the true test of this innovation is whether it can make a difference to the lives of individuals with severe mental illness and their families.

RÉSUMÉ

Cette communication décrit un programme de suivi communautaire centré sur la famille (family-focused case management—FFCM), à partir des résultats d'une évaluation formative d'un programme pilote. Le FFCM est une formule innovatrice dans les services de santé mentale communautaire qui fut conçue pour soutenir à la fois les consommateurs/survivants et leurs familles. L'évaluation formative a utilisé une approche à informateurs multiples et méthodes multiples afin de décrire les services du FFCM et évaluer leur qualité. Des groupes test formés des joueurs-clés du programme ont permis de produire un «modèle conceptuel de programme» (program-logic model) et d'identifier des normes minimums pour le

FFCM. Les activités et les résultats définis dans le modèle conceptuel du programme étaient typiques de ceux offerts aux consommateurs/survivants dans les programmes de suivi communautaire intensif, mais un soutien était offert à leurs familles en supplément. Une surveillance continue des activités du service a révélé des contacts réguliers entre les intervenants et intervenantes communautaires et les familles, offrant à ces dernières un mélange de services directs et indirects qui correspondent dans la plupart des cas aux normes définies par le programme. Des entrevues avec 14 membres de familles et 8 consommateurs/survivants recevant les services de FFCM ont révélé des niveaux de satisfaction élevés pour la plupart des aspects du programme. Dans l'ensemble, les résultats de l'évaluation suggèrent qu'il est possible d'élargir le suivi communautaire intensif de façon à inclure un soutien aux familles. Des lignes directrices pour le développement futur de programmes FFCM sont discutées.

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APPENDIX

Program Standards for Family-Focused Case Management: Client

Outreach and engagement

- a. Clients will be interested in receiving services from the program within 6 months of first contact.

Individualized assessment

- a. An assessment will be conducted on each client.

Service planning

- a. Each client will have an individualized service plan.
- b. Service plan will include individual goals as defined by the client.

Direct service provision

- a. All clients will receive practical help as part of the service package.
- b. All clients will receive emotional support as part of the service package.
- c. All clients will receive education on the presentation and treatment of mental illness.
- d. Assistance with development of life skills will be provided to those clients needing and wanting it.
- e. Case manager will provide crisis intervention on an as-needed basis.

Linking and coordinating

- a. Case manager will help all clients link with appropriate services and supports.
- b. Case manager will mediate between service providers and clients on an as-needed basis.

Monitoring and follow-up

- a. Case manager will have regular contact with clients (i.e., minimum of once per month).

Termination

- a. Procedures for termination of the Mental Health Community Support Services* will be followed, supplemented by the input of family members.
- b. Case manager will develop a service and support plan with all clients and their families at termination.

Program Standards for Family-Focused Case Management: Family

Outreach and engagement

- a. Families identified as needing and/or interested in receiving case-management services will be informed about the program.

Identification of expectations regarding client care

- a. Expectations for client care will be identified for all families.

Direct service provision

- a. All families will receive practical help as part of the service package.
- b. All families will receive emotional support as part of the service package.
- c. All families will receive education on the presentation and treatment of mental illness.

Linking and coordinating

- a. Case manager will help families link with appropriate services as needed.

Monitoring and follow-up

- a. Case manager will have regular, ongoing contact with families (i.e., minimum once per month).

*Mental Health Community Support Services refers to an administrative coalition of 10 agencies in Ottawa-Carleton providing mental health case management. The coalition operates a central intake procedure, provides standardized training of personnel, and develops common procedures related to service delivery across the agencies.