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PLEASE SCROLL DOWN FOR ARTICLE
Confidentiality Policies and Practices in Regard to Family Involvement: Does Training Make a Difference?

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Despite the evidence that including families, relatives, friends, and other “significant people” (SP) of mental health clients in treatment and recovery services enhances client outcomes, confidentiality concerns and misconceptions by agency staff remain a major barrier to the implementation of family inclusion efforts for adult clients in behavioral health systems nationally and internationally. This article reports on a survey of providers and administrators regarding their beliefs about sharing information with these significant individuals in clients’ lives in a behavioral health system that is undergoing a system transformation to become more recovery oriented. Furthermore, it describes an agency pilot program that involved clarifying agency confidentiality policies and state regulations or laws, training staff about this information, and assessing the effects of the training. Evaluation results of staff training about these policies are also reported.

Nationally as well as internationally, there is increasing recognition of the beneficial effects of including family members and other significant support people in the planning and treatment of persons with severe psychiatric disorders (Andrew, Farhall, Ong, & Waddell, 2009; Cleary, Freeman, & Walter, 2006; Dixon et al., 2001; Gray, Robinson, Seddon, & Roberts, 2008; Lakeman, 2008; Stanbridge & Burbach, 2007; Stanbridge, Burbach, & Leftwich, 2009). Despite mental health practice guidelines, governmental reports, and policies in the U.S. and elsewhere encouraging the inclusion of families in the delivery of mental health services, the realization of such involvement has been limited due to a variety of implementation barriers. Along with some providers’ continuing negative attitudes toward families and lack of empathy and skills in collaborating with families, a primary barrier is confusion and inadequate knowledge and understanding regarding confidentiality policies and issues of privacy of client information (Bogart & Solomon, 1999; Cleary, Freeman, & Walter, 2006; Gray et al.; Jakobsen & Severinsson, 2006; Kim & Salyers, 2008; Lakeman; Marshall & Solomon, 2003; Rubin, Cardenas, Warren, & Pike, 1998; Spaniol, 2004; Stanbridge et al., 2009). Although certain specific client information cannot be released to a third party without the explicit consent of clients, other more general information can be communicated to families and significant people (SP) involved in the life and care of clients (Bogart & Solomon, 1999; Wynaden & Orb, 2005). Sharing of certain critical information at times of crises or to prevent potential crises from occurring may also be not only permissible, but imperative for good clinical care (Petrila & Sadoff, 1992). Furthermore, procedures have been developed that enable the release of
specific personal information with family-friendly release forms, specifically designed for use in releasing information to family members (Bogart & Solomon, 1999; Marshall & Solomon, 2004).

The present article reports on the findings of the views of mental health staff and administrators regarding confidentiality issues that were obtained from staff of behavioral health providers and related agencies, such as prisons, in Philadelphia. Representatives of a coalition of family education, support, and advocacy organizations distributed the surveys at presentations concerning family inclusion. Significant people was defined as all people whom a client or staff member identify as important to the client’s recovery and treatment, such as biological relatives (parents, siblings, adult sons and daughters), friends, spouses or romantic partners, and roommates, as well as landlords, employers, and clergy. People who were important because they could have a negative effect on a consumer’s recovery if they were not supportive were also included. In addition, we will report on the outcome evaluation of a pilot program at one of the local agencies that involved clarifying agency confidentiality policies and training staff in these policies. Such an effort was deemed necessary given the preliminary results of the surveys.

BACKGROUND

For public behavioral health providers and administrators to increase family inclusion in the delivery of their services, they need to be knowledgeable about the parameters of confidentiality policies, regulations, and laws in relation to the family members and SP of the individuals they serve. Without a solid foundation regarding confidentiality policies, the likelihood of inclusion of family members and SP in their clients’ services will be diminished. Providers have to be made aware of strategies to balance the rights and interests of clients regarding their private information, while at the same time being sensitive to the needs and responsibilities of those who care for and are affected by the people they serve (Furlong & Leggatt, 1996). All too frequently providers are reluctant to share information with others regardless of their relationship to the client as they are unable to differentiate information that falls within the purview of client confidentiality as opposed to information which can be and, in some cases, should be shared with those significantly involved in the lives of their clients (Wynaden & Orb, 2005). In some
instances, this lack of knowledge could lead to detrimental consequences for the client or his or her family. Almost 2 decades ago, Petrila and Sadoff (1992) called for a reexamination of the interpretation of confidentiality “with the aim of broadening the type of information routinely made available to families acting as caregivers to a mentally ill relative” (p. 137). Others have noted the importance of approaching families in a more sensitive manner regarding this issue (Furlong & Leggatt, 1996).

THE DILEMMA OF VIOLATING A CLIENT’S RIGHT TO CONFIDENTIALITY

The protection of private information of their clients by public behavioral health service providers is essential to retaining a therapeutic alliance with their clients and maintaining their trust. Confidentiality is a legal right for clients as well as a professional ethical responsibility of providers. Consequently, mental health providers are confronted with the dilemma that if they work with the family, they might jeopardize the established relationship with their client who is their primary responsibility (Furlong & Leggatt, 1996). Although confidentiality is a legal right of clients, it is not an absolute, but rather is open to some discretion and interpretation based on clinical judgment of what is in the best interest of the client and the rights and interests of others (Furlong & Leggatt). As noted by Zipple, Langle, Spaniol, and Fisher (1990), providers are frequently “caught between their desires to be supportive to families and their ethical and legal obligations to protect the confidences of their clients. Complicating this potential conflict is a fear of legal liability of improperly disclosing information, as well as fear of liability for failing to warn or take other protective action in emergencies that might demand disclosure of confidences” (p. 535). In some situations family members and SP have a right to certain information for their own safety and well-being (Wynaden & Orb, 2005).

STRATEGIES FOR RECONCILING THE DILEMMA

Caught within this dilemma, providers often resort to a conservative approach of not engaging clients’ family members, leading family members to believe that providers use confidentiality to not engage with them (Wikinson & McAndrew, 2008). This conservative strategy
on the part of providers often results in ignoring families and not providing them with even basic nonconfidential information, as well as not receiving information from the family about the client that might be essential for effective planning, treatment, and rehabilitation services (Furlong & Leggatt, 1996) or even the safety of the client and others. Being unwilling to speak with families can be a missed opportunity for obtaining crucial information that may not otherwise be available to providers who see the client on only a limited basis. Families and significant support persons frequently are aware of early signs of exacerbation of their relative’s illness before the provider, but without contact with the provider they have nowhere to share this information (Marshall & Solomon, 2004; Bogart & Solomon, 1999). As a result, family members often experience feelings of anger, frustration, and a sense of powerlessness and hopelessness at the lack of opportunities for communication and collaboration with providers in working together to support their loved ones’ recovery process.

Providers have recognized that releasing basic information about the client’s condition without written permission, such as whether the client is receiving services from the agency, is a breach of the client’s right of confidentiality (Marshall & Solomon, 2003). Some agencies have therefore developed policies that forbid providers to communicate at all with families—even to the extent of listening or giving out non-client-related general information, for fear that by implication they will be divulging that the client is receiving services from the agency (Zipple et al., 1990). However, offering nonconfidential information to family members and SP may be extremely helpful. Providers can make clear to family members that they are not authorized to acknowledge whether their relative is receiving treatment at the agency, but this does not preclude the provider from answering general questions such as what is schizophrenia and what are the known treatments without specifying the client or any confidential information (Zipple et al.). The provider is allowed to offer didactic information, distribute written educational material, and provide information about community educational resources without written permission from the client (Zipple et al.).

When it comes to providing confidential information to family members and other, SP, some states (Pennsylvania is not one of them) have included specific statutory language within their mental health laws that permits release of confidential information to
families prior to obtaining consent (Bogart & Solomon, 1999). However, requiring consent from the client is vital, as it safeguards clients' trust, empowers clients, and validates clients' decisional capacity (Bogart & Solomon). Furthermore, there are specific consent procedures that enable providers to release confidential information to family members. Although one can use an agency's general release form for this purpose, there are forms designed specifically for families. These forms allow for specific types of information to be released to a designated family member or significant person rather than a general release of information form. These family forms also have a longer time frame of 1 year as opposed to the usual 30, 60, or 90 days to ensure continuity, but still maintain a statutory time limit (Bogart & Solomon; Marshall & Solomon, 2004; Solomon, Marshall, Mannion, & Farmer, 2002). These forms thus enable the client to have control over what specific information is shared and with whom. In addition, these permit the information to be communicated verbally rather than written in order to prevent confidential information inadvertently "ending up in the wrong hands" (Marshall & Solomon, p. 4).

KNOWLEDGE OF CONFIDENTIALITY

Behavioral health providers frequently are reluctant to share information with their clients' family members and SP because they are not able to distinguish between confidential and nonconfidential information (Gray et al., 2008; Slade et al., 2007; Wynaden & Orb, 2005). A study by Marshall and Solomon (2003) of 59 providers from partial hospitalization and case management programs found providers were confused as to which information was confidential. Providers themselves recognize their need for training on issues of confidentiality (Gray et al., 2008). In another study, providers noted how stressful it was for them to balance a family's desire to know and their obligation to a client's refusal to release information. But these providers also indicated that release forms for families were infrequently used (Nicholls & Pernice, 2009). Some training for family inclusive services have included issues of confidentiality (Stanbridge & Burbach, 2007; Stanbridge, Burbach, & Leftwich, 2009). Marshall and Solomon (2004) conducted an intervention examining the clarifying of confidentiality policies and using a specific family release form. They found that family members
associated with providers faithful to the intervention of having clients sign a specific family release form reported more contact with providers, received more information from providers, and were more satisfied with the degree of contact they had.

PHILADELPHIA CONFIDENTIALITY EFFORTS RELATED TO FAMILIES

We will now describe two different efforts: first, assessing providers’, graduate students’, and administrators’ knowledge of confidentiality issues related to families and SP, and second, a pilot training program and evaluation influenced by the findings of the first effort.

SURVEY OF FAMILY CONFIDENTIALITY ISSUES

Between 2008 and 2010, mental health staff, administrators from the Philadelphia area behavioral health and governmental agencies, and social work/psychology graduate students in public behavioral health placements completed a family attitude survey that included two questions about family inclusion related to confidentiality issues. The surveys were distributed at presentations about family involvement by representatives of a coalition of family education, support, and advocacy groups called the Family Resource Network (FRN). The FRN includes Philadelphia affiliates of the National Alliance on Mental Illness, the Training and Education Center and Parents Involved Network programs of the Mental Health Association of Southeastern Pennsylvania, the Psychoeducational Program of the Northeast Community Center for MH/MR, and the family support specialist at mental health civil courts. Additional representation comes from the Consumer Satisfaction Team, the Department of Behavioral Health/Mental Retardation Services, Community Behavioral Health (local public managed care agency), the Philadelphia Compact, and Philadelphia Connections. FRN is funded by the Department of Behavioral Health/Mental Retardation Services of the City of Philadelphia. The presentations took place at such locations as community mental health agencies, behavioral managed care programs, prison mental health programs, psychiatric programs at hospitals, and student seminars.
The survey consisted of the FRN Family Attitudes Inventory (FAI), which is a nine-item measure of beliefs and knowledge about families of people with major mental illnesses (developed by three of the authors, E.M., M.M., K.C.), derived from an earlier measure (Marshall, Solomon, Steber, & Mannion, 2003). The measure included items about confidentiality as well as about attitudes toward families, such as whether poor parenting caused mental illness and whether families are harmed rather than helped by being involved in their relative’s treatment. The items had Likert response categories of “strongly agree” to “strongly disagree,” and “not sure.” The measure was piloted with 10 outpatient therapists at a community mental health center in 2008, after which redundant items were removed, a definition of major mental illness was added, and some items were revised for clarity. Two of the questions in the FAI concerned confidentiality and communication with SP:

1. Imagine that you have a consumer in your program and the significant people (SP) of the consumer know that the consumer is in your program. Based on your conversations with the consumer, the SP appears to be no threat to him/her. Even so, confidentiality requirements will still prevent you from listening to any information that a significant person tries to give you unless you have the consumer’s permission.

2. Imagine that the family of a consumer knows that their family member is in your program and based on your conversations with the consumer, the family is no threat to him/her. However, confidentiality requirements will still prevent you from giving even general information about family resources (such as a family support group) to families without the consumer’s consent.

In both cases, there are no local, state, federal, or individual agency policies known to the authors that prohibit listening to a caller or giving resource information as long as no client-related information is revealed.

FAI Survey Results

The FAI was completed by 640 provider staff, administrators, and students at 37 presentations by FRN speakers between December 2008 and May 2010. Provider staff included case managers,
therapists, supervisors, and administrators at behavioral health outpatient, inpatient, case management, and day programs. Other groups included Philadelphia behavioral health system administrators and graduate students (mostly masters of social work students).

On both questions noted above, large numbers of respondents endorsed both agreement and disagreement with the statements: 40% \( (n = 251) \) agreed or strongly agreed versus 53% \( (n = 339) \) disagreed or strongly disagreed, respectively, on Question 1; 42% \( (n = 267) \) agreed or strongly agreed versus 50% \( (n = 319) \) disagreed or strongly disagreed on Question 2; others were unsure. Overall, 40% of 635 respondents believed that they could not even listen to what a caller might have to say, and 42% of 638 respondents believed that they could not mention even general resource information to callers. This pattern of responses was similar in most of the groups surveyed.

There was some, limited, variation among groups. Between 12/08 and 5/10, 177 new provider case managers receiving training on the behavioral health system; 169 graduate students, 41 inpatient workers and supervisors from three hospitals, and 26 customer service representatives at the local managed care organization for clients on medical assistance were surveyed, accounting for 65% of the total surveys collected. No more than 54% of any of these groups disagreed with an absolute prohibition on communication without a release, even when no client information was revealed. Only two groups comprising 12% of the total surveyed showed higher agreement (>60% of the group) concerning negative responses to both questions: at least 70% of targeted case management (TCM) supervisors (46 total) and 63% of mental health staff at a prison facility (32 total—mostly social workers) disagreed with both statements about an absolute prohibition on any communication in the absence of the client’s consent.

AGENCY PILOT PROGRAM ON CONFIDENTIALITY POLICIES RELATED TO FAMILIES

The anonymous surveys provided empirical data in addition to considerable anecdotal evidence that more intensive work was necessary with community agencies in order to make significant changes in family involvement practices. FRN members decided
on a strategy of doing a pilot project with a specific program (TCM), at an agency that was receptive at all levels of administration to improving family involvement efforts. The pilot included working with agency and TCM administrators to clarify agency confidentiality policies related to families and interpretations of state laws, and then to conduct staff training on these policies with an outcome evaluation. Client and family representatives were solicited for feedback on the project. Because of the widespread confusion about confidentiality policies and practices, these issues were a primary focus of training and assessment.

Training Intervention

The program and agency administrators decided this training would be mandatory for all staff of the TCM program. The training would be part of a regularly scheduled, monthly all-staff meeting. Based on the agreed-upon agency/program confidentiality policies and laws, FRN members developed a 90-minute training session concerning these issues. The training covered four topics: (a) definition of social support people (called “significant people” or “SPs”), (b) consumer consent and professional responsibility, (c) sources of guidance and policy regulations, and (d) case examples covering a series of situations that might arise involving confidentiality issues related to SP and clients. The concerted and continued effort to obtain a signed release of information form was discussed (as part of the family inclusion initiative, a family release form that had been used in another agency program was adopted for the TCM program). Four sources of guidance were presented: administrative/Supervisory judgment, agency policy, regulations and laws, and professional and personal ethics. The final part of the training was a case situation presentation on a series of issues, which were then summarized, and relevant guidance was presented.

Pilot Study Sample

Twenty-four TCM staff participated in the training session. Demographic forms were distributed after the training was over but were completed by only 11 of the staff—and not all respondents replied to all questions; this may have been due partially to uncertainty on the part of some staff concerning how the information would be used.
All responding staff members were targeted case managers except for one TCM assistant and one TCM supervisor. The mean ± SD age of 10 staff members was 43.7 ± 14.1 years. Of the 11 staff members, 7 (70%) were women and one person failed to identify his or her gender. Five of 11 staff members identified themselves as African American or black (45.5%), 2 were white or Caucasian (18.1%), and 4 did not identify their race. Nine staff members listed completed bachelor degrees in social/human services, psychology (4), and one degree in literature. One staff member said her bachelor’s degree was pending, and one failed to list a degree. Two of the 10 staff members with bachelor’s degrees also had masters degrees in mental health counseling and recreational therapy. All 11 respondents identified how many years they had worked in any mental health setting (mean ± SD of 12.4 years ± 6.9) and how many years they had worked at their current program/agency (mean ± SD of 8.4 years ± 5.9).

Confidentiality Issue Test

FRN representatives first discussed family/support, person-related, confidentiality policies with agency and TCM program administrators in an ongoing project work group. FRN presented the work group with a list of 10 situations involving confidentiality issues for comment and discussion. After agency administrators clarified policies internally, a confidentiality issues test (CIT) was developed by FRN members and discussed and revised by the work group. The final measure contained seven scenario descriptions and 10 questions involving confidentiality issues and family members/SP. Answers were multiple choice or true/false. The CIT was piloted by members of the project team to check for clarity and completion time. These questions corresponded to those case situations covered in the training session.

Two example items (correct answers are bolded):

1. The Situation:

A woman calls you about a consumer on your caseload and identifies herself as the consumer’s mother. You have no release, but the consumer has mentioned that he visits his mother frequently and you have no reason to believe that the caller is a danger to the consumer. The caller says she wants to make sure that her son’s case manager gets certain very important
information about his financial and legal situation—information that he often does not mention to staff.

1a. All you can say is that you cannot give out any information about consumers without a release, including whether any particular person is a consumer at your agency.

1b. You are only allowed to take the caller’s name and contact information and tell her that if any information can be released, someone will get back to her.

1c. While stating that you cannot give out any information, you are allowed to ask the caller about the information she is concerned about conveying and say that if it turns out that her son is a consumer there, you will make sure the information gets to the right person.

1d. Since the caller is an immediate family member and has important information, you are allowed to confirm that the son is a consumer at your agency, but not to release any other information.

5. The Situation:

A consumer has told you (or someone at your agency) that she plans on taking an overdose tonight, and has a large number of pills saved up at her apartment. You know that she has a roommate and you have the roommate’s contact information, but you have no signed release to talk to the roommate.

5a. Even in this situation, you must get a signed release from the consumer to be able to call and talk to the roommate about the consumer’s safety.

5b. You do not need to have a release to talk to the roommate if there is a question of imminent death or serious injury to the consumer, as long as the information you share is restricted to the issue of the consumer’s safety.

5c. Neither of the above choices is correct.

5d. not sure

Pilot Study Design

A pretest (the CIT) was administered and collected at the beginning of the training session followed immediately by a review of all correct answers and clarification of any misunderstood questions or disagreements about correct answers. The same test was administered
## Table 1. Correct answers to pretest, posttest, and retest

<table>
<thead>
<tr>
<th>Question Topic</th>
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</thead>
<tbody>
<tr>
<td><strong>Pretest</strong> N = 20</td>
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<tr>
<td>-----------------</td>
</tr>
<tr>
<td>1. No release—caller wants to convey information to staff</td>
</tr>
<tr>
<td>2a. No release—caller concerned about client’s drug/legal problems: Can listen?</td>
</tr>
<tr>
<td>2b. No release—caller concerned about client’s drug/legal problems: Can give resources?</td>
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<tr>
<td>3. Verbal release only—spouse to call</td>
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<tr>
<td>4. No release—client wants staff member to talk to roommate</td>
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<tr>
<td>5. No release—imminent threat of suicide</td>
</tr>
<tr>
<td>6a. No release—caller concerned about danger to client/roommate: Listen, no info?</td>
</tr>
<tr>
<td>6b. No release—caller concerned about danger to client/roommate: Listen plus info to protect?</td>
</tr>
<tr>
<td>6c. No release—caller concerned about danger to client/roommate: Listen and questions only?</td>
</tr>
<tr>
<td>7. No release—caller concerned about client’s homicide threat</td>
</tr>
</tbody>
</table>
as a posttest at the end of the training session. Eleven months later, one month before a retest, all staff received their posttests marked with the correct answers for any incorrect responses. This allowed staff to review all questions and answers in preparation for the retest (same questions as pre- and posttests) which was given 1 year after the original training.

Pilot Evaluation Results

All pretest/posttest correct answer percentages were analyzed for difference of proportion (see Table 1). A difference of proportions showed test scores improved significantly between pre-post testing at the <.05 level for 3 of the 10 items, and significantly at the <.01 to <.0001 level for 6 of the 10 items. Only one item failed to reach significance at the $p < .05$ level, and that question was answered correctly both times by 90% or more of the staff.

At pretest, less than 50% of the participants chose the correct answer to half the items. Only one item was answered correctly by more than 65% of the staff members.

On the posttest, 80% or more of the participants answered 8 of the 10 questions correctly. On the two questions with <80% correct answers, there were still significant increases in the number of correct answers: from 15% and 25% on the pretest to 65% and 60%, respectively, on the posttest.

On the retest, scores were obtained for 17 staff who took both the pre- and posttests and received the training a year previously. Percentages of correct answers on the retest decreased on all items from the pretest. At the same time, there were significantly higher numbers of correct answers to six questions on the retest as compared with the pretest. Specifically, correct answers remained significantly higher than at pretest at the .05 level in 3 of 10 items and significantly higher at the .01 level in another 3 of the 10 items. Compared to the pretest, responses to the remaining four retest questions did not reach a difference that was statistically significant at the .05 level.

CONCLUSION AND DISCUSSION

The results of the survey of provider staff and administrators of the Philadelphia behavioral health system indicate that almost half the respondents believed that even without revealing any information
about a client they cannot listen to a family member or a significant support person with no release form from the client, or are unsure whether they can. This raises concerns as to whether providers would refuse to listen to even potentially lifesaving information that families and others feel are necessary to convey for the protection of their relative or themselves. This lack of clarity regarding confidentiality policies and procedures also became apparent when discussing clarification of agency confidentiality policies with administrative staff. These findings instigated the program for training of agency staff on these issues. Training did improve the participants’ understanding and knowledge at the end of the training. However, their ability to retain much of this information on a 1-year retest deteriorated significantly, even with some effort at giving minimal feedback prior to retaking the questionnaire. The deterioration in scores even applied to a question about a clearly stated agency policy concerning verbal releases that supervisory staff had taken pains to emphasize. Clearly, a single training session on confidentiality policies did not seem to be effective in maintaining a high level of knowledge 1 year later. There is a need for more frequent training or at least periodic booster sessions which could be integrated with ongoing supervision of staff.

One limitation of our program training test results is that our sample size was small and confined to a single type of behavioral health program (i.e., TCM), and may not be representative of other staff populations or programs. However, the phenomenon of behavioral health workers’ believing that one should not talk with family members or significant persons is likely not unique to this system, given prior literature noting that some agencies take the position of not talking with such persons to avoid violating client rights to confidentiality (Zipple et al., 1990).

Another limitation was that other educational, training, or supervisory efforts concerning confidentiality that the staff may have been exposed to during the year between training and the retest were not controlled for. It is possible that other factors besides the training influenced staff retention of knowledge demonstrated on the CIT retest.

A further limitation of this evaluation became apparent through discussions with the TCM program staff as to why there were incorrect answers on the posttest and follow-up test. Initial feedback was that the test measure needed further refinement to clarify the answer options on three of the items with which some staff members had
difficulty. Feedback obtained from three staff team meetings after the follow-up test revealed that some participants were not comfortable with the “correct” answers. A typical staff comment after the retest concerning the need to break confidentiality if a client’s life is in danger from suicide was: “But if a roommate calls me 4 hours after I’ve seen the consumer, how do I know if the consumer is still suicidal?” Other staff indicated that they would attempt to avoid being in a situation where they had to implement a policy that seemed to have too many drawbacks in actual practice. It appeared that a number of staff either never agreed with what was presented as the correct answer in the first place, or else their discomfort with the consequences of the correct course of action interfered with their ability to remember the correct answer. This feedback underlined the fact that acquiescence (including giving the officially correct answer on a test or in response to supervisors) does not imply staff agreement or intention to integrate what they see as suspect new knowledge into practice. It also suggests that miscommunication, incomplete discussion, or lack of a trusting atmosphere between direct care staff and trainers/administrators may diminish the effectiveness of training in improving practical knowledge and skills utilized in actual practice, but further research is needed to investigate this hypothesis.

The measure will be revised with the help of pilot staff participants and the new measure will be pilot tested. Despite the limitations noted above, it seems clear that a single training can significantly increase staff knowledge in the short run, but that the difficulties in maintaining this knowledge in the face of time and staff disagreement with policies or practices are substantial.

A common problem with training, including the one described in this article, is that learning new information is unlikely to translate into changing actual staff practices (Fixsen, Blase, Naoom, & Wallace, 2009). The Annapolis Coalition on the Behavioral Health Workforce in its Action Plan for Behavioral Workforce Development (Annapolis, 2007) states that “there is clear evidence of [the ineffectiveness of] single-session, didactic in-services’ or workshops’ in changing practice patterns…” (p. 13). For this reason, an additional component of the TCM program project will be a review of documentation of staff practices around confidentiality. The agency has also agreed to build such reviews into future quality assurance and quality improvement record reviews. It is probably unrealistic to expect that even several staff training sessions on a topic will lead
to consistent changes in staff practice in the absence of specific policies, clear supervisor expectations, ongoing coaching and consultation, and staff awareness of documentation monitoring—which suggests that those elements should be considered as part of a successful training effort.

As for the large-scale survey involving the FAI, limitations include a lack of psychometrics of the measure, possible misinterpretation of items by participants, and lack of data on whether these particular participants’ answers translate into actual practices. In addition, information on participants’ experience working with families, which was not assessed, may have influenced their responses. However, lack of staff knowledge about confidentiality is apparently a major barrier internationally to involve families in the treatment and rehabilitation of persons with severe mental illness as previously indicated (Cleary et al., 2006; Furlong & Leggatt, 1996; Gray et al., 2008; Jakobsen & Severinsson, 2006; Lakeman, 2008; Nicholls & Pernice, 2009; Slade et al., 2007; Stanbridge & Burbach, 2007; Stanbridge et al., 2009; Wynaden & Orb, 2005). Systems need to provide more guidance, regulation, training, and assessment in this area if a recovery orientation that is not only client centered, but also family-friendly is to be established. Without a solid foundation in family-friendly confidentiality policies and procedures, the proactive and systematic inclusion of behavioral health clients’ families and SP will not become a regular mode of practice, and many clients will continue to be deprived of this important practice. Also, training for direct care and supervisory staff will only be successful if care is taken to move past one-shot training sessions and to assess training results in terms of staff competence, rather than relying on the potentially false assumption that the information has been learned, retained, and ultimately translated into practice.

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