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Barriers to Social Network Interventions with Persons with Severe and Persistent Mental Illness: A Survey of Mental Health Case Managers

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ABSTRACT: In order to empirically assess the existence, strength, and relative influence of barriers to social network interventions for persons with severe mental disability which have been cited in the literature, a survey of the knowledge and attitudes of social networks and social network interventions of eighty mental health case managers and case management supervisors was conducted. Findings indicate gaps in case managers' level of knowledge of social networks, with items based on empirical knowledge about social networks and severe mental disability least likely to be answered correctly. Case managers both perceive, and have experienced, a significant number of obstacles that affect their ability to develop social network interventions–system barriers (paperwork, caseload size, lack of case manager time, etc.), community barriers (stigma and lack of resources), and client/family barriers (lack

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of interest in social networks, clients having a "burnt out" network, clients not wanting to identify social network needs, etc.). Case managers cited few major barriers pertaining to their own level of knowledge, skills, or interest in, social network interventions. Strategies to address identified barriers are presented.

INTRODUCTION

The relationship between social support and health status has been the subject of extensive examination. Social support has been found to have both indirect and interactive effects on physical and mental health status. An extensive body of research indicates that people with more social resources are in better physical and mental health and better able to adapt to change (Cohen & Wills, 1985). Research concerning social networks and severe mental disability indicates that persons with severe and persistent mental illness have social networks that are smaller in size and social support systems that are weaker than persons without mental illness. Furthermore, the social networks of persons with severe mental disability are tenuous. Thus, over the course of their illness persons with severe mental illness are left with an even more restricted network which is not capable of providing the degree and type of support needed for maintenance in the community (Tracy & Biegel, 1994).

Given this evidence, it is not surprising that the enhancement of social support networks–strengthening existing ties, enhancing family ties, and building new ties–is an important thrust of case management services for persons with severe mental illness (NIMH, 1987). Unfortunately, the development of comprehensive community based support systems for persons with severe mental illness remains an unrealized goal. An examination of social network interventions with persons with severe mental illness reveals that state or county mental health systems have not developed truly comprehensive approaches to strengthening the social support systems of persons with severe mental illness and thus do not offer the wide range of social network interventions needed to help integrate persons with severe mental illness into the community (Biegel & Tracy, 1993).

For the purposes of this paper, social network interventions are defined as including a wide range of interventive services designed to change the structure, composition, and or functional quality of relationships within an individual's social network. Typical social network interventions include peer consumer support, connection with natural helpers, volunteer matching, family education and support, and link-

age with formal and informal community resources. Skills training approaches, such as social, communication, and life skills training, can also be considered part of social network interventions since a principal goal of such activities is to strengthen an individual's capacity to be able to develop and maintain relationships with significant others.

A review of social network interventions with other populations as well as a review of the case management literature suggests that case managers may face a number of obstacles in efforts to enhance the natural support systems of their clients (Biegel, Tracy, & Corvo, 1994; Biegel & Tracy, 1993). First, the range of roles demanded of case managers is often high, as is worker caseload size. Large caseload sizes are usually accompanied by case managers needing to spend disproportionate amounts of time in helping to manage client crises. Large caseload sizes are also concomitant with significant amounts of case manager time spent in paperwork activities. Thus workers may not have adequate time to spend on interventions designed to strengthen clients' social support networks.

Second, social network interventions, in and of themselves, are often difficult to implement because of negative past experiences of both clients and family members. Clients are frequently resistant to enhancing their networks, believing that their networks will not be helpful to them. They have often "burnt out" their family and non-family network members. Clients may also lack the social skills necessary to form and maintain interpersonal relationships, such as in forming a relationship with a volunteer. For these clients, interventions to address this problem must precede activities to strengthen their social networks.

Third, the stigma of mental illness has a negative effect on case managers' abilities to expand clients' social networks. Potential community resources and natural supporters may be reluctant to get involved with the mental health system because mental illness carries with it such fear and stigma. This stigma often results in a lack of community resources which are available and accessible to persons with severe mental disability (Cutler & Tatum, 1983; Hatfield, 1978).

Fourth, the development of linkages with natural support networks requires skills in community organization to enable workers to successfully identify, contact, and mobilize community based resources, such as clergy and church groups, community organizations, and social clubs that can provide support to persons with severe mental illness (Biegel, Shore, & Gordon, 1984; Roberts-DeGennaro, 1987; Kisthardt, 1992). Most mental health case managers are primarily trained in direct person oriented helping approaches; therefore they lack skills or

experience in working with and organizing larger systems, such as groups, neighborhoods, and organizations. In fact, evidence suggests that case managers spend more time on assessment, planning and monitoring activities, than they do in linking activities which are so essential to network interventions (Kurtz, Bagarozzi, & Pollane, 1984).

In order to empirically assess the existence, strength, and relative influence of barriers to social network interventions, a survey of the knowledge and attitudes of mental health case managers of social networks and social network interventions was conducted. This paper reports and discusses the results of this survey and presents recommendations to overcome identified barriers.

METHOD

Study Sample

In an attempt to examine potential obstacles to greater involvement by case managers in strengthening the social networks of their clients with severe mental disability (certified by the state mental health agency as having chronic mental illness), mental health agencies that provided case management services to such persons were asked to participate in a survey of case managers. Eight out of nine such agencies having contractual relationships with a local county mental health board in a large, midwestern urban community agreed to participate in the study. Case managers at these agencies had not received any prior training about the use of social network interventions nor did they have experience in conducting social network interventions prior to this study. In fact, this research was part of an effort by the local county mental health board to gather baseline data prior to the initiation of a social network training and consultation program for case managers.

Case managers and case manager supervisors at the eight study agencies who had clients with severe mental disability were asked to complete a brief survey questionnaire. There were 191 case managers and supervisors at these eight agencies; almost half (46%, N=88) were non-white and over one-third (36%, N=68) were male. Completed questionnaires were received from 75 case managers and five case management supervisors. This group represents almost half (47%) of the eligible case managers and almost one-fifth (16%) of the eligible case management supervisors at these agencies. Data on the race and gender of the respondents in our sample is not available. However, based upon the demographic characteristics of case managers and supervisors and our response rates at each of these agencies, we estimate that our sample is over one-third non-white and a little less than one-third male. Thus, we believe that non-white respondents are under represented in our sample. Also, our sample slightly underrepresents the male population in these agencies.

Data Collection Instrument

A data collection instrument was developed to assess case managers' knowledge about social networks, perceived obstacles to social network interventions and the obstacles to social network interventions they actually had experienced in their work. In addition,

case managers were asked information about their human services and case management experience, education, caseload size, and type of client caseload.

Social Network Knowledge Inventory. Case manager knowledge about social networks was assessed through a twenty-two item inventory of true/false questions created by the investigators for this study. The questions were derived from information about social networks and social supports contained in a social network training manual for mental health case managers developed by the authors (Tracy, Biegel, & Corvo, 1991). The development of the training manual, in turn, was based on a comprehensive review of social network intervention strategies with persons with severe mental disability. This review consisted of the following research activities: a computerized literature search on social support systems of persons with severe mental illness; a survey of national and state level mental health organizations and departments to obtain information about current projects and activities designed to strengthen support systems of individuals with severe mental disability; and contacts with key informants to obtain information about current and recent research and demonstration projects concerning social networks and mental health service delivery. Upon the completion of these activities, a set of objectives were developed, identifying the worker skills and knowledge needed to implement social network interventions with this population. The Social Network Knowledge Inventory utilized in this study and the above training curriculum were developed as a direct result of these activities.

The initial list of items for the knowledge inventory was reviewed to confirm its face validity by a case manager supervisor as well as by a mental health program administrator from one agency and then was pre-tested with fifteen case managers from a different agency. As a result of this pre-test, a number of questions that failed to adequately distinguish levels of knowledge among respondents were eliminated from the inventory. The final knowledge inventory contained twenty-two items pertaining to the role and characteristics of social networks and social support, the role of case managers, and the effects of social networks on client outcomes.

Perceived Obstacles to Social Network Interventions Scale. A twenty-eight item scale was developed by the investigators of this study to measure perceived obstacles to social network interventions. Respondents rated each scale item from Not an Obstacle At All (1) to a Major Obstacle (3). Items included in the scale were based upon the above cited training manual and also a careful review of obstacles to social network interventions cited in the literature. Items in the scale can be grouped into four types: obstacles pertaining to the mental health system (paperwork, caseload size, etc.) (9 items), obstacles pertaining to case managers (interest in social networks, knowledge of informal resources, etc.) (7 items), obstacles pertaining to the client and the client's family (not wanting to work on network goals, family members unwilling to get involved, etc.) (10 items), or obstacles pertaining to the community (stigma and lack of community resources) (2 items). The reliability of the overall scale was acceptable, Cronbach's alpha= .83, and the reliability coefficients for three of the four subscales were satisfactory (System obstacles, r= .68, case manager obstacles, r= .78, and client/family obstacles, r=.76). The reliability of the community obstacles subscale, which contained only two items, was not satisfactory and therefore these two items were used separately rather than as a scale in our subsequent data analyses.

Experienced Obstacles to Social Network Interventions. Respondents were also asked to indicate which of the twenty-eight items they had personally experienced as obstacles in trying to build or enhance the social networks of their clients. An Experienced Obstacles score was computed by counting the number of obstacles cited by respondents.

FINDINGS

Sample Characteristics

Findings indicate that these case managers were a fairly experienced group, with respondents having worked an average of almost three and one-half years in their current position and having a total of almost eight years of experience in human services/mental health work. Almost all (90%) of the case managers were college graduates, while almost one-quarter (22%) held graduate degrees. Caseload sizes were high, with a mean of 41 cases per worker. Over two-thirds of the workers (68.5%) had thirty cases or more.

Knowledge of Social Networks

Findings indicated gaps in a number of areas in case managers' level of knowledge of the social networks of this population. Overall, the number of correct answers to this twenty-two item inventory ranged from 3 to 19 with a mean of 12.2 or 56%. While fifteen of the twenty-two items were correctly identified by over half of the case managers, only four of the twenty-two knowledge items were correctly identified by three-quarters or more of the case managers.

Examination of the percentage of correct responses for each item indicated that those items based on empirical knowledge of social networks and severe mental disability were least likely to be answered correctly. The case managers participating in this survey scored less well on items reflecting specific knowledge of social network size, structure and composition as compared with items reflecting general knowledge about social networks and social support. For example, while well over half of case managers were aware that persons with severe mental disability had smaller social networks and limited social resources for social support, less than half could respond correctly to items regarding network structure and composition (e.g. reciprocity, density, and multiplexity). While it is possible that the case managers were not familiar with the terminology of social network research and practice, considerably more than half the group responded incorrectly to several basic items concerning the relationship between social support and rehospitalization. In fact, about three-fourths of the respondents felt that smaller networks were better than larger networks for persons with severe mental disability. While it is true that maintaining a large

number of network relationships is beyond the skill level for some persons with severe mental disability, the research evidence overwhelmingly supports large, diverse networks for optimum community adaptation (Cohen & Sokolovsky, 1978; Morin & Seidman, 1986).

A number of analyses were conducted in order to examine relationships between the knowledge inventory and other study variables. There was no relationship between case managers' scores on the knowledge inventory and length of time having worked as a case manager, length of time in human services, or level of worker education. However, there was a weak to moderate correlation between knowledge score and caseload size such that the smaller the caseload size, the higher the social network knowledge score ($r = -.25$, $p < .05$).

Obstacles to Social Network Interventions

Findings concerning obstacles to social network interventions which were perceived by case managers are very consistent with those obstacles which were actually experienced by case managers (See Table 1). Findings indicate that case managers both perceive and have experienced, a significant number of obstacles that affect their ability to develop social network interventions for their clients.

Perceived Obstacles to Social Network Interventions. As indicated above, case managers were given a list of twenty-eight potential obstacles to social network interventions and asked to rate each one on a three point scale from Major Obstacle (3) to No Obstacle At All (1). The number of items indicated as either minor or major obstacles ranged from 11 to 28 with a mean of 23.9 obstacles cited by respondents. Table 1 presents mean scores for each of the twenty-eight items in the Perceived Obstacles to Social Network Interventions Scale and also indicates the type of obstacle–system, case manager, client/family, or community.

The top ten perceived obstacles can be grouped into three types of barriers as follows: *obstacles pertaining to the mental health system*–paperwork, high caseload size, lack of case manager time, and too many client crises; *obstacles pertaining to the community*–community stigma/bias and lack of community resources; and *obstacles pertaining to clients and their families*–clients lack of interest in social networks, clients not wanting to work on network goals, clients having a burned out network, and family members unwilling to get involved.

The perceived obstacles to social network interventions by respondents were consistent across case manager characteristics and thus

TABLE 1

Perceived and Experienced Social Network Obstacles

Perceived Obstacles		*Experienced Obstacles*	*Barrier*	
Mean	*SD*	*(% Yes)*	*Type*	*Item*
2.84	.37	55	S	1. Paperwork requirements
2.80	.49	50	S	2. High caseloads
2.60	.61	56.3	S	3. Lack of time on the part of case managers
2.52	.62	40	S	4. Too many immediate client crises for case manager to handle
2.51	.60	42.5	CO	5. Community stigma/bias
2.50	.57	37.5	C/F	6. Client not choosing to work on social support goals
2.48	.68	38.8	CO	7. Lack of community resources, such as support groups
2.44	.59	38.8	C/F	8. Client has "burned out" network
2.43	.59	41.3	C/F	9. Client's lack of interest in social networks
2.40	.59	40	C/F	10. Family members' unwillingness to get involved
2.39	.61	31.3	C/F	11. Client not wanting to identify social support needs
2.37	.60	25	C/F	12. Client reluctant to involve network members
2.25	.57	20	C/F	13. Client's lack of relationship building skills
2.24	.62	13.8	CM	14. Lack of knowledge of informal community resources
2.21	.63	16.3	S	15. Difficulty coordinating informal helping resources
2.20	.54	21.3	C/F	16. Social support being a lower priority compared to other client needs

TABLE 1 (Cont'd.)

Perceived Obstacles		*Experienced Obstacles*	*Barrier*	
Mean	*SD*	*(% Yes)*	*Type*	*Item*
2.18	.62	12.5	C/F	17. Network members' unwillingness to get involved
2.18	.69	20	CM	18. Competing/conflicting case management roles
2.15	.66	8.8	CM	19. Lack of knowledge of formal community resources
2.11	.73	23.8	S	20. Geographic isolation of clients
2.05	.86	16.3	S	21. Lack of support from agency for social network interventions
2.05	.73	11.3	CM	22. Lack of knowledge of cultural issues
2.04	.74	12.5	S	23. Geographic dispersion of clients
2.04	.74	8.8	CM	24. Lack of knowledge of social network interventions on the part of case managers
2.03	.60	10	CM	25. Lack of experience in social support interventions on the part of case managers
1.94	.72	21.3	S	26. Confidentiality requirements
1.75	.80	05	S	27. Lack of support from supervisor for social network interventions
1.64	.73	02.5	CM	28. Case manager's lack of interest in social networks

Key:
3 = Major Obstacle; 2 = Minor Obstacle; 1 = Not an Obstacle At All
SD = Standard Deviation; Barriers: S = System level; C/F = Client/Family level; CO = Community level; CM = Case Manager level

were not associated with the length of time respondents had worked as case managers, length of time in human services, level of education, or caseload size. Also, we found no significant association between the knowledge score and the number of perceived or experienced obstacles. It is interesting to note that although the scores on the social network knowledge inventory reported above indicated significant gaps in case manager knowledge, case managers perceived few major obstacles pertaining to social network interventions that they believed were related

to themselves. Thus, as can be seen in Table 1, potential obstacles relating to case managers possible lack of knowledge about social networks interventions, lack of experience with social network interventions and lack of interest in social networks were among the items with the lowest mean scores. Case managers only see themselves as minor obstacles to social network interventions. While the social desirability effect might be a possible threat to the finding of low mean scores on case manager obstacles due to case managers' unwillingness to reveal their inadequacies in knowledge, the self-administration and anonymity of the questionnaire may mitigate this threat (Rubin & Babbie, 1989; Sudman & Bradburn, 1982).

As a next step in the analyses, correlations between the system, client/family, and case manager obstacle scales, and the individual items relating to community (stigma and lack of resources) were examined. Findings in Table 2 indicate considerable interrelationship among the types of obstacles. The strongest relationship was between the case manager and system obstacle scales. Thus, respondents with higher scores (greater obstacles) on the case manager scale felt that system obstacles were greater as well ($r = .52$, $p < .001$). There was also moderate correlations between client/family obstacles and community level obstacles. Respondents that reported greater client/family level obstacles also reported that stigma ($r = .38$, $p < .001$) and lack of community resources ($r = .39$, $p < .001$) were obstacles. Other relationships that were statistically significant can be found in Table 2; however, these relationships are fairly weak.

Experienced Obstacles to Social Network Interventions. As can be seen in Table 1, each of the ten obstacles with the highest mean scores was personally experienced by over one-third of the case managers. Case managers reported experiencing a mean of 7.2 obstacles, with one-third (32.5%) of the respondents having experienced 10 or more obstacles. Similar to respondents' perceived obstacles, most of the obstacles experienced by the highest percentage of respondents were system level obstacles–lack of time, paperwork requirements and large caseload sizes.

As with the case with perceived obstacles, case managers do not see themselves as a major source of obstacles to social network interventions with their clients. Thus, less than one-tenth of the respondents reported a lack of case manager experience with social network interventions, a lack of case manager knowledge about social networks, or a lack of case manager interest in social networks.

TABLE 2

Correlations of Perceived Obstacles Scales

	S	*C/F*	*CM*	*CO*[1]	*CO*[2]
System Level (S)	–				
Client/Family Level (C/F)	.18*	–			
Case Manager Level (CM)	.52***	.24*	–		
Community Level: Stigma (CO^1)	–.01	.38***	.11	–	
Community Level: Lack of Resources (CO^2)	.21*	.38***	.11	.27**	–

Key:
* $p \leq .05$
** $p \leq .01$
*** $p \leq .001$

There was no relationship between respondents' actual experience with network obstacles and their length of time in human services, level of education or caseload size, or, as stated above, with their knowledge of social networks. However, there was a weak, but statistically significant relationship between the length of experience as a case manager and the number of obstacles experienced. Thus, respondents with less experience as a case manager, reported a higher number of experienced obstacles ($r = -.19$, $p < .05$).

DISCUSSION AND IMPLICATIONS FOR PRACTICE AND RESEARCH

This paper has reported the findings of a case manager survey of obstacles to implementing social network interventions with persons with severe mental disability. While both empirical evidence and mental health policy support the enhancement of social networks as part of case management services, there are a number of obstacles which limit or inhibit greater involvement of case managers in enhancing the social networks of their clients.

A number of our findings are congruent with the case management literature on this topic (Cutler & Tatum, 1983; Rapp, 1992). Most

notable were the system barriers reported by the respondents to this survey. Paperwork, high caseload size, and too many client crises result in crisis oriented service provision. Obstacles at the community level to social network interventions were also reported in this survey. Community stigma and lack of community resources were among the top ten obstacles perceived and experienced by case managers in this study.

Consumers of mental health services and their families also present obstacles to social network interventions. Obstacles relating to the case managers were the least frequently reported. Lack of knowledge of, or experience with, social network interventions were not viewed as major obstacles, even though case managers did evidence gaps in knowledge of social networks as measured by the social network knowledge inventory used in this study. Respondents either were not aware that they did not know this information, or else they did not see lack of this knowledge as an obstacle in light of the other, more pressing obstacles they faced in their work.

The findings based on bi-variate analyses in this study must be interpreted with caution due to the cross-sectional nature of the study design. However, some hypotheses can be put forward. The finding that less experienced case managers reported encountering a higher number of obstacles suggests that case managers with more experience may be better able to address potential roadblocks to social network interventions than their colleagues with less experience and are thus less likely to identify items as actual obstacles.

It can be hypothesized that the association between knowledge of social networks by case managers and caseload size might be explained by the fact that case managers who have small caseload sizes and more time to spend with individual clients, might be more involved in linkage activities of case management and therefore have developed greater knowledge of social networks and social network interventions. This assumption needs to be tested in further research.

Study findings also indicated that the levels of barriers were significantly interrelated. Concerning the relationship between case manager and system level barriers, it can be hypothesized that respondents who cite case manager obstacles of lack of knowledge, experience, etc., may relate the locus of these obstacles as partly in the mental health system. For example, if it weren't for the paperwork, large caseload size, etc., then case managers would have time to pay attention to, and receive assistance with, social network interventions. The relationship between client/family and community level barriers suggests that the interest of clients and families in strengthening social networks may be

influenced, in the eyes of the respondents, by the lack of community resources to assist clients and families and by community stigma as well which may result in isolating clients from needed supports.

In order to successfully address barriers to strengthening the social networks of persons with severe mental disability, we believe that intervention strategies must be developed on all four obstacle levels– the system level, the community level, the client and the family level, and the case manager level. Unfortunately, often only single levels, such as the case manager, are targeted for change. Therefore, we offer the following recommendations, by barrier level, to enhance social network interventions for persons with severe mental disability and to foster an environment more conducive to social network interventions.

On the system level, efforts need to be made to remove disincentives that prevent or inhibit case managers from engaging in social network interventions. Depending on the locale and setting, these may include caseload size, inadequate numbers of case managers, paperwork, or limits on case managers' activities, such as the extent of collateral versus direct client contacts, individual versus group activities, or the degree to which case managers are tied to an office or able to go out in the community and meet with clients and actual and potential members of their networks. Some mental health systems have moved to performance contracting, which requires agencies to demonstrate that case managers are providing a required percent of their time in face to face contact with clients. Some of these systems do not give workers credit for collateral contacts with family members or other significant individuals that are such an important part of social work interventions. In addition, some mental health systems count only case managers' contacts with individual clients and not their work with a group of clients, such as staffing of a social skills group.

Focusing on community level obstacles, case managers need the assistance of resource persons with community organization skills to help build new community resources for clients and to help identify and engage individuals and organizations in the community which can provide social support to persons with severe mental disability Community educational programs also need to be further developed and expanded to address issues of the stigma of mental illness in the community. Admittedly, addressing community stigma is not solely the responsibility of the mental health system. Collaborative efforts between the mental health system, religious and community based organizations are needed. Community wide strategies to involve churches, ethnic, fraternal and social organizations in becoming aware of the

needs of persons with severe mental disability in their community, and identifying ways in which their organizations can assist these individuals to become more integrated into the community is urgently required. Community-based organizations can be of tremendous value in addressing this issue and need to be involved in leadership roles.

On the client and family level, we believe the best way to address obstacles to social network interventions is to increase the number and the accessibility of mental health supportive services in the community, including peer support groups and programs, social skills training groups, recreational programs, family educational programs, and volunteer matching programs. Services of this nature would help address barriers presented by clients, and would provide more options for case managers to expand or enhance clients' social networks.

Barriers presented by case managers can be addressed in part by education and training for case managers in the knowledge base, skills, and techniques for mobilizing support systems for clients. While training by itself may not be sufficient for case managers to successfully strengthen support systems and enhance social networks, training is an essential component. The finding of this study that workers with graduate degrees are no more knowledgeable about social network interventions than workers without graduate degree suggests that graduate curriculums in mental health do not provide sufficient focus on social networks and social support systems and that curriculum changes are needed to address this issue.

In closing, several limitations of this study should be noted, together with suggestions for future research. Although the scales used in this study were developed through a thorough review of the literature, their psychometric properties need to be examined further. The lack of association between scores on these scales and other tested variables may be due to a true lack of association. However, it is also possible that these findings indicate insufficient construct validity in the instruments.

Second, due to the exploratory nature of this study, the analyses were limited to descriptive analyses and associations on the bi-variate level. Experimental studies should be conducted to examine if training for case managers in the knowledge base, skills and techniques of social network interventions can help them to successfully mobilize support systems for clients. Furthermore, longitudinal research studies are needed to identify the critical factors that affect the ability of case managers to successfully implement social network interventions.

Third, the results of this study are based upon a survey of case managers in only one city. Given the contextual nature of a number of

the cited barriers, the extent and severity of individual barriers may be expected to vary by community. Therefore, assessments of case manager views of barriers to social network interventions, supplemented by data from clients and their families, should be undertaken on the local level as part of any attempt to develop community based strategies to address these barriers.

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