This exploratory study examined the frequency and nature of providers’ contact with families of persons with severe mental illness. Fifty-nine providers in six community mental health programs completed a self-administered survey. A subsample of 8 providers also completed two in-depth interviews. Although most providers had some family contact, the contact was restricted to a small percent of their caseloads. The nature of contact that providers have with families is generally limited by their professional role. Best practice guidelines for the treatment of mental illness and agency administrators responsible for instituting these guidelines will need to clarify the types of providers who are expected to implement various aspects of family involvement.

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Family involvement in the treatment of severe mental illness has been found to have beneficial effects for both consumers and their families. The provision of education and routine sharing information with families about their relatives’ illness and treatment process allows families to recognize prodromal symptoms and more effectively support their ill relatives. For these reasons, current practice guidelines for the treatment of severe mental illness recommend ongoing contact with families (APA, 1997; Lehman & Steinwachs, 1998).

Because most mental health programs do not record the frequency or type of contact that providers have with families (Lucksted & Dixon, 1999), it is unclear how fully these recommendations are being implemented. Research indicates that between 31% and 77% of families have some contact and receive information from their relative’s provider (Greenberg et al., 1997; Dixon, Lucksted, et al., 2000; Marshall & Solomon, 2004).
Frequently, contact with families is in response to a crisis, which consequently limits the focus and length of the exchange (Dixon, Lyles, et al., 1999).

Consistent with best practice recommendations, research suggests that providers educate and assist families in supporting their relatives more often than they provide family therapy (Dixon, Lucksted, et al., 2000; Wright, 1997). However, there is also some evidence that the nature of provider-family contact is limited by the role of the provider (Tessler et al., 1991). Because different providers are involved at various stages of the treatment process, the type of provider with whom families have contact is likely to vary over the course of the illness.

Previous research calls for further examination of the nature of provider-family contact. Therefore, this study examined the frequency and nature of contact that case managers and therapists in community mental health agencies have with family members of adults with severe mental illness.

**METHODS**

The study setting included six community mental health programs within two agencies in a county outside Philadelphia. The two agencies were identified by the County Office of Mental Health. These two agencies were typical of public mental health agencies that deliver mental health services and treatments to a diversity of client populations—including adults, children, and families—who are generally low income and frequently on public support. The agencies offer the full range of outpatient services (medication management, counseling, and therapy), case management services, and partial hospitalization programs. Both agencies were located in a suburban setting and served mainly adults (84% and 84%) with less than $10,000 income (86% and 81%). The percent of minority clients served at each agency was 11% and 13%. Interviews with agency directors were conducted to determine if administrative barriers to working with families existed. The directors indicated that no formal family education programs or groups were offered. Although working with families was reimbursed in both agencies, neither agency offered training to providers to cover how they should interact with families, nor did the agencies have procedures to guide providers' work with families. Given that there were no administrative barriers to working with families, these were ideal agencies in which to conduct the current survey.

Clinical providers completed a self-administered survey that asked how many families of clients with severe mental illness in their caseloads they had contact with in the past 6 months, if they shared or received nine types of information (diagnosis, medications, clients’ functioning, and so on) in the past 6 months, and who in the agency was responsible for communicating with families regarding these same nine types of information (responses included psychiatrist, social worker, therapist, and so on). Respondents were asked to select all that apply. All items were adapted from preestablished measures that had been used in previous research with similar populations (Bernheim & Switalski, 1988; Grusky, 1986). The measures were also pretested with 10 providers from nonparticipating agencies. (The survey instrument is available from the authors.)

Of the 59 providers who completed the survey, 29 (49.2%) were employed in one of two partial hospitalization programs, 15 (25.4%) were employed in one of two case
management programs, and 15 (25.4%) worked in one of two outpatient programs. From the six participating programs, 11 providers (15.7%) refused to participate. Ten of the 11 (90.9%) worked in the outpatient programs, and 1 (9.1%) worked in a partial hospitalization program. Agency administrators attributed the refusals among outpatient providers to their status as contract employees.

Most providers were female (n = 50, 85%), White (n = 52, 88%), ranged in age from 24 to 82 (Mdn = 32, M = 37), and had graduated from college (n = 24, 40.7%) or graduate school (n = 20, 33.9%). Over half of the providers held a title of “therapist” (n = 32, 54.2%), and a quarter were case managers (n = 15, 25.5). Three quarters worked full time (n = 45, 76.3%), and almost all worked during the day shift (n = 53, 89.8%). Caseload sizes ranged from 2 to 130 (Mdn = 15, M = 23.66). Although outpatient providers served some clients without severe mental illness, case managers and partial hospitalization staff worked solely with clients with mental illness.

Of the 59 providers, a subsample of 8 providers was selected through stratified random sampling and asked to participate in an in-depth, semistructured interview. The subsample was selected based on providers’ survey responses in order to represent providers with a variety of views regarding family involvement. The subsample included providers from each of the six participating programs. The selected providers participated in two half-hour interviews to gather information regarding the factors that influenced whether providers had contact with families of clients with severe mental illness, how and when family contact occurred, and the nature of that contact. Interviews were taped, transcribed, and analyzed using the software program ATLAS/ti to manage the text. The following procedures were used to code the text for content analysis. First, a narrative analysis was conducted to search for anticipated themes. During the process of conducting this analysis, other regularities in terms of words, themes, and concepts emerged that described provider-family contact. The text was decontextualized and descriptive codes were created until the text was coded exhaustively. The coding structure was then focused and refined by grouping together categories with similar meanings. The text was recontextualized and decontextualized several times in order to create meaningful categories within the coding structure. Descriptions and interpretations of the text were then developed by examining the major concepts in context.

**RESULTS**

**Frequency of Family Contact**

Most providers (n = 50, 84.7%) who completed the survey reported that they never saw the family members of the majority of clients in their caseloads. Providers who saw families of their clients during the prior 6 months indicated that this contact occurred with a small percent of their caseload (see Table 1).

Similarly, in-depth interviews with the subsampled providers indicated that family involvement is an infrequent occurrence:

“I know very few clients that have family support or involvement.”

“What we find with long-term, chronically mentally ill clients in many cases is that just the individual is involved.”
Nature of Providers’ Contact with Families

Over half of the providers reported that they sometimes or often received information from families about clients’ functioning \( (n = 43, 72.9\%) \), acquainted families with community resources \( (41, 69.5\%) \), taught families coping skills \( (n = 32, 54.2\%) \), or taught families how to handle a crisis \( (n = 34, 57.6\%) \). Again, over half of the providers indicated that they rarely or never gave families information about their relatives’ diagnoses \( (n = 39, 66.1\%) \), medications \( (n = 35, 59.3\%) \), or prognosis \( n = 32, 54.2\% \). Similarly, over half of the providers indicated that they rarely involved families in treatment planning \( (n = 32, 54.2\%) \) or requested help from families in monitoring medication side effects \( n = 35, 59.3\% \). (See Table 2.)

When asked who in the agency was responsible for these tasks, a third to two thirds of the providers stated that therapists and case managers were responsible for teaching families coping skills, teaching families how to handle crises, collecting information from families about the clients’ functioning, and involving families in the treatment process. Case managers were the key providers believed to be responsible for acquainting families with outside resources, with almost 80% responding as such. Two thirds or more of providers believed that psychiatrists were responsible for informing the families of their relatives’ diagnoses, medications, prognoses, and for asking families to help monitor medication side effects (see Table 3).

Similarly, in-depth interviews with the subsample of providers indicated that the type of information shared with families is related to the providers’ professional roles. Although outpatient providers discussed involving families for the purpose of collecting more accurate information about the client or to provide family therapy, partial hospitalization providers noted that medications, treatment information, and prognosis were commonly requested.

Outpatient provider: “One on one they [clients] might have a hard time relating or describing presenting problems . . . and having a family member there helps them to interact better.”

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**Table 1**

Provider Report of Frequency of Contact with Families (\( N = 59 \))

<table>
<thead>
<tr>
<th>Frequency of Contact</th>
<th>Percent of Client Caseload</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Weekly</td>
<td>39</td>
</tr>
<tr>
<td>66.1%</td>
<td>23.7%</td>
</tr>
<tr>
<td>Monthly</td>
<td>29</td>
</tr>
<tr>
<td>49.1%</td>
<td>32.2%</td>
</tr>
<tr>
<td>Every 3 mos.</td>
<td>35</td>
</tr>
<tr>
<td>59.3%</td>
<td>23.7%</td>
</tr>
<tr>
<td>Every 6 mos.</td>
<td>39</td>
</tr>
<tr>
<td>66.1%</td>
<td>22%</td>
</tr>
<tr>
<td>No contact</td>
<td>12</td>
</tr>
<tr>
<td>20.3%</td>
<td>6.8%</td>
</tr>
</tbody>
</table>

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*www.FamilyProcess.org*
Partial hospitalization provider: “They wanted to know what the course of treatment was. They had a lot of questions about the medications and how this would be helping. A lot of times families want to know when will they be better and be able to be themselves again.”

Case management providers reported that family involvement is frequently instigated by a crisis for which they often share information about community resources.

“the reason that the family became involved was that they were at their wits end.”

“the families have gotten involved . . . to see if we can assist with getting [their ill relative] hooked up with [services].”

Generally, however, providers did not see involving families as part of their professional responsibility, job functions, or as a mission of the program.

“This is not a program [partial hospitalization] where the family members can get deeply involved.”

“In my experience, I [services case manager] don’t always have favorable relationships with the family members, but some of the ICMs [intensive case managers] are very close with their caseload’s family members because they see them on a more frequent basis. They establish a relationship with the family.”

“Unfortunately, we [partial hospitalization providers] don’t work with the family so we can’t delve too deeply into it.”

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Table 3

Professional Responsible for Sharing Nine Types of Information with Families, N = 59

<table>
<thead>
<tr>
<th>Item</th>
<th>Psychiatrist</th>
<th>Team Leader</th>
<th>Social worker</th>
<th>Nurse</th>
<th>Psychologist</th>
<th>Case manager</th>
<th>Therapist</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informing a family about their relative’s diagnosis</td>
<td>39</td>
<td>7</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>15</td>
<td>26</td>
<td>11</td>
</tr>
<tr>
<td>Informing families about medication side effects</td>
<td>47</td>
<td>3</td>
<td>4</td>
<td>23</td>
<td>4</td>
<td>6</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>Informing families about the likelihood for improvement</td>
<td>37</td>
<td>2</td>
<td>6</td>
<td>6</td>
<td>5</td>
<td>12</td>
<td>27</td>
<td>12</td>
</tr>
<tr>
<td>Teaching families coping skills</td>
<td>9</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>24</td>
<td>30</td>
<td>16</td>
</tr>
<tr>
<td>Teaching families how to handle crises</td>
<td>10</td>
<td>4</td>
<td>13</td>
<td>5</td>
<td>10</td>
<td>26</td>
<td>31</td>
<td>12</td>
</tr>
<tr>
<td>Acquainting families with outside resources</td>
<td>16.9%</td>
<td>6.8%</td>
<td>22%</td>
<td>8.5%</td>
<td>16.9%</td>
<td>44.1%</td>
<td>52.5%</td>
<td>20.3%</td>
</tr>
<tr>
<td>Involving families in treatment planning</td>
<td>5</td>
<td>4</td>
<td>11</td>
<td>2</td>
<td>5</td>
<td>47</td>
<td>28</td>
<td>4</td>
</tr>
<tr>
<td>Getting information about clients’ functioning from families</td>
<td>17.8%</td>
<td>15.3%</td>
<td>20.3%</td>
<td>1.7%</td>
<td>8.5%</td>
<td>37.3%</td>
<td>59.3%</td>
<td>15.3%</td>
</tr>
<tr>
<td>Asking families to help monitor medication side effects</td>
<td>20.8%</td>
<td>22.2%</td>
<td>22%</td>
<td>6.8%</td>
<td>11.9%</td>
<td>52.5%</td>
<td>64.4%</td>
<td>8.5%</td>
</tr>
</tbody>
</table>

Note. Because respondents were asked to select all professionals who apply, percentages will not add to 100%. 
DISCUSSION

This study was limited in size and scope, including only a small sample of providers from an array of community mental health programs. Therefore, the findings should be interpreted with a degree of caution. However, the findings support previous research and build on the current knowledge regarding the frequency and nature of providers’ contacts with families. Although the findings indicated that providers had some family contact, the contact was limited to a small percent of their caseloads. Contrary to the practice guidelines, providers did not routinely involve families as collaborators in the treatment process or offer them ongoing education.

Currently, the American Psychiatric Association (APA) guidelines recommend that psychiatrists educate families about their relatives’ mental illness, early signs and symptoms of relapse, medications and side effects, and prognosis so as to involve them in treatment planning and the monitoring of their relatives’ functioning. Psychiatrists are also encouraged to help decrease family distress by teaching coping skills and acquainting families with community resources such as family support groups. The Patient Outcomes Research Team (PORT) guidelines and other expert clinical guidelines recommend that all families of persons with schizophrenia receive education about their relatives’ illness, family support, crisis intervention, and problem-solving skills training. These guidelines have been targeted to the full range of mental health providers. However, the study findings replicate previous research, which indicates that the type of contact that providers have with families is associated with their professional role (Tessler et al., 1991). Similarly, this study found that providing information regarding diagnosis, prognosis, and medications is generally seen by case managers and therapists as the responsibility of the psychiatrist, while these case managers and therapists see their roles as informing families about community resources, teaching coping skills, and providing crisis intervention. This raises questions as to the type of information that different members of the treatment team should be responsible for sharing with family members of their clients. Should psychiatrists be responsible for providing families with information regarding community resources as recommended by the APA guidelines, or is this more appropriately the function of a case manager? Further research is needed to examine whether the quality of information that providers share with families differs depending on their roles and expertise.

Additionally, the findings indicated that providers believe that psychiatrists are responsible for engaging families in the monitoring of medication side effects, but therapists and case managers are responsible for collecting information from families about the clients’ functioning and involving them in the treatment process. Further research is needed to examine the effectiveness and efficiency of requiring families to have ongoing contact with multiple providers. Designating one provider on the treatment team to serve as a coordinator of the family involvement in the client’s treatment may help to alleviate duplication and ensure the establishment of a relationship with families of their clients.

The findings of this study show that some providers do not see family involvement within the scope of their programs’ missions. Future practice guidelines and agency administrators who are responsible for implementing these guidelines must emphasize that these recommendations span the entire range of community mental health programs, and clarify who within the various programs should be implementing specific components of family involvement.

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REFERENCES


