

## **Rural Community Support Services For The Chronically Mentally Ill**

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### **Abstract**

*Results are presented of a descriptive analysis of case management and other community support services (CSS) offered the chronically mentally ill served by rural CSS programs as compared to services offered by non-rural programs. These findings are dis-*

*cussed as they relate to the relevance of a community support system model for the delivery of mental health services for the chronically mentally disabled in rural settings.*

Models for the delivery of mental health services in the United States have essentially been urban models that have failed to take into account the different needs and resources of most rural areas (Bachrach, 1982; Clayton, 1977; Keller & Murray, 1982). For example, the Task Panel on

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The data reported here were collected as part of an evaluation of the New York State CSS program funded by a contract between the New York State Office of Mental Health and the Psychotechnical Applied Research Organization, Inc.

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Rural Mental Health of the President's Commission on Mental Health (1978) noted the difficulty for rural areas in even qualifying for funding of Community Mental Health Centers (CMHCs). A key problem regarding the CMHC legislation was the difficulty for rural areas in providing the broad range of required services, a problem facing rural areas in attempting to implement any model of comprehensive services. In addition to the problem of having available only a limited range of services as well as service providers, other issues which must be considered in the delivery of rural mental health services include: distance and spatial isolation acting as barrier to the delivery of services, different rural social and cultural patterns that limit planning and service delivery, problems in the recruitment, retention and training of rural mental health professionals and special problems in rural program development and administration (Keller & Murray, 1982).

Recently, a new model, the community support system approach as developed by the Community Support Program (CSP) of the National Institute of Mental Health (NIMH) (Turner & Shifren, 1979, Turner & TenHoor, 1978) has gained widespread acceptance as a potentially more effective approach to providing community-based care for the seriously mentally disabled. The CSP guidelines specify 10 essential components for comprehensive care including various medical, rehabilitative, and social support elements and case management, the latter being given the key role of linking clients to needed system components. While not specifically designed with rural mental service delivery systems problems in mind, the model is being applied widely to rural as well as urban areas. Our purpose here is to compare the results of its implementation in rural and urban areas in one state.

Since 1977, the New York State Office of Mental Health (NYSOMH) has been developing its own state-wide community support system program. This redeployment of funds to community-based programs has involved contracts to local state and nonstate agencies to make a comprehensive array of treatment and life support services available to the state's chronically mentally ill. An attempt to take into account the unique needs of the local areas is made through the funding of different "service modules" to augment the existing service systems. The modules of service include the following: (a) **case management** which is intended to hold together an individualized "package" of services for each client, with a paraprofessional case manager specifically hired to act as a link between the client and the provider system; (b) **day program activities** which include opportunities for work and successful social interaction such as sheltered workshops, competency skills programs, social clusters, evening and weekend recreation programs, etc.; (c) **mental health outreach and crisis intervention** to avoid decompensation and rehospitalization:

(d) **clinic treatment and day treatment** programs to supplement inadequate therapeutic interventions; and (e) **life support services** including transportation, housekeeping and homemaking services.

In 1980, the New York Office of Mental Health contracted to have the authors conduct an outside evaluation of the CSS program in upstate New York. After an initial implementation analysis focusing on case management, the focus of our evaluation effort broadened to a study of the impact of the whole Community Support Services (CSS) program as it affected the members of a cohort of CSS clients over time. The cohort includes 844 clients served by seven selected CSS programs in the four upstate New York mental health regions (Baker & Intagliata, 1984). The selection of programs was guided by information provided by both regional and central OMH office staff and by the consideration that high levels of cooperation would be needed from program administrators and staff to facilitate the overall project design's expensive data gathering requirements. While the seven programs selected for the evaluation do not necessarily represent all CSS service sites in the four upstate regions, they do vary along five key program dimensions. These dimensions include: (a) program auspices (state facility based versus purchase of service agreement with other community agencies), (b) the range of CSS program components funded, (c) total number of CSS clients being served, (d) regional location (NYSOMH's four upstate administrative regions), and (e) whether they primarily serve urban or rural populations.

Our ongoing study will eventually permit an evaluation of the effects of community support services on the clients' levels of community adjustment and their quality of life. However, even at this point the inclusion of clients from both rural and nonrural areas allows a comparison of service utilization in the two areas and thereby a test of the relevance of the community support system model for rural service delivery. The descriptive analysis of case management and other community support services offered the chronically mentally ill served by rural programs as compared to services offered by nonrural CSS programs constitutes the focus of this paper.

## Method

### Cohort Selection

A stratified-random sampling procedure was used for selecting members of the CSS evaluation cohort. After a site agreed to participate in the program evaluation, an enumeration of all clients residing in the community who were currently being served by the site was obtained. This

sample was stratified into three groups of clients according to whether they had entered the program within the last 6 months, had been in the program for 6 months to 2 years or had been in the program for 2 years or more. Since there was particular concern about the impact of the programs on clients during their initial phase of receiving CSS services, oversampling as necessary at each site was carried out for those clients enrolled in service for shorter periods of time.

As a primary source of information about clients, case managers already were required to complete a variety of OMH forms, and it was considered important not to overwhelm them further. Therefore, a case-load level of stratification also was imposed on the random sampling procedure for selecting clients chosen so that the number of clients each case manager would be asked to assess was limited to approximately 15. In the analyses reported here, the data are weighted by the inverse of the sampling fractions to deal with these variations in sampling.

### **Questionnaire Administration**

Once the sampling was completed, project staff presented a 1-day training session for the case managers at each site in completing the Community Support Services Evaluation Questionnaire which constitutes the basic source of the data for this study. On-site research assistants were made available to answer the case managers' questions as they completed the questionnaires about clients and to check for completeness and accuracy as questionnaires were turned in to them. Through this procedure 844 usable questionnaires from 67 case managers were initially collected.

The CSS evaluation questionnaire was completed by case managers at each site at two points in time approximately 9 months apart. The questionnaires provide data on clients' demographic characteristics, residence situation, case management and other CSS services being utilized in addition to information about their community adjustment and quality of life.

### **Definition of Rurality**

A recent review of the definition of "rural" used in research on community mental health and rural sociology indicated that studies have used population definitions including towns of less than 2,500 population to less than 40,000 (Bosak & Perlman, 1982). One of the questions included in the first questionnaire identified the size and location of the community in which each client resided. For the purposes of the analyses

reported here, clients were defined as living in rural programs if their case managers indicated that they resided in a rural area or a small town of 2,000 or less population. The determination of whether a client lived in a rural area or not was possible for 839 clients and that constitutes the possible N for analysis in this paper. Of this total number of clients, 151 were identified as residing in rural areas and 688 and living in nonrural communities. Because of missing data the N varies slightly, but not significantly, in some of the analyses that follow.

## Results

### Demographic Characteristics

The median age of the overall sample of clients in our CSS cohort was 56 years. The mean age of the rural clients (59.6) was significantly older than that of the urban clients (53.0) ( $t = 3.41, p = .001$ ). The distribution of rural and urban clients by age groupings was also significantly different ( $\chi^2 = 26.12, df = 4, p < .001$ ). Proportionately more of the rural clients (43.8%) were included in the age group of 65 and over than the nonrural clients (26.5%). Correspondingly, the clients from the larger population areas included approximately twice as many in the 18 to 34 age category (17.8% vs. 9.3%) as the clients from the less populated rural areas.

A significantly larger proportion of rural CSS clients were female (67.8%) than was the case for urban clients (53.2%) ( $\chi^2 = 10.11, df = 1, p < .01$ ). Differences between the two groups regarding racial/ethnic status were not statistically significant, although there was a trend for more blacks and Hispanics to be receiving CSS services in the rural areas ( $\chi^2 = 7.78, df = 3, p = .051$ ).

### Residential Settings

Although CSS does not fund residential care, it is important to consider the types and levels of residential care provided to the CSS study cohort, since where a client lives influences the availability and accessibility of services and community living opportunities. Also, since clients spend a significant proportion of time in their residential environment, the nature of this setting is important to consider in terms of the behavior opportunities and demands that it presents.

Table 1 presents the proportions of clients in our cohort from rural and nonrural areas living in each of a number of different types of resi-

dential settings. As this table shows, clients in rural communities differ significantly from those in urban communities in the types of residence in which they lived ( $\chi^2 = 58.84$ ,  $df = 9$ ,  $p < .001$ ). While the single most common residential setting for both the rural and urban groups is a private proprietary home for adults (PPHA)<sup>2</sup>, rural clients make consider-

**Table 1**

**Residences of CSS Study Cohort Living in Rural and Urban Areas<sup>1</sup>**

Residence type	Rural areas	Urban areas
Skilled nursing facility or health related facility	2.7% ( 4)	.9% ( 6)
Community residence or cooperative apartment	14.1% (21)	2.8% ( 19)
Family care home	18.1% (27)	8.9% ( 60)
Private proprietary home for adults	31.5% (47)	36.7% (247)
Boarding or rooming house	5.4% ( 8)	10.3% ( 69)
Private house or apartment:		
Alone	5.4% ( 8)	13.5% ( 91)
With spouse	8.1% (12)	7.4% ( 50)
With parents	8.7% (13)	10.0% ( 67)
With other relatives	4.7% ( 7)	5.3% ( 36)
With unrelated others	1.3% ( 2)	4.2% ( 28)
	100% (149)	100% (673)

<sup>1</sup>Because of missing data, it was not possible to specify residence type for 2 clients living in rural areas and 15 living in urban areas.

<sup>2</sup>A type of board and care facility which is one of the most widely available supervised community living situations for chronic psychiatric patients in upstate New York.

ably greater use of other supervised living situations including community residences and cooperative apartments, and family care homes. Urban clients make proportionately greater use of unsupervised settings including boarding homes and rooming houses, and private houses and apartments, whether the client lives in these alone, with parents, other relatives, or unrelated others. However, this pattern does not hold for clients living in private houses or apartments with their spouses, and a slightly higher proportion of rural clients than urban clients are found in this residential situation.

When case managers compared the areas where clients were living on the general adequacy and accessibility of community services and facilities, rural residential settings received significantly poorer ratings than urban ones ( $\chi^2 = 53.21$ ,  $df = 4$ ,  $p < .001$ ). Twenty-five percent of the rural CSS clients were rated as living in places with poor to very poor access to services, while only 8% of the urban clients received such low ratings. Similarly, the adequacy of available transportation in meeting a client's needs was rated as significantly poorer for clients living in rural areas ( $\chi^2 = 64.36$ ,  $df = 4$ ,  $p < .001$ ).

## Services Received

Overall, the clients in rural communities participated more days per week in day programming ( $\bar{X} = 2.58$ ) than clients in urban areas ( $\bar{X} = 2.16$ ) and this difference was statistically significant ( $t = 2.13$ ,  $p < .05$ ). Further, when rural clients did attend a day program they tended to spend more hours per day ( $\bar{X} = 3.47$ ) than nonrural clients ( $\bar{X} = 3.03$ ) although this was not quite statistically significant ( $t = 1.86$ ,  $p = .06$ ).

Table 2 presents the percentages and frequencies of rural and nonrural clients who received and did not receive each of 16 needed services. For both clients living in rural and those in nonrural areas the most frequently received services were direct and indirect case management followed closely in frequency by medication review, medical/dental services and crisis case management. More than 90% of both groups also were the recipients of CSS-funded transportation services.

In most cases, the differences in receipt of needed services between rural and nonrural clients were not significant. However, as Table 2 indicates, there were significant statistical relationships regarding who received training in competency skills ( $\chi^2 = 6.76$ ,  $df = 1$ ,  $p < .01$ ) and coping skills ( $\chi^2 = 4.81$ ,  $df = 1$ ,  $p < .05$ ) with proportionately more rural than nonrural clients, by a ratio of about 2 to 1, receiving these needed services.

**Table 2**  
**Clients in Rural and Nonrural Areas Receiving**  
**Needed CSS Services**

Services	Rural		Nonrural		Significance
	Not Received	Needed Received	Not Received	Needed Received	
Direct case management	9% ( 1)	99.1% (116)	1.3% ( 7)	98.7% (524)	NS
Indirect case management	0 ( 0)	100.0% (111)	6% ( 3)	99.4% (497)	NS
Crisis case management	12.5% ( 1)	87.5% ( 7)	7.1% ( 6)	92.9% ( 78)	NS
Medical/dental services	3.3% ( 2)	96.7% ( 58)	6.3% ( 15)	93.7% (225)	NS
Competency skills training	33.3% ( 9)	66.7% ( 18)	63.8% ( 60)	36.2% ( 34)	.01
Coping skills training	38.5% ( 10)	61.5% ( 16)	65.1% ( 56)	34.9% ( 30)	.05
On-site rehabilitation	36.8% ( 7)	63.2% ( 12)	38.1% ( 40)	61.9% ( 65)	NS
Sheltered workshop	33.3% ( 9)	66.7% ( 18)	46.7% ( 70)	53.3% ( 80)	NS
Other vocational services	76.9% ( 10)	23.1% ( 3)	67.0% ( 59)	33.0% ( 29)	NS
Day treatment	21.4% ( 15)	78.6% ( 55)	31.5% ( 68)	68.5% (148)	NS
Psychosocial club	73.9% ( 17)	26.1% ( 6)	70.9% (141)	29.1% ( 58)	NS
Evening/weekend recreation	45.9% ( 28)	54.1% ( 33)	50.7% (152)	49.3% (148)	NS
Homemaker/housekeeping services	22.2% ( 2)	77.8% ( 7)	48.7% ( 19)	51.3% ( 20)	NS
Individual/group therapy	12.3% ( 8)	87.7% ( 57)	17.1% ( 60)	82.4% (290)	NS
Medication Review	3.2% ( 3)	96.8% ( 91)	4.0% ( 16)	96.0% (388)	NS
Transportation funding	1.0% ( 4)	93.0% ( 53)	8.3% ( 22)	91.7% (244)	NS

## Case Manager Services

As Table 2 shows, virtually all clients received the case management they needed in both the rural areas (99.1%) and the nonrural areas (98.7%). However, there are some differences in the frequency of specific case management services offered to the clients living in the two population areas. As part of the second wave questionnaire, case managers were asked to indicate for 20 specific case management activities the frequency with which they performed that activity for each client remaining in the cohort at that time. Grouping these data into services provided not even once, those provided less than monthly, and those provided at least one, or two times a month, there were significant differences for three case managed services between clients served in rural and nonrural areas.

Rural clients were less likely than clients in nonrural areas to have their case managers go someplace with them ( $\chi^2 = 8.60$ ,  $df = 2$ ,  $p < .01$ ). Similarly, clients in rural areas were less likely to have their case managers provide transportation for them than clients in nonrural areas ( $\chi^2 = 6.05$ ,  $df = 2$ ,  $p = .05$ ). Rural clients were also less likely to have their case managers help them with crises ( $\chi^2 = 6.49$ ,  $df = 2$ ,  $p < .05$ ). Finally, there was a trend for rural clients to be less likely to have their case managers facilitate needed rehospitalization ( $\chi^2 = 5.66$ ,  $df = 2$ ,  $p = .0589$ ).

The general pattern in these items seems to be that case managers are less likely to engage in activities involving travel for clients in rural areas than with clients being helped in more urban communities. This relates to the problem mentioned earlier in delivery of rural mental health services; that is, distance and spatial isolation act as a barrier to the delivery of some services. The finding that case managers were less likely to act in case of a crisis situation for rural clients may also be related to physical barriers in getting to a client in a crisis situation. The slight difference in facilitation of needed rehospitalization may also be related to reluctance to readily transport an individual to the hospital unless it is absolutely necessary.

## Summary and Conclusions

The findings that CSS clients being served in rural areas differ from those in nonrural areas by including more women than men and more older than younger clients have implications for the difficulties that case managers face in serving clients in rural areas. Other analyses of the

relationship of age with client behavior for the entire cohort have shown that younger clients tend to be more noncompliant in taking their prescribed psychiatric medication, to exhibit more maladaptive behavior, and to refuse needed services (Intagliata & Baker, 1984). Younger clients also are more likely to be male. Thus it would appear that CSS programs serving clients in rural areas might find clients somewhat more cooperative and easier to deal with than clients in nonrural areas.

The finding of some differences between urban and rural clients regarding type of housing in which they live also has implications. In a series of analyses described in a previous report (Baker & Intagliata, 1983), it was found that, regardless of the amount of services that clients were receiving, those who lived in residential settings rated as inferior showed poor outcomes. The finding in this paper that clients in rural areas were living in housing which received significantly poorer ratings regarding general adequacy and accessibility of community services suggests that some clients living in rural areas may face poorer outcomes over time.

In general, there were few dissimilarities between rural and nonrural clients in the medical, rehabilitative and supportive services that were provided to them. However, some needed services appeared to be more readily available to rural clients than urban clients including training in competency skills and coping skills training.

There were also relatively few differences found in the type of case management services offered to rural and nonrural clients. However, those differences that were found appeared to present a picture of case managers being somewhat more reluctant to engage in activities which involved travel for their clients in rural areas. At the beginning of this paper, we noted that distance and spatial isolation have been shown in the past to act as a barrier to the delivery of services, and that may be the explanation here as well.

In summary, these data showed little disparity between the rural and nonrural clients in terms of the types of services provided, a finding which speaks well for the appropriateness of the community support services model for application in rural areas. At least in the programs examined in New York State, it was possible to overcome many of the limitations in the range of services and service providers which usually characterize rural locations. Given the fact that the CSS program specifically provides money for missing services, this would suggest appropriate planning and adequate funding of needed services.

These findings that implementation of the CSS model can provide as wide a range of services in rural settings as in urban ones are particularly encouraging, when one considers the difficulties that rural communities have traditionally faced in meeting the specialized needs of deinstitutiona-

lized chronic mental patients (Bachrach, 1982). The CSS model as it has been implemented in New York State deals with several major problems in serving the mentally ill in the rural community. It deals with the limited array of mental health and other supportive services available in rural areas by providing funding for needed services, it also provides two new service system development and integration mechanisms. These are the core service agency and the case manager. The role of the core service agency is to identify and to help develop missing service elements and to help integrate the available services into an effective system of community supports for chronic mental patients. The case manager also has an integration function, but not so much at the large system level as at the level of the individual client, cutting across boundaries of programs and specific services to provide the whole system of services needed for a specific client. Case managers also provide other benefits to clients including social support, some limited direct services and advocacy (Baker & Weiss, 1983). Advocacy is of singular importance in rural areas since other types of patients are typically in competition for the same scarce resources and chronic mental patients are particularly ill equipped to advocate for themselves (Bachrach, 1982).

The strength of the community support system model as it was applied in New York State appears to be both in the funding of missing elements of service and in the success of case managers in delivering a full range of needed services of most types despite geographical problems of availability and accessibility. Continuation of the longitudinal study of the impact of community support system services may reveal whether these essentially similar patterns of residence and service provision show similar patterns in outcome for clients in both rural and urban settings.

At the national level, although like most federally funded human service programs, the future of the NIMH Community Support Program is somewhat in doubt because of the Reagan administration's attempted cuts in such programs, some federal funding of CSP presently continues. At the end of 1983, all but two states had received or were receiving grant support for CSP projects; more than 20 CSP research and evaluation projects were still ongoing from 1983; and 8 new "state service systems" research projects were funded for 1 year to study service delivery programs for persons with severe and persistent mental illness (Brown, 1984). Although the amount of federal money available to fund CSP projects was limited from the beginning of the program, CSP has been quite successful in stimulating state mental health agencies to invest considerably more funds in community support systems (Turner & Shifren, 1979). Whatever happens to the level of CSP federal funding in the future, the extent of current commitment by state mental health agencies to the community support systems model along with the successful expe-

rience of numerous local agencies in developing such service programs, should result in continued interest in this service model and its evaluation.

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