Cooperative Programming: A Survival Technique For Rural Aftercare Programs

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With the current push for increased deinstitutionalization of mental patients in many states, the development of aftercare programs for these patients has become a priority for many mental health centers. This paper describes a cooperative aftercare program that was designed to help meet the needs of an impoverished rural county in Virginia. The problems inherent in starting any mental health project in a rural area are discussed. The program described is a multi-agency effort to provide day treatment facilities and mobile "mini clinics" to better serve the rural population. An evaluation of the program shows that it is very successful in preventing rehospitalization of aftercare clients. The benefits and drawbacks to cooperative, multidisciplinary, multi-agency programs are discussed.

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Introduction

Everyday, it seems, we read about "ex-mental patients" doing all kinds of nasty things. Psychiatrists are being held accountable for the violent acts of their clients, and there seems to be a general shift in mood in the public and the media away from deinstitutionalization towards advocacy for more restrictive alternatives of care. The fact is that many deinstitutionalized clients are released to nonexistent or inadequate aftercare programs. Without the support necessary for reintegration into the community or their families, some of these clients begin to deteriorate and cause problems in the community. This can lead some individuals in the community to feelings of hostility and resentment toward the mentally ill and toward the programs designed to help the mentally ill. If we are to prevent a situation in which the general public calls for increasingly restrictive treatment for the mentally ill, this problem must be addressed.

That people being discharged from a hospital need aftercare services of some kind is a widely held belief. Anthony, Buell, Sharratt, and Althoff (1972), in their review of the literature, found that aftercare programs greatly reduced the rate of recidivism in postdischarged clients. Johnson, Fox, Schaefer, and Ishihauon (1971) suggested that aftercare clients require a very supportive environment. The NIMH estimates that as many as 80% of all discharged clients could remain in the community permanently if family counseling was provided (Wynne, Note 1). Byers, Cowan, and Harshbarger (1978) demonstrated that the amount and quality of aftercare programs were powerful variables in the prevention of recidivism.

Provision of adequate aftercare services is a difficult and financially demanding task at best. In rural areas, it can be almost impossible. It is sometimes bad practice to make a difference between subgroups within a general population, because difference is often read as deviance, hence inferior. But there is a growing amount of literature that indicates that there are substantive differences between rural and urban environments. While it would be an error to make a value judgment regarding the two environments, it is important to pay attention to the special problems encountered in aftercare service delivery in rural areas.

There are numerous impediments to the development of comprehensive aftercare services in rural areas, some obvious, others less so. Solomon (1980), in his review of the literature, cited some of the problems facing rural mental health centers. Geographic isolation, lack of public transportation, poverty, negative attitudes toward mental health problems, and lack of services all have been well documented. Many rural residents are distrustful of outside professionals, especially those professionals providing services that are not perceived as necessary (F. Miller, 1981). Jeffrey and Reeve (1978) have documented the problems that rural mental health care centers have in
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guaranteeing confidentiality and the difficulty urban trained mental health professionals have in understanding the rural culture.

Some road blocks to service delivery exist within the rural sociology itself. Libertoff (1980) has pointed out that rural areas are often characterized by lack of comprehensive human service programs, and weakened social networks. Berry and Davis (1978) indicated that not only are rural citizens distrustful of mental health professionals, but so too are the other professionals in the community. The mental health program, as the "new kid on the block", has a lot to prove to the community. For many rural residents, deviance from norms is not acceptable, and deviant individuals become labeled in the community (Kantor, Kausch, & Smith, 1978) (Turnick, Platt, & Bowen, 1980).

Safety is a primary issue with the rural population. Rural people are not psychologically minded and view mental health intervention as a measure of last resort to be utilized only when the deviant behavior crosses some nebulous community standard (Bagarozzi, 1982). It is not unusual to have situations in which "social drinkers" consume alcohol in amounts equal to, or even greater than, the "town drunks," but fail to be labeled as alcoholics because they do not beat their wives or steal food from the families. Thus with negative attitudes toward mental health, with reluctance to accept services for fear of labeling, and with the paramount importance of safety issues, it is not surprising that many rural residents view mental health programs designed to keep deviant people in the community as incomprehensible.

Mental health care providers, then, are placed in a rather unique situation in rural environments. Their training and experience (as well as State law or policy in many areas) dictate that they do their best to treat problems in the community. This stance often conflicts with the perceived needs of the community or family, which is to remove the deviant individual from the environment. With this type of conflict, it is not surprising that a needs assessment conducted in a rural area found little expressed interest in traditional therapy-oriented mental health programs, and no concern for developing aftercare programs, in favor of mental health education and prevention activities (Collins, 1981). The increasing impetus from professionals and state bureaucrats for deinstitutionalization has disturbed the equilibrium of rural areas by forcing them to treat and tolerate persons who previously were locked away in state hospitals (Bagarozzi, 1982).

Rural communities have the additional burden of providing services in an area where need is great and resources are small. Poverty is a characteristic found in almost all rural population, and the per capita income in this country shows a wide disparity between urban and rural populations (F. Miller, 1981). Rural environments tend to rely on nondiversified economies, built on agriculture, mining, or single industries. Vagaries of the economy can have a more profound effect on rural life than on areas where
there are more resources. Rural governments often have difficulty in seeing the financial savings of community-based treatment. Prior to the advent of community care, mentally ill people were treated in state facilities, and the cost to the rural community was hidden. Now, these communities in financial extremes are being asked to fund expensive mental health programs, programs for which they can see no real need.

Because of the paucity of resources, it often is difficult to attract "state of the art" mental health professionals. Keller, Zimbelman, Murray, and Feil (1980) found that psychiatrists and PhD level psychologists tend to concentrate in urban areas. Rural areas have difficulty in developing comprehensive services and in paying top salaries to attract professionals to staff them. As a result, most rural community mental health centers are forced to rely on crisis intervention modalities. Individual therapy is the most used technique, and little supervision or consultation is available to the rural therapist. (Hollingsworth & Hendrix, 1977).

### Networks

With all these problems, it is tempting to view effective rural aftercare programs as logistically impossible to set up. Deinstitutionalization has been difficult to implement in rural areas because of the urban bias of the aftercare model, lack of resources, and lack of anonymity for the clients. But, rural areas also have several advantages. The rural therapist is more likely to know the family and the support system of the deinstitutionalized client (Bachrach, 1977). Byers et al. (1978) demonstrated that, while aftercare services are important in preventing rehospitalization, a good support system is equally necessary.

Given all the problems inherent in the rural system, it is not surprising that rural therapists are in the vanguard of mental health professionals adopting a community network approach to solving difficulties. Aponte (1980) has pointed out that an ecological approach is perhaps the treatment of choice for the poor. He pointed out that society has encumbered families with rules, direction, care, and guidance that progressively restricts the ability of the individual or the family to decide on priority. Attnavee (1976) suggested that we all live in social networks that have a role in determining behavior at any given moment. This is particularly true in rural areas. It is difficult to exist in a rural environment without many people knowing what one is doing. Most of us are susceptible to social or peer pressure to some degree, and in rural areas, the amount of community involvement in an individual’s life is quite high.

Because of this environmental pressure, many therapists have
adopted an ecological approach to therapy, which views the individual or family not as an isolated unit, but as a part of a system. Significant others from the environment are drawn in to discuss problems that individuals or families are having, so as to achieve change. Family therapists have had a great deal of success in applying ecological approaches to therapy (Anderson, 1976; Fleisher, 1975; Gattie & Coleman, 1976). Others have stressed the importance of involving the "natural helping network" in developing therapy programs (Bagarozzi, 1982; Bergstrom, 1982; D'Augelli, Vallance, Danish, Young, and Gerdes, 1981; Liberto, 1980). Janzen (1974) has even shown the importance of using indigenous volunteers in establishing a rural day-care program for psychiatric clients.

Establishing truly effective aftercare programs in rural areas is, obviously, a staggering task. Economic pressures limit the ability of rural governments to fund new programs. Clients spread over large geographical areas with limited or nonexistent public transportation limit accessibility to programs. Negative attitudes lead rural residents to misperceive the need for mental health aftercare programs. With all of these obstacles in place, it is easy to get discouraged and not even contemplate starting a full-service aftercare program. But, until innovative aftercare programs are in place in rural areas, the mentally ill will continue to be underserved and rural areas will be prevented from achieving the growth of which they are capable.

The Program

Just as rural areas differ in economic resources, geographic area, population, and countless other factors, so too, do they differ in their mental health needs. Therefore, establishing a rural aftercare program is an individual process, taking into account the unique set of factors in each area. There is a tendency for therapists to try to force clients into a model of therapy, rather than designing a therapy program to meet the needs of the client. When models are chosen which are not syntonic with familial or cultural belief, programs break down (J. Miller, 1981). As a result, the program described here should be viewed for its heuristic value, not as something that can be transplanted as a whole into another environment. The principles of establishing cooperative programming, though, can and should be applied.

The area in which this program developed is a small, rural community in south central Virginia. The population of 16,000 is, by and large, poor. The largest population center in the area is the county seat, with a population of 1,500. The nearest city is approximately 70 miles to the north. The
economy is agrarian based, with tobacco, lumber, and dairy farms predominating. There are no major industries located within the county with the exception of small textile shops and a shoe factory. The major employer is a prison recently built in the county. There is no public transportation available, and geographic isolation is common. It can take as much as an hour to get from one end of the county to the other by car. The county coffers are in poor shape because of the lack of an adequate tax base and the drying up of State and Federal funds.

The mental health program in the county started in 1976, and began providing minimal aftercare services in 1977. Currently, the clinic has 150 active clients, 120 of whom have been hospitalized at least once. Before the current aftercare program was established, most aftercare clients received sporadic checks by the clinic staff, medication, and quick evaluations by the consulting psychiatrist. The clinic started with 1 psychiatrist day per month, and currently has 4 days per month. It was obvious to the staff that they were only scratching the surface of the needs of the aftercare population. Increasing the scope of services was difficult, though, because there were no funds available for space, transportation, supplies, and additional staff.

But it became apparent that a truly functional aftercare program could meet many needs, and that others might be able to provide some of the needed resources. For example, the local community college maintained a Human Services tract, which required, as part of its curriculum, three internship experiences. Since the college was having difficulty in finding suitable sites for their students, the mental health staff proposed a cooperative day-treatment program. The community college was willing to provide space, utilities, and two internship students. In return, the mental health center agreed to provide supervision to the students, clinical programming, and clients. After two negotiating sessions with the Director of the Human Services program, the Dean, and the President of the community college, the program was set.

The next major obstacle was transportation. Initially, the county administrator agreed to provide an old sheriff's department car for the mental health center's use, if the agency would pay for gas. The agency was able to obtain gasoline at a discount through the county purchasing plan. Maintenance on the car was provided by the public school bus garage. Due to financial difficulties, the county was forced to sell the car midway through the 1st year of the program. Staff from the mental health center filled in for the balance of that year by driving the clients in their personal cars. For the 2nd year of the program, the local activity center for the developmentally disabled offered the mental health center the use of one of their vans, if the mental health center would agree to make certain repairs. This was done, and this van continues to be the major form of transportation for the pro-
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Two alternative transportation programs were dropped once this offer was made. The mental health center was negotiating with the school system to provide counseling services for their students in return for a used school bus. The staff was also hoping to involve RSVP volunteers in providing transportation, but this was not necessary once the van was secured. The director of the program drives the route to pick up the clients each day, which takes about 1 hour each way. The clients who can afford to pay are requested to contribute $1.00 per trip to help defray costs.

Supplies for the program were necessary, but again, the money was not there. The interns and staff began scouring the community for materials that could be utilized. Many local businesses were more than happy to donate materials such as glue, clothespins, yarns, etc., for arts and crafts activities. Manufacturing facilities and home supplies stores donated scrap materials that also could be used. As a result of these donations and some financial contributions, the program had more than enough arts and craft supplies to run the program the first 18 months. The community college provided sports equipment for recreational activities. Even the human services club at the college contributed money from their annual bake sale so that we could conduct a “graduation ceremony” and picnic on the last day of the 1st year of the program.

Due to the exigencies of the community college schedule, and other demands on the time of the mental health staff, the clients meet at the college 2 days per week. They receive group therapy, reality orientation exercises, social skills training, recreational therapy, and limited movement therapy. Humor, joke telling, and story telling are central components of the program. The clients also participate in as many college activities as possible. The clients also eat their lunch in the student lounge with the other students, and utilize the library and audio-visual facilities at the college. The clients have taken several field trips to different occupational sites and have had the opportunity to see various local industries in action.

The staff at the mental health center viewed the day-treatment component of the aftercare program as successful, but also felt it was not sufficient to meet the needs of the aftercare population not currently enrolled in the day-treatment program. The major difficulty that the agency found was lack of accessibility. The center had a policy of requiring each client to come in for evaluation each month. But many clients complained that they could not afford the $10.00 to $20.00 in transportation costs that they faced as a result of this policy. Therefore, many clients were only being seen when they came in for quarterly evaluations by the psychiatrist. As a result, the staff could not adequately monitor such things as medication compliance, reactions to environmental stress, family difficulties, and mental status changes without costly and time-consuming individual home visits. As a result, many aftercare clients were seen only when they became
problematic to family or neighbors.

Decentralization of services was the answer, but again the mental health staff could not do it because of lack of resources. The staff began a search for alternative sites for “mini clinics.” Unable to afford rent or utility cost, the center staff hoped to find some free lodging. By negotiating with several local churches the mental health center was able to locate sites in various outlying areas of the county. The churches agreed to make their social halls or the church itself available to the mental health staff once a month. The churches provided heat and light. The mental health staff brought medications, did blood work, took blood pressures, temperatures, etc., and provided socialization experiences in group therapy. It is hoped that these groups will foster a sense of community in the mental health client. It is hoped that other human service providers will come to the “mini clinics” to discuss common problems such as health issues, welfare difficulties, etc. Also, these mini clinics were intended as “drop-in” centers for new clients, but to date, no one has availed themselves of this service.

Pleased with the success of the two cooperative programs, the mental health staff was instrumental in setting up an human service council, composed of representatives from all the human service agencies in the county. The stated purpose of this organization was to serve as a multidisciplinary team for child abuse prevention, as a predischarge planning team for Mental Health, and to prevent duplication of services. While it has served these functions well, it has also served as a resource for cooperative programming. To date, the council has sponsored multidisciplinary workshops on substance abuse, parenting, and child abuse. It is also sponsoring a support group for families with frail, elderly members.

Evaluation

That the cooperative aftercare program was successful should not be surprising, given the bulk of research indicating that aftercare programs reduced recidivism (Anthony et al., 1972). None of the 15 clients who went through the first 2 years of the day-treatment program, or the additional 15 clients enrolled in the first few months of the “mini clinics” were hospitalized. Prior to their participation in the program, each of the clients had been hospitalized many times, the mean number of admissions being 4.3. This is somewhat deceptive, because two of the clients had been hospitalized only twice, but their first admission had resulted in long stays, in excess of 10 years. During the time the program was in operation, the mental health center prescreened 35 people for admission to State facilities.
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All had been hospitalized at least once before. In addition, two of the day-treatment clients left to accept unsubsidized employment, and another went to a vocational rehabilitation program in another part of the State. While it is still too early to claim an unqualified success, it is clear that the day-treatment program is fulfilling its purpose of preventing rehospitalization.

Client satisfaction with the program is high. While there were a few growing pains in the first few months of the program, a cohesive group of clients was formed. All clients responded favorably to client satisfaction questions, and all but one of the clients who finished the 1st year of the program re-enrolled in the 2nd year. The program was also viewed as successful by the community college staff, and no staff members had any objections to the continued presence of the day-treatment clients, despite a high degree of contact with those clients. Even community members expressed satisfaction with the program. As one town policeman said, "We don't have as many crazy people on the streets like we used to. In fact, I can't think of the last time we had a major problem."

Discussion

So, it is clear that the aftercare program had some beneficial effect on the community. It is also clear that it could not have started without cooperative efforts. The mental health center budget has remained at the same level for the past 3 years, and will likely continue to be funded at low levels. Cooperative programming is clearly one way to forestall budget shortfalls and establish new programs. Most rural mental health centers in Virginia do not have day-treatment capabilities, and those that do must transport their clients to a population center. This program exists in the rural area, for the rural residents it serves. It could not function without total community involvement.

It has other benefits as well. As a result of these cooperative programs, the conventional mental health program has become more visible and more accepted. The increased exposure to mental health clients has helped some community members adopt more rational attitudes toward mental illness. The clients themselves tend to identify with the community they live in, and are more aware of the problems facing others. They also tend to de-label themselves, and many of the day-treatment members came to view themselves as part of the college community, rather than as aftercare clients. It has assisted the community in developing a relatively strong human service network, and thus helps increase the quantity and
quality of services available to the community. It has led to an increase in communication and understanding between human service providers, and programs tend to develop a multidisciplinary flavor. In addition, the program has generated a need for continued aftercare services. The State Department of Mental Health has granted the agency increased funding for day-treatment programming for the future. In short, the cooperative nature of the program has led to a number of benefits in addition to the ones it was designed to achieve.

This is not to say that there are no pitfalls to cooperative programming. By involving other agencies in a program, the community mental health center must surrender some of its control over the program, and thus might be forced to make some compromises it might not want to make. Confidentiality becomes very problematic, because many people become involved in the treatment package, although our clients did not find this objectionable, and were already known in the community as mentally ill anyway. Involving other agencies results in dependence on them for particular functions, and a breakdown in one area can seriously affect the total program, as was evidenced in this program when the county administrator was forced to recall the source of transportation.

Despite these problems, though, cooperative programming may be the only way rural community mental health centers can survive and offer quality services in these days of bad economic news. The fact is that cooperative programming may be the only way an agency can start a needed program. If, through creative thinking, a community can come up with cooperative programs to meet its own unique needs, it is hoped that the ecology as a whole will change in a positive direction. Each community is a system and taking a systems approach toward solving problems is likely to result in positive changes throughout the system. In the very least, it is better than doing nothing.

Reference Note

References
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