AN ANALYSIS OF THE SOCIODEMOGRAPHIC ATTRIBUTES OF UTILIZERS AT A COMMUNITY MENTAL HEALTH CENTER'S RURAL SATELLITE CLINICS

by

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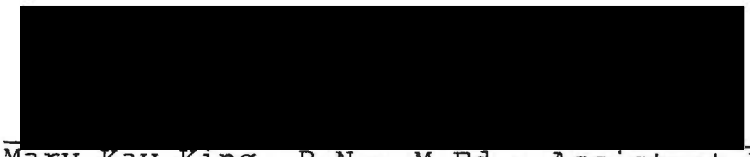

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Chapter I

INTRODUCTION

The goal of this study was to describe the clients of a rural mental health service in order to provide direction for clinical practice and to contribute to the understanding of utilization of rural mental health services. The Task Panel on Rural Mental Health (1978) has declared rural America unserved and underserved. This report to the President's Commission on Mental Health identified forces contributing to the lack of rural mental health service delivery and recommended alternatives for effecting improvements in those services.

The delivery of relevant services was identified as the most important concern and the paucity of research into rural mental health issues was identified as one of the major factors limiting the delivery of relevant mental health services to rural America. The Task Panel recommended that research activity be directed toward building a knowledgable data base pertinent to the development of rural mental health services. Through clinical research and program evaluation studies, specific to rural areas, the current deficit can be reduced.

The rural mental health literature describes numerous barriers in the delivery of mental health services to rural

communities. The most frequently cited barriers to service are: acceptance of the mental health system by the rural community (Berry & Davis, 1978; Conference Report, 1977; Daniels, 1967; Duran, 1970; Gertz, Meider & Pluckhan, 1975; Jeffrey & Reeve, 1978; Lee, Gianturco & Eisforfer, 1974; Wedel, 1969), the stigmatizing effects of mental disorders (Berry & Davis, 1978; Lee et al., 1974; Wedel, 1969), and population dispersal (Berry & Davis, 1978; Daniels, 1969; Duran, 1970; Gertz et al., 1975).

No research was located that described client use of rural mental health services. The Task Panel on Rural Mental Health (1978) reported that rural populations have general characteristics sufficiently different from those in urban catchment areas to require distinctive models of service delivery. Those differences were not clarified by the Task Panel. One of the complaints of the panel was conducting their deliberations without the "benefit of a substantial body of scientific verified data" (p. 1160). They have called for research to be conducted on rural issues, suggesting that the research, for the most part, be descriptive in nature.

Clinical nurses, as primary care givers in both rural and urban settings, are often in the position to generate and use practice oriented research. This mental health clinic utilization study compared the sociodemographic characteristics of those individuals seeking services at a rural community mental health clinic with other utilization

literature to begin to identify differences, if any, between rural and urban use of community mental health facilities. The data was also compared with epidemiological literature. Needs assessment studies often serve as the basis for community mental health program development in planning services and projecting expected outcomes.

This descriptive retrospective study investigated the sociodemographic characteristics of clients at a rural mental health clinic which is located in a rural community. It was proposed that a utilization program evaluation study of an existing rural mental health service could: (1) increase the data base about that segment of a rural population that seeks mental health services; (2) begin to identify rural/urban differences in mental health clinic use; (3) serve as a guide for further rural research; and (4) provide information on rural mental health service use which would aid in program planning and development.

Literature Review

The Task Panel on Rural Mental Health (1978) reported that rural America lacks adequate mental health services and that those services which exist are not meeting the needs of the rural population. The panel cited lack of research as foremost in hindering effective program planning. The rural literature reports that rural populations have been reluctant to use mental health services when those services have been provided in their community. The question arises

as to the relationship of the mental health clinic to the rural population. Who in a rural community chooses to use a mental health service? Who chooses not to use the services? Attempts to answer those questions formed the basis of the conceptual framework for this study.

Following a statement of the conceptual framework this review of the literature defines the term "rural" and then presents the major findings from needs assessment research and utilization research.

Definition of Rural Populations

Rural populations are complex and diverse. There has been no consistency defining the term "rural" in the rural mental health literature. The U.S. Department of Health, Education & Welfare (1973a) has defined as rural that area outside of a standard metropolitan area, consisting only of counties in which more than 59% of the 1970 population lived in communities of 2500 or less. Some writers have used the above definition (Duran, 1970; Husaini, Neff & Stone, 1979). Others have limited their definitions to descriptions of the rural area of interest (Edgerton, Bentz & Hollister, 1970; Lee et al., 1974; Leighton, Harding, Macklin, Hughes & Leighton, 1963; Turner, 1979).

A statistical definition of rurality adds little to understanding rural communities. Flax, Wagenfels, Ivens and Weiss (1979) have suggested that an evaluation of population structure, composition and distribution are crucial

to understanding rural communities. Youmans (1977), from a social approach, has described a rural community as a "folk society" where there is a strong emphasis placed on conventional behavior and conformity to traditions and customs. The need to assess and evaluate rural mental health delivery within the framework of the rural communities culture and value system was stressed by the Task Panel on Rural Mental Health (1978).

Needs Assessment in Rural Mental Health

Needs assessment research is concerned with determining needs, wants and demands for human services through direct surveys and/or indirect measures like social indicators. Historically, the needs estimates on which mental health planning is based have turned to epidemiological findings from the Midtown Manhattan studies (Srole, Langer, Opler & Rennie, 1962). These important studies attempted to estimate the incidence and prevalence of psychiatric disorder in the general population. From these studies it has been estimated that between 20% and 40% of the population in the United States suffer from a severe mental illness which markedly interferes with effective functioning. Later epidemiological studies in the incidence and prevalence of mental illness have been more conservative in their findings. Studies conducted in rural communities (Edgerton et al., 1970; Leighton et al., 1963) estimated that approximately 12% to 14% of rural populations are "high risk," evidencing major psychiatric symptoms.

The Midtown Manhattan study (Srole et al., 1962) was conducted in New York City during the mid to late fifties. A random household survey was conducted of 1700 residents in downtown Manhattan. The structured questionnaire, consisting of 22 symptom items compiled by a panel of psychiatrists, was designed to measure psychophysiologic manifestations as well as dimensions of anxiety, depression and inadequacy. The questionnaire discriminated between the patient and well groups at the P = .01 level of significance. Data from that study indicated that 23.4% of the urban population surveyed had "serious" symptoms and varying degrees of impairment.

A year following the Midtown Manhattan study a second major epidemiological study was conducted by Leighton and colleagues (1963) in a small rural county in eastern Canada. The purpose of the Stirling County study was to determine the prevalence of psychiatric disorder and to identify the possible effects of the environment on mental health. Data were collected by a structured questionnaire survey of a sample of 1010 adults in the community; the information obtained from each individual in the sample consisted of self-reported physical and psychiatric symptoms. These data were supplemented by interviews with the local physicians about all of the individuals surveyed. Then, two or more psychiatrists examined the data and came to a mutual consensus of what constituted a "psychiatric case." The

investigators concluded that out of 1010 household heads, 31% showed "clear" psychiatric disorder, 26% had "probable" disorder, and 11% had no psychiatric disorder. The researchers grouped these findings into categories according to the need for psychiatric attention and concluded that at least 20% of the general population has a definite need for psychiatric help. The demographic attributes found to be associated with mental disorders were: female, over age 68 and low occupation status. A major conclusion from the Stirling County study (Leighton et al., 1963) was that social integration is the greatest determinant of mental health.

To test the hypothesis that the state of social integration of the environment affects the mental health of the persons living in that environment, the authors of the Stirling County study conducted their investigation in communities which they defined as integrated or disintegrated. The criteria for identification of a disintegrated community included: broken homes, few and weak community association, inadequate leadership, few recreational activities, hostility, and lack of communication, as well as poverty and cultural confusion. From their data analysis, Leighton et al. (1963) concluded that no single factor led to mental disorder, rather the net effect of all sociocultural factors which characterizes a community as either integrated or disintegrated makes the difference in the level of risk for psychiatric disorder for the people living there. The authors concluded that

there is less risk of psychiatric disorder for a person who is a member of a local, well-integrated group than for one from a disintegrated community.

A number of surveys in rural communities have used the Health Opinion Survey (HOS) developed from the questionnaire used by the Leightons in their Stirling County study (Edgerton et al., 1970; Henisz, Flynn & Levine, 1977; Husaini et al., 1979; Macmillan, 1957; Peterson & Brinerhoff, 1976). The HOS, a 20-question instrument, was designed to assess prevalence of mental disorder in rural communities. Scores range from 20 to 60; a higher score indicates mental disorder. The rationale behind the instrument was that mental disorder is reflected in behaviors which are indicative of reactions to stress, and these reactions can be identified by questioning. The tool has identified mainly psychoneurotic and psychophysiologic symptoms. The instrument was also designed to correlate with descriptive symptom patterns in the American Psychiatric Association (APA) Diagnostic and Statistical Manual for the major psychiatric disorders. The instrument is viewed as valid by researchers and has been widely used.

In 1970, Edgerton and associates used the HOS to assess the levels of disorder in three rural communities in North Carolina. Emphasis of the study was on the relationship of various demographic factors with psychiatric symptoms. The questionnaire was administered to a random sample of 1,105 subjects between the ages of 20 and 70 years of age

in rural counties. The population of equal proportion white and non-white, was described as rural, stable, poorly educated and low income. The mean HOS score for the total sample was 26.8, with a standard deviation of 5.7.

The authors interpreted this score as reflecting a relatively mentally healthy population for the communities as a whole. There were 14% who scored in the range of 30 to 34 which was interpreted as "borderline" or "probable" psychiatric disorder. The remaining 10% had scores of 35 or over indicating with greater confidence "psychiatric disorder" among that portion of the sample group. There were no differences in scores between communities or between males and females. Statistically significant differences were found for the variables: age, race, marital status, and low socioeconomic status (defined by occupation, income and education). Non-whites had significantly higher scores than white subjects as did those with greater age. Widowed, divorced and single groups showed higher scores than married groups. Social class was the variable most often found to be related to mental health.

Based on their findings, Edgerton et al. (1970) recommended that mental health services should expect to serve at least the 10% of the population with marked psychiatric disorder and specific subgroups of the population which are vulnerable to psychiatric disorders. They suggested that those with disorders and those vulnerable require

special attention by program planners. They point out that a previous study (unpublished) of mental health clinics in North Carolina indicated that the clinics are utilized mainly by "middle-class, white, middle-aged mothers and their children--subpopulations quite different from the key target groups revealed by their study" (p. 1969).

An epidemiological investigation similar to the Edgerton study was conducted by Husaini and colleagues in 1979. This household survey examined mental health needs in nine rural counties in Tennessee. The sample consisted of 713 residents, interviewed to: (1) estimate the prevalence of psychiatric impairment in that rural population; (2) determine which characteristics of the population were associated with higher levels of impairment; and (3) cross-validate three indices of psychiatric impairment. The three nationally known symptom indices used in the study were: (a) the HOS; (b) the General Well-Being Schedule (GWB), which measures subjectively perceived psychological functioning during the past month; and (c) the Center for Epidemiologic Studies-Depression Scale (CES-D), a measure for monitoring depressive symptoms during the past week. The researchers estimate that 12% of the population is psychiatrically impaired. Husaini et al. (1979) judged their conclusions to be consistent with the findings from the research by Edgerton et al. (1970) in the North Carolina study. Analysis indicated that impairment is most likely among females, those in lower

socioeconomic strata, and that depression is higher among the divorced, widowed or separated. Depression was also more common among the young, while physical and psychosomatic complaints were more common among the elderly.

To assess the relationship between need for services and utilization behavior, Husaini et al. (1979) had the respondents self-rate the severity of their problems, whether they felt they might need professional help, and whether they had ever utilized mental health services at a clinic/center or elsewhere. A series of chi-square analyses were done to examine the relationship between the three indices and each of the criterion variables. With regard to utilization only the GWB discriminated between users and nonusers of mental health services. The authors state that the discrepancy between the proportion of the sample in need and the proportion who acknowledged having utilized services points to the need for new strategies to make the public aware of available services.

Four variables were consistently noted in the epidemiological investigations on the prevalence of mental illness. These variables are: age over 65, female, disrupted marital status and low socioeconomic status.

The early epidemiological studies by Srole et al. (1962) and Leighton et al. (1963) have estimated the prevalence rate of mental illness to be approximately 20% to 40% of the general population. These figures are moderated

in later studies by Edgerton et al. (1970) and Husaini et al. (1979) who estimate the prevalence rate on mental illness to be 12% to 14% of the general population. The latter researchers have suggested that there is a need for mental health services for about 10% of the population and that there are specific subgroups which require special program planning. Only Husaini et al. (1979) noted the lack of knowledge about the relationship between need for services and utilization of services. This review of the literature will turn next to studies of utilization of mental health services.

Utilization Research

Federal guidelines for community mental health program planning suggest that community mental health centers should be directly involved in providing services to 50% of the "high risk" population or 10% of the total population in the catchment area (Tarail, 1977). Regier and Goldberg (1973), in a survey of outpatient mental health services, estimated that approximately 1.7% of the population used the services.

There were no studies located describing utilization of rural mental health facilities. The following studies refer to urban populations.

In 1975, Tishler, Henisz, Meyers and Boswell published the results of a study exploring the association between patienthood and the prevalence of symptomatology in the

community. The prevalence data was obtained from a household survey of 938 adults in a neighborhood of New Haven, Connecticut. The sample represented a cross section of metropolitan New Haven and included all ethnic, racial and socioeconomic groups. The mental health status of survey participants was measured by the Gurin Mental Status Indices. This instrument had been shown to significantly discriminate between groups of psychiatric patients and nonpatients living in the community; individuals judged by clinicians to be psychiatrically impaired and those deemed unimpaired, and between hospitalized and nonhospitalized psychiatric patients. Data indicate that a relationship between patienthood and the prevalence of symptomatology in the community existed for the following factors: race, marital disruption, education level, welfare status and social class. Variables not associated with prevalence in the community but associated with high utilization were described by the authors as lack of social support, not necessarily related to social status. The variables associated with over-utilization were: unmarried, unemployed, living alone and lack of religious affiliation. The researchers described their center as being used extensively by young people, the socially disadvantaged and those who are isolated or lacking social supports. They found that symptomatology is only one factor in whether or not a person becomes a patient. The authors concluded their report by stressing the importance of social integration

for achieving intrapersonal stability. They stated "It is almost as though these individuals have sought out and are willing to accept the patient role in an effort to compensate for the absence of viable social supports" (p. 415).

Jackobsen, Regier & Burns (1978) examined data on the use of mental health services to identify the relationship of demographic and diagnostic variables to rates and patterns of utilization. The setting was Charlestown, a Boston, Massachusetts neighborhood. The population was described as largely white, cohesive, working class, with enclaves of white-collar professionals and welfare recipients. Data were presented in both percentages and/or rates, not necessarily both, so that understanding the findings was somewhat difficult. The authors concluded that 5% of the population used the center. The majority of the patients were of low socioeconomic status. A high proportion of the utilizers were children and married adults.

Rosen, Olarte & Masnik (1980) conducted a study of the utilization patterns of a community mental health center in an urban ghetto area in New York City's Spanish Harlem. Data collected from 235 client charts over a one-year period of time showed that a majority of the individuals utilizing the mental health services were non-white, relatively young (averaging 36.9 years of age), divorced or single, non-high school graduated, unemployed, and of low socioeconomic class.

Bachrach and Zatura (1980), in a study conducted in Salt Lake City, Utah, to, in part, compare service utilization of a community mental health center with the social characteristics of the census tracts and to compare the social characteristics of clients with those of the catchment area population. The setting was described as containing a large university population, the downtown population, and suburban housing. The population was described as predominantly white with 10% of the population below poverty level. Their data showed that census areas with higher proportions of disenfranchised groups (e.g., divorced, low SES, and non-white) had high utilization rates at the mental health center. Their proportion of divorced, high school educated and unemployed who utilized the services was higher than their proportion in the population.

The utilization studies, through center sampling, indicate that utilizers of any specific mental health facility have characteristics unique to the community and consistent across all of the utilization studies. Four variables were found to be indicative of high utilization. These variables are marital disruption, low socioeconomic standing, unemployment, and young age. The study by Tishler et al. (1975) was the only one located that attempted to link symptomatology in the community with patienthood. The study concluded that there had been overutilization of clinic service by persons who do not have psychiatric symptoms.

There has been extensive literature by rural mental

health workers describing barriers in providing services to rural populations (Berry & Davis, 1978; Conference Report, 1977; Daniels, 1967; Duran, 1970; Gertz et al., 1975; Jeffrey & Reeve, 1978; Lee et al., 1974; Wedel, 1969). These barriers indicate a disparity between the provision of mental health services and the use of the services by the rural community.

Epidemiological research has provided the foundation for the development of most mental health services (Tarail, 1977). These researchers identify: over age 65, female, disrupted marital status and low socioeconomic status as variables associated with vulnerability for mental illness (Edgerton et al., 1970: Husaini et al., 1979; Leighton et al., 1963; Srole et al., 1962).

Utilization research indicates a perceived need for mental health services as demonstrated by client use of the services. Variables found to be associated with mental health clinic use are: young age, unemployment, disrupted marital status and low socioeconomic standing (Bachrach et al., 1980; Jackobsen et al., 1978; Rosen et al., 1980; Tishler et al., 1975).

Summary

The Task Panel on Rural Mental Health (1978) cites the lack of research on rural mental health issues as a major factor inhibiting effective program planning of mental health services for this segment of the population.

The panel stated that the most important concern facing rural mental health service delivery is relevant services. It recommended that research into rural mental health issues include conducting clinical investigations and program evaluation studies which are specific to rural areas. It was proposed, by this investigator, that a program evaluation study which examines client use of a rural mental health clinic could fulfill both of these objectives.

Needs assessment research and utilization studies provide a data base with implications for planning mental health service delivery. Estimates derived from epidemiological studies indicate that 10% of the population has need for mental health services (Tarail, 1977). At the present level of development a relationship between vulnerability for mental illness and use of mental health services has not been established. Only two variables were found to relate to both epidemiological findings and utilization findings. These variables are disrupted marital status and low socioeconomic status (Bachrack et al., 1980; Edgerton et al., 1970; Husaini et al., 1979; Jackobsen et al., 1978; Leighton et al., 1963; Rosen et al., 1980; Srole et al., 1962; Tishler et al., 1975). Leighton et al. (1963), in his needs assessment study, presented the hypothesis of the relationship between social integration and mental health status.

Data from epidemiological studies identified: over age 65 and female as variables associated with vulnerability for

mental disorders. Those over age 65 have been identified as low users of mental health services (Hegabak, 1980). Utilization studies have identified unemployment and young age as factors associated with mental health service use. Rosen et al. (1980) and Tishler et al. (1975), in their respective utilization studies, concluded that factors other than symptomatology are associated with higher mental health clinic use. These researchers, in evaluating clinic use, both proposed that community mental health services fulfill a role as a social service support agency as well as a treatment center for mental illness.

From the review of the literature three concepts emerged which helped to guide this investigation of rural mental health service use. These concepts were: those at risk for developing mental disorders; community disorganization as a factor to the development of mental disorders; and stigma as a barrier to service delivery. Epidemiological research attempts to identify the sociodemographic characteristics which identify those at risk for developing mental illness. Grundy (1973) argued that the term at risk should be confined to describing contributing factors in illness. He proposed the term risk marker as a more accurate definition of the epidemiological measures which are not amenable to intervention. Leighton (1963) has proposed that level of community organization or disorganization is a risk factor in the development of mental illness.

Stigma or fear of identification with mental illness has been cited as a major barrier in the delivery of mental health services to rural populations. That fear of mental illness might be related to the rural value system of independence and self-sufficiency. Larson (1978) described value systems as governors of behavior. In that context, the rural value system contributes to the lack of use of mental health services.

The nursing question being asked in this investigation was, "Who uses a rural mental health clinic?" This utilization study investigated the sociodemographic characteristics of clients at a rural mental health clinic which is located in a rural community.

Chapter II

METHODS

Design

This investigation described the utilizers of a community mental health center's rural satellite clinics in terms of their sociodemographic and illness attributes. Retrospective record review was used to collect data.

Setting

The setting for this study was a County Community Mental Health Center's three rural satellite clinics. This Center was a federally funded comprehensive mental health agency providing a full range of mental health services, as outlined by federal guidelines. The Center served a catchments area population of 241,919 (Census of Population and Housing, 1980). The three rural satellite clinics serve a sub-population of 62,120 persons in the catchment area. The newly released 1980 population census indicated that the county had a 45.8% population increase over the past 10 years.

The three rural satellite clinic sites were chosen to facilitate use of the services by the rural population. The rural clinics provided adult and adolescent outpatient

services. Clients in need of other mental health services are referred to the appropriate program component, such as alchohol and drug abuse services or aftercare services (an integrated service for the chronically mentally ill). Appointments for services at the rural clinics were obtained by two methods. The major one was by phone call for services to the Center's central appointment center. The other method was requesting services by walking into one of the rural clinics. The rural clinics were staffed by a mental health team consisting of six mental health professionals. The team rotated between the three clinics, providing services eight hours a day, Monday through Friday.

At the time of this study, the county in the study was an extremely heterogeneous county, containing a mix of urban and rural populations. The areas defined as rural, and served by the three rural satellite clinics were primarily rural and manufacturing areas with older settlements (Appendix A). The rural areas consisted of small lumber companies and agricultural areas. Housing tended to be relatively crowded (over 6 persons to a home) and fairly old. Income and education levels of the adult population residing in the areas were fairly low. A high proportion of the population lived in poverty. Socioeconomic status was described as low with a high proportion of both men and women occupying low status jobs. A high proportion of the families were large (6 or more members). Transportation problems presented substantial

barriers to service delivery in these rural areas. The rural areas are characterized by a traditional value system.

Sample

The subjects of this study were all of the Center clients who reside in the designated rural areas and sought treatment during time period from July 1, 1980 through June 31, 1981. This client population included those clients seen in the three rural satellite clinics and those who had been referred to more appropriate center programs.

Variables

Both sociodemographic data and program data were collected on each client. The variables were selected on the basis of the literature review; their definition was limited by agency forms and procedures for data collection. These factors also preclude assessment of reliability and validity.

Independent Variables:

Each client was described in terms of the following sociodemographic variables:

1. age
2. sex
3. ethnic group
4. marital status
5. education level
6. employment status
7. occupation level
8. income level

In addition, data relevant to program utilization for each client was collected; variables included:

1. program assignment
3. hospitalization for

2. diagnosis — psychiatric illness in the past five years

4. proximity to clinic

Dependent Variable:

The major dependent variable was utilization of the rural mental health clinics. This variable was measured by counting all of the clients seeking services from the Center with addresses in the rural areas served by the rural clinics.

Procedure:

Client data was obtained on computer printout from the Center data processing division by the Center statistician. Data pertinent to the study was then extricated, by this investigator, by identifying the rural code of those living in the prescribed rural location. This data was then grouped into individual variable aggregates for frequency distribution analysis. Due to the limitations of data retrieval cross tabulation of the variables were not possible.

Protection of Human Subjects

This researcher had no direct access to individual client records. The data analyzed were an aggregate of socio-demographic data and program data, collected from the client records by the Center's statistician from computer files of the Center. Approval for data retrieval was obtained from the Administrative Office of the Center prior to data collection (Appendix A).

Data Analysis

Data analysis consisted of frequency distributions for the sociodemographic variables and the program data variables. These data were compared with findings from utilization studies to identify commonalities in the patterns of clinic use. The data were compared with epidemiological studies to identify those in the community who were likely to need mental health services but were not receiving the service. At the time of the study the only 1980 Census data available was population census. Statistics on demographic data were not yet available therefore a comparison of client with the entire population was not possible.

Chapter III

RESULTS AND DISCUSSION

Little research exists concerning rural mental health issues. The purpose of this study was to describe the demographic characteristics of those in a rural community who used a rural mental health clinic. Sociodemographic data and client program data were collected from all of a county Community Mental Health Center clients who resided in the designated rural areas and sought treatment during the time period July 1, 1980 through June 31, 1981. Frequency distributions for the study variables were compared with findings from other utilization and epidemiological studies.

Clinic Use

The three rural mental health clinics serviced a rural population of 62,210 (26% of the total county population). During the time period of the study, 419 individuals sought services from the rural clinics. This was less than .01% of the rural population or a utilization rate of approximately 7 per 1000 population. Fity percent of those seeking services were referred to other center services; 40% were referred to a drug or alcohol program and 10% were referred to a chronic care program. Ninety-two clients reported they were seeking

services for the first time and 90% lived within 10 miles of a clinic.

The comparing of clinic use with other utilization findings was difficult because of the variety of methodological differences in data collection and procedures and because of service differences. The rate of 7 per 1000 population can be compared to a 48.7 per 1000 rate reported by Jackobsen et al. (1979) and national rate of 17.9 per 1000 per private and out-patient services (Regier & Goldberg, 1973).

The literature indicated that rural populations are low-users and unlikely-users of all mental health services (Berry & Davis, 1978; Daniels, 1967; Duran, 1970; Gertz et al., 1975; Jeffrey & Reeve, 1978; Lee et al., 1974; Wedel, 1975). Recent studies suggested that rural people, if they perceived a need for mental health services, would prefer to obtain those services in a city where privacy could be maintained (Taylor, 1982). Rural individuals have been described as self sufficient, turning to family and neighbors for emotional, social and economical support (Hanton, 1980; Hegabak, 1980). Youmans (1977) suggested the primary support network in a rural community takes the place of outside mental health resources.

Epidemiological findings have served as a source for estimating the need for services in community mental health service delivery. Federal guidelines for community mental health services recommended that services be provided for the

10% of the general population identified by episdemiological researcher as vulnerable for mental disorder (Tarail, 1977). The services of the rural clinics were planned to target this 10% impaired population.

Recent investigators into rural mental health issues advise caution in interpreting psychiatric epidemiological research and drawing assumptions about rural populations (Babich, 1982; Task Panel on Rural Mental Health, 1978). Flax (1979) and Taylor (1982) addressed the issue of expected use of rural mental health services based on ascribed need for services rather than on community defined need for services. Flax (1979) pointed out that measures of mental health derive their norm from urban populations and suggested that rural residents, especially the poor and the elderly with strong rural values, will always appear deviant on these measures. The Task Panel on Rural Mental Health (1978) recommended that mental health services to rural populations should be structured around the rural culture and value system.

Description of Utilizers

The age and sex distribution of the rural clinic utilizers is shown in Table 1. Almost half of those using the clinics were between the ages of 24 and 44, with 84% of the sample under 44 years. Those 60 years and older comprised only 4% of the sample. These findings are consistant with most utilization studies (Bachrach et al., 1980; Jackobsen et al., 1978; Rosen et al., 1980; Tishler et al., 1975) which found

Table 1

Age and Sex Distribution of Utilizers,

Rural Mental Health Clinic, 1981

	Utilizers	
Age and Sex	Number	Percent
1-17	79	19
M	43	10
F	35	8
18-24	70	17
M	53	13
F	17	4
25-44	203	48
M	113	27
F	90	21
45-59	49	12
M	29	7
F	20	5
60+	15	4
M	8	2
F	7	2
Totals	416	100
M	247	59
F	169	40

young age to be associated with increased use of community mental health services.

The rural clinics were used slightly more by males, in all age ranges, than females. Males comprised 59% of the sample. Kessler, Brown, and Browman (1981), reporting on four large-scale surveys of sex differences in psychiatric help seeking behavior, found a consistent tendency for women to seek psychiatric help at a higher rate than men. Of the utilization literature reviewed sex differences varied in relation to service use. Jackobsen et al. (1978) and Rosen (1980) reported clinic use significantly higher by women than by men. Tishler et al. (1975) combined sex and age for measuring clinic use. They reported use to be more dependent on age group rather than on sex.

A large proportion of the sample were referred to an alcohol program. The rural staff reported that this group was primarily male, and many have been required to obtain services by legal agencies. Greater use by males may reflect low use by the rural population and a high referral for mandated services.

Epidemiological studies have identified the elderly as a population vulnerable for developing mental health disorders (Edgerton et al., 1970; Husaini et al., 1979). The elderly in this study were low users of the rural clinics, a finding noted in other utilization literature (Bachrach et al., 1980; Jackobsen et al., 1978; Rosen et al., 1980; Tishler et al.,

1975). Hegabak (1980) reported the elderly as under-utilizers of all mental health services. Hanton (1980), in a study on the rural aged, found the elderly depend on their extended family and neighbors as their primary helping resource and are unlikely to use formal services.

There was a greater proportion of non-white admissions, 8% of the sample, than in the general county population which was 3%. The population from which this sample was taken had such a low non-white population that it was difficult to draw meaning about race and clinic use. Moreover, the findings on the relationship between race, mental disorders and utilization of mental health services are inconclusive. Bachrach et al. (1970), Rosen et al. (1980) and Tishler et al. (1975) found that race was a factor in using mental health services, reporting blacks as more likely to use the services. In contrast, Jackobsen et al. (1978) did not find a relationship between race and clinic use in their Boston study. Edgerton et al. (1975) found race to be a factor for developing psychiatric problems, yet, Husaini et al. (1970) failed to find such a relationship.

The marital status of the rural clinic sample is presented in Table 2. The married and living as married were the largest proportion of individuals seeking services at 31% of the sample. Singles (after deducting those under 17 years) and disrupted marital status were almost equally represented at 23% and 22% of the sample. This finding contrasted to

Table 2

Marital Status of Utilizers

Rural Mental Health Clinic, 1981

	Utilizers	
Marital Status	Number	Percent
Married	142	30
Living as Married	5	1
Divorced	56	13
Separated	31	7
Widowed	7	2
Single	180	42
Unknown	16	4
Totals	419	99

most utilization literature which identified marital disruption to be associated with high clinic use (Bachrach et al., 1979; Rosen et al., 1980; Tishler et al., 1975). Jackobsen et al. (1978) also found married adults to be the most frequent users of their Boston mental health service.

Unfortunately, there was no recent data describing marital status in the general population of this community. Utilization research and epidemiological research were inconsistant in defining marital status. Some of the studies identified singles as one variable and disrupted marriage as another (Bachrach et al., 1980; Husaini et al., 1975; Jackobsen et al., 1978; Rosen et al., 1980) while other studies used married and not married as variables (Edgerton et al., 1970; Tishler et al., 1975). Rosen et al. (1980) found singles to be the highest users of their Spanish Harlem mental health clinic. Tishler et al. (1975) found the not-married group to be the highest clinic users in New Haven.

The educational level of the rural utilizers is shown in Table 3. Those with a high school or greater education were the largest proportion of those seeking services from the rural clinics. A surprising number of the sample (29%) did not designate their education status. Education level was inconsistently related to utilization of mental health services and may be a reflection of community variation. This community, although the income level was fairly low, was a predominately white population with ready access to

Table 3

Education Level of Utilizers

Rural Mental Health Clinic, 1981

	Utilizers	
Education Level	Number	Percent
Not a High School Graduate	96	23
High School Graduate	137	33
Education Beyond High School	63	15
Unknown	123	29
Totals	419	100

educational resources. Tishler et al. (1975) in New Haven, and Rosen et al. (1980) in Spanish Harlem, found lack of a high school education a factor in higher clinic use. The utilization study conducted in Salt Lake City (Bachrach et al., 1980) reported high school education to be related to high clinic use.

In epidemiological studies; education, income, and employment are generally grouped into a classification of socioeconomic status (Edgerton et al., 1975; Husaini et al., 1979). In these needs assessment studies low socioeconomic status has been identified with vulnerability for developing mental disorders.

Table 4 shows the employment status of those seeking mental health services. The largest proportion of clinic users were unemployed or working less than full time. After deducting those under 17 years and those who did not specify employment status, 48% of the sample were unemployed or looking for work. Twelve percent were employed less than full time and 29% were employed full time. During the time period of the study the present recession had begun to have a serious impact on the rural community under investigation. Utilization researchers (Bachrach et al., 1980; Jackobsen et al., 1978; Rosen et al., 1980; Tishler et al., 1975) have found unemployment consistently related to increased use of mental health services. Epidemiological surveys have generally identified employment as a component of socioeconomic status.

Table 4

Current Employment Status of Utilizers

Rural Mental Health Clinic, 1981

	Utilizers	
Employment Status	Number	Percent
Full Time	121	29
Part Time	29	7
Irregular	22	5
Looking for Work	33	8
Not Working	166	40
Unknown	48	11
Totals	419	100

The occupational level of the clients is shown in Table 5. Occupation was a write-in item on the Intake/Admission Record (shown in Appendix B) which was then coded into one of 16 categories. For purposes of this study, this investigator grouped these 16 categories into the following classifications: white collar worker; blue collar worker; service worker; student; and homemaker. Thirty-five percent, a major proportion of the clients did not write in their occupation. Of those who did report occupation blue collar workers were the largest group seeking services. Although neither the utilization or epidemiological studies reviewed dealt with occupation as a separate variable, low occupational status had been suggested as relating to both prevalence (Edgerton et al., 1970; Husaini et al., 1979; Leighton et al., 1963) and demand for service (Bachrach et al., 1980; Jackobsen et al., 1978; Rosen et al., 1980; Tishler et al, 1975).

Table 6 presents the distribution of the utilizers' estimated monthly income, based on family income. The data indicated a strong relationship between low income and an increased use of the rural clinics. Seventy percent of those using the clinics had a monthly income of less than $750.00.

Epidemiological research generally included income as a component of socioeconomic status. Low socioeconomic status has been consistently associated with vulnerability for developing mental disorders (Edgerton et al., 1970;

Table 5

Occupation Level of Utilizers

Rural Mental Health Clinic, 1981

	Utilizers	
Occupation	Number	Percent
White Collar Worker	44	11
Blue Collar Worker	112	27
Service Worker	27	6
Student	76	18
Home Maker	15	4
Unknown	145	35
Total	419	101

Table 6

Estimated Monthly Income Distribution of Utilizers

Rural Mental Health Clinic, 1981

	Utilizers	
Estimated Monthly Income	Number	Percent
0-499	238	57
500-749	55	13
750-999	29	7
1000-1499	49	12
1500-1999	25	6
2000-2499	12	3
2500+	11	2
Totals	419	100

Husaini et al., 1979; Leighton et al., 1963; Srole et al., 1962) and with patienthood (Bachrach et al., 1980; Jackobsen et al., 1978; Rosen et al., 1980; Tishler et al., 1975).

The program assignment of the rural clients is presented in Table 7. Whether treated in the rural clinics or referred to other Center programs, each individual seeking services was assigned to a program category. Those assigned to the Child, Adolescent and Family Program or to the Adult Services Program were primarily followed in the rural clinics. Those assigned to Transitional Services (a chronic care program) or to Alcohol and Drug Services were referred to other programs within the Center system. The data shows that 208 of the 419 individuals seeking services were provided service by the rural clinics. Slightly more than half of the sample were referred to services outside the rural clinics. Approximately 40% of the service seekers (169 individuals) were referred to the Alcohol and Drug Service. Of these 169 persons, 119 were referred to alcohol services and 50 persons were referred to a drug abuse service. Rosen et al. (1980), the only other utilization study noted to address clinic referrals, reported that 25% of their clients were referred to other services.

Diagnosis of the clinic utilizers were based on the American Psychiatric Association (APA) Diagnostic Classification system. The general breakdown of the diagnostic categories are listed in Table 8. The greatest frequency of

Table 7

Program Assignment of Utilizers

Rural Mental Health Clinic, 1981

	Utilizers	
Program Assignment	Number	Percent
Child, Adolescent, Family	77	18
Adult Services	131	31
Transitional Services	42	10
Alcohol, Drug	169	40
Totals	419	99

Table 8

Diagnosis of Utilizers,

Rural Mental Health Clinic, 1981

	Utilizers	
Diagnosis	Number	Percent
Substance Abuse	117	28
Anxiety Disorder	115	28
Personality Disorder	27	6
Schizophrenic Disorder	25	6
Marital Problems	25	6
Disorder of Infancy, Childhood, and Adolescence	23	6
Affective Disorder	13	3
Anti-Social Problem	10	2
Organic Mental Disorder	4	1
Interpersonal Problem	4	1
Psychosexual Problem	1	0
Diagnosis Deferred	52	12
Totals	416	99

diagnosis were in two categories: anxiety disorder (28%) and substance abuse (28%). The frequency of anxiety as a diagnosis was discussed with the rural treatment team. Members stated that a diagnosis of anxiety was frequently given to meet requirement for client insurance coverage. According to the team, many of the diagnostic categories in the APA Diagnostic manual were not included for payment by the insurance companies. Further analysis of the data, however, indicated only about 15% of the clients had coverage with medical insurance companies. Jackobsen et al. (1978) and Rosen et al. (1980), after assessing the variable diagnosis in their respective studies, concluded their services had a high use by those with major psychiatric illness.

In this study there appeared to be a strong relationship between alcohol and increased use of the rural clinics. Approximately 28% of those seeking mental health services from the rural clinics were diagnosed as having a substance abuse problem and were referred to an alcohol program. This portion of the sample included those who have been mandated by the court system to receive alcohol treatment. The inclusion of court mandated treatment as a variable would have added considerably to the data received as the rural staff anecdotally reported that virtually all of those referred to an alcohol program had been court ordered to seek services.

Utilization literature did not report as high a percentage of alcohol related admissions as was found in this study.

The Boston neighborhood study (Jackobsen et al., 1978) reported 2.4% of their clinic users as having an alcohol disorder. The Spanish Harlem study (Rosen et al., 1980) listed alcoholism as accounting for 11% of the diagnosis recorded at evaluation. The 1971 National Institute of Mental Health (NIMH) diagnostic data showing distribution for outpatient episodes of psychiatric services, reported that alcohol disorders account for 5.4% of the admission diagnoses (Jackobsen et al., 1978).

The rural team, in responding to the information, felt alcohol abuse was a more significant issue in clinic use than drug abuse. They described the community, at the time of the study, as undergoing the impact of increased unemployment with the local bars serving as a meeting place for the idle timber workers.

The literature reported less alcoholism in rural communities than in urban (Cahalan, 1974; 1977). Alcohol studies, however, have been plagued with methodological problems (Furst & Bechman, 1981; Kitteridge, Franklin, Thrasher & Berdiansky, 1977). Other studies suggested there may be a greater incidence of alcohol abuse in rural communities than previously expected. Recent data, from surveys of health care needs in rural Montana, identified alcoholism as a frequently cited mental health problem (Taylor, 1982). Cockerham (1977) reported white rural adolescents value drinking and consider complete abstinence almost deviant. Hatch (1973) reported that rural communities exert strong social pressure to keep drinking problems from intruding into the

local system.

The history of prior episodes of mental health service use, including hospitalizations is presented in Table 9. Ninety-two percent of the sample reported they were seeking services for the first time. The utilization literature reviewed was inconsistent on episodes of clinic use. Rosen et al. (1980) reported 55% of their clients had no prior psychiatric history. Jackobsen et al. (1978) and Tishler et al. (1975) did not address the issue of prior service.

Table 10 shows approximate distance of clients' residence from the clinics. Not all clients were seen in the clinic nearest to their residence. Movement within the three rural clinics might occur because of client or therapist preference. A client might choose to have follow-up services in one of the neighboring towns rather than chance being seen, by friends or neighbors, entering a mental health service. And as noted earlier, half of all the clients who came initially to the rural clinics were treated in programs other than those offered by the rural clinics. Bachrach et al. (1980), in their Salt Lake City study, found that distance to the service did not relate to clinic use. Jackobsen et al. (1979) conversely, suggested that a close proximity of the clinic to the client increased the effectiveness of clinic use. Much of the rural literature cites transportation difficulties as a major problem in the delivery and use of rural mental health services (Berry & Davis, 1978; Daniels, 1969; Duran,

Table 9

History of Utilizers Mental Health Care in Last 5 Years

Rural Mental Health Clinic, 1981

	Utilizers	
Admissions	Number	Percent
1st Admission	384	92
Inpatient	15	4
Out Patient	12	3
Both Above	6	1
Unknown	2	0
Totals	419	100

1970; Gertz et al., 1975).

This portion of the study has presented the results of sociodemographic data and client program data about users of three rural mental health clinics; and discussed the results in relation to the literature and this particular rural community. Where applicable, the frequency distributions for the study variables were compared with findings from epidemiological and utilization studies. Similarities and differences were found between use of urban mental health clinics and use in the rural clinics. Differences seemed to reflect inconsistency in the variables chosen for utilization research and individual community differences.

For most of the clients seeking services at the rural clinics this was a first interaction with a mental health service. The person who most frequently used the clinics was a young, unemployed, married male with a low income. He was likely to have been a high school educated blue collar worker. Alcohol appeared to be a major factor in those seeking mental health services and may represent a community problem. The total rural population did not use the clinics in the numbers that could be expected.

Limitations

The utility of the information gained through utilization studies is limited. The data from this study, as with other utilization studies, provides no information as to why the studied variables are associated with more or less clinic

use. There is also a problem of what to measure the data against. The data might be measured against prevalence data or compared against other programs and populations as attempted in this study. The lack of uniformity across utilization research design limits comparison between the various available studies.

Further limitations to data interpretation exist within the design of this particular study. The 1980 U.S. Census demographic data was not available for comparing the findings from this study with the sociodemographic characteristics of the community. Nor did the design include other mental health resources within the community which might be used rather than the rural clinics. The inclusion of a broader range of variables could have led to a greater understanding of the patterns of clinic use, such as mandated versus voluntary help seeking behavior.

A further limitation was the types and arrangements of the data received from the mental health center. The resource for data collection was unable to provide information for cross-tabulation of the data, a measure which would have added meaning to the data.

Chapter IV

SUMMARY, CONCLUSION IMPLICATIONS AND RECOMMENDATIONS

Summary

The 1978 Task Panel on Rural Mental Health reported that the lack of research in rural mental health issues contributes to the imbalance in rural mental health service delivery.

A review of the rural mental health literature identified barriers to mental health service delivery. These barriers included: acceptance of the mental health system by the rural community, the stigmatizing effects of mental disorders, and population dispersal. There was no literature found about the clients who use rural mental health services. Epidemiological literature and utilization literature identified variables in the general population which relate to those who need and those who use mental health services; and served as a guide for this investigation of a rural mental health service.

The goal of this investigation was to describe the sociodemographic characteristics of clients of a rural mental health service in order to provide direction for clinical practice and to contribute to the body of under-

standing about rural mental health issues. Sociodemographic data and client program data were collected on all of the rural catchment area population that sought services from the community mental health center during the time period of July 1, 1980 through June 31, 1981. The frequency distribution of the variables were compared with the literature and analyzed in relation to the community.

A comparison of the data from this rural utilization study with other utilization literature indicated similarities and differences among rural and urban mental health clinic users which have implications for practice and further research. Young adult status, unemployment and low income were variables associated with increased use of all mental health services. This study suggested greater clinic use by married males rather than by females in marital distress, as was found in other utilization findings. The general population used the clinics in fewer numbers than might be expected. The elderly were also found to be low users of the service, a group identified by epidemiological studies as vulnerable for developing mental disturbance. There was a high incidence of clinic use by those with alcohol related problems.

Limitations were encountered in both the design and the methodology of the study.

Conclusions and Implications

The goal of this study was to describe the clients of a rural mental health service to provide direction for clinical practice and to contribute to the understanding about the use of rural mental health services. The data from this study, through comparison and analysis in relation to the literature, accomplished that goal. Conclusions have been drawn about: the rural client seeking mental health service in this community; and the mental health clinic.

There were more differences than similarities found between clients of the rural clinics and users of urban mental health services. The sociodemographic profile of the most frequent rural clinic user was a young, high school educated, married male with a low income. This client was likely to have been a blue collar worker who had recently lost his job due to changing economic conditions and may have been court mandated for alcohol abuse. This profile contrasts rather sharply with the most frequent client at an urban mental health center who was a young, unskilled, unemployed female of disrupted marital status, with a low income (possibly on welfare). The first profile is suggestive of an individual experiencing an acute reaction while the second profile is suggestive of a longer chronic problem. Each profile points to different problems and needs of the client.

The similarities found between this study and other utilization studies were: young adult, unemployment and low

income. These findings describe a young person without money or a job. Tishler et al. (1975) concluded that the clients most often using their New Haven clinic were young adults with life problems and few social supports, who used the clinics for a support system. These similarities provide clues with implications for planning rural mental health services. Community mental health services, including the clinics in the study, are often patterned after a traditional mental health model. This model generally includes a diagnosis, perhaps medication and therapy. Sensitivity to the stigmatizing effects of "being crazy" has been a major factor inhibiting mental health services to rural people. A program that minimizes the medical connotation of mental illness, focusing on meeting the current psycho-social and economical needs of the client through training or retraining, may be more relevant and acceptable to rural populations.

Meeting the needs of individuals with psychological, social and cultural problems presents practical and ethical problems for the mental health movement. How can these problems in rural communities be met? Who would be the appropriate personnel to meet such a broad range of needs? Should community planners and educators be included in the treatment team? Would that be feasible with the lack of resources and funds which restrict rural health care delivery? Should there be a retraining program and should it be in the rural community or in the nearest large urban center?

How would transportation problems be solved? What other programs and goals would meet psychological, social and cultural needs in rural areas?

What is the role of the mental health center in meeting the need of those experiencing difficulty coping with life situations? Should the service be that of a socio-economic agency? Or should the services be limited to assisting persons in learning coping skills? These are ongoing, unresolved questions that plague the mental health community in providing services to rural populations.

The differences found between the rural clinic users and the urban utilizers in the literature appear to be related to the communities in which the studies were conducted. The profile of the rural clinic user was suggestive of a young male in an acute life situation during a time of community change and disintegration. The profile of an urban clinic user was suggestive of a young divorced female seeking services for a progressively stressful situation, which might be related to the disruption of an interpersonal relationship. In urban environments young divorced females, especially those with children, are likely to be living in a low socio-economic neighborhood. Leighton et al. (1963), from his Stirling County study, proposed that mental illness was related to community disintegration. The findings from this study, when compared with other utilization findings, suggested both individual and community level in integration might be related to an individual's level of mental wellness.

When compared with the literature and Center estimates of use, there was low clinic use by the general rural population, as measured by the rate of use per 1000 population. A conclusion drawn from this investigation, however, was there is no applicable measure of expected use of the rural clinics. Estimates for service have been, for the most part, based on professionally ascribed need for services and may have no relationship to how the clinics are actually used. The individual most in need of mental health services, as identified by needs assessment findings, was an elderly female, over 65 years of age, with a disrupted marriage (probably due to death of spouse). According to findings from utilization studies, this profile of a little old lady, isolated in a one room walk-up apartment or in a nursing home is the very individual least likely to seek out mental health services. This profile also contrasts markedly from those who do perceive and act on a need for those services. To date there has been no link between those identified as needing mental health treatment and those who seek out that service. Further research is needed to identify both those in need of mental health services but not using available resources, and those who use mental health services but are not identified in current needs assessment research.

The data from this study suggested problems with alcohol have played a primary role in the use of the rural clinics. Forty percent of the clients seeking services were referred

to an alcohol program. The data may reflect either clinic or community issues. The high incidence of alcohol referral may reflect resistance on the part of the community to use other aspects of the rural clinics. The data may reflect a high incidence of alcoholism in the community. Or, the clinic may have an effective substance abuse program with integrated referrals and services. The data may also be due to an actively involved local court system. Implications are for further assessment of the relationship between alcohol issues and the community, and alcohol services and the rural clinics.

In summary, the main conclusion drawn from this study is that this rural community has unique characteristics, factors which should play a major role in identifying the community's mental health problems and needs. Perhaps other rural communities are also unique. This study has pointed out the lack of knowledge about need and demand for services. The findings suggest that persons who seek mental health services have socio-demographic characteristics which can be related to levels of community stability. It is also suggested that the community from which this study was conducted may have a problem with alcoholism which may or may not need additional or different mental health services. Further research is urgently needed, as was called for by The Task Panel on Rural Mental Health (1978), to guide mental health actions in rural communities.

Recommendations

Utilization research gives directions for investigation and gains strength with repetition. This researcher recommends that further rural utilization studies be done to develop a data base about rural mental health use. The use of a basic format with similar variables for utilization study designs would facilitate comparisons of clinic use across a variety of settings.

Utilization studies are necessary for program evaluation. More rural utilization studies are needed to evaluate the appropriateness and relevancy of the services being provided to the particular community.

Delivery of relevant mental health services for rural populations have been hampered by the lack of research identifying the mental health needs of those living in rural communities. Needs have, for the most part, been ascribed by urban researchers. Further research, in the form of needs assessment surveys and specific to rural residents, is needed to identify the mental health problems, needs and wants of this population.

There has been no link between epidemiological data on vulnerability for developing mental illness and utilization of mental health services. Findings about incidence and at-riskness are measures of professional opinion and utilization data are measures of client opinion. Research into the causative factors associated with help seeking behavior

is needed.

The literature reports that rural communities are resistant to accepting mental health services. There is little available information about how those in rural communities meet their mental health needs. Research targeted towards identifying the natural caregivers in rural communities would begin to alleviate the deficit. Observation/ participation studies conducted in a rural community would facilitate this knowledge.

The data from this study indicated a major proportion of the utilizers of the rural clinics have alcohol related problems. Recommendations for further research include continuing efforts to identify special problem areas in rural communities, such as drug and alcohol related issues among rural populations.

This study has provided information that the clinic has found useful in examining its role in the community. The rural team indicated that a study of the needs of these particular communities is imperative for a thorough evaluation of the rural clinics program. The study has raised questions about the appropriateness of using epidemiological studies done in other communities as a primary guideline for program planning. It has indicated the necessity for more research about utilization of services and the sources of mental health help in rural communities. This exploratory study has, as was intended, indicated the need of and direction for other research.

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APPENDIX A

CLACKAMAS COUNTY COMMUNITY MENTAL HEALTH CENTER

ADMINISTRATIVE APPROVAL FOR DATA COLLECTION

CLACKAMAS COUNTY

DEPARTMENT OF HUMAN RESOURCES

COMMUNITY MENTAL HEALTH CENTER 65

ROBERT J. KING, Ph.D.
DIRECTOR

February 25, 1982

To Whom It May Concern:

This memo is to document that Helen J. Gavin is working with Clackamas County Mental Health Center in gathering information on our rural clients. Her proposal has passed our Research Committee. The Centers understanding is that she will not be contacting individual clients or presenting information with respect to any particular client. Data presentation will be group form, and consequently, we do not view her project as a threat to client confidentiality.

Sincerely,

Byron N. Fujita, Ph. D
Senior Psychologist

BF/jb

ADMINISTRATION & PLANNING
FLAVIA HALL - P. O. BOX 164 - MARYLHURST, OREGON 97036 - 655-8651

APPENDIX B

INTAKE/ADMISSION RECORD

CONTACT RECORD

me: Last First M.I.

INTAKE / ADMISSION RECORD
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se Number: __ __ __ __ __ Date of Birth: __ __ / __ __ / __ __

take Interviewer: __ __ __ __ RU: __ __ __ __ Date: __ __ / __ __ / __ __ Time: __ __ : __ __ A.M. P.M.

ouse's Name (if applicable): (30)

ddress: (25)

ty: (16)

ate: __ __ Zip Code: __ __ __ __ __

nergency Contact: (30)

ddress: (25)

ty: (16)

ate: __ __ Zip Code: __ __ __ __ __

one: (__ __ __) __ __ __ __ __ __ __

elationship:
) Parent
) Spouse
) Sibling
) Friend
(5) Other Relative
(6) Legal Guardian
(7) Unknown
(9) Other

ient's Legal Status at Admission:
) Voluntary
) Voluntary (Court Recommendation)
) Involuntary (Under Court Order)
) Involuntary (With Legal Pressure)

ving Arrangement:
) Alone
) With Spouse
) Parents / Relatives
) Foster Parents
) Group Home
(6) Institution
(7) With Friends
(8) Refused
(9) Unknown

otal Number of Dependents including Self _____
umber of Dependents (including self):
Under 6 yrs. of age _____ 18 to 64 yrs. of age _____
6 to 17 yrs. of age _____ Over 64 yrs. of age _____

ype of Residence:
) House / Mobile Home
) Rooming House
) Group Quarters
) Homeless
(5) Apartment
(6) Nursing Home
(7) Jail
(9) Other _____

rents Living:
) Both
) One Parent
(3) Neither
(4) Unknown

ilitary Status:
) Never Served
) Veteran
) On Active Duty
(4) In Reserves
(5) Retired
(6) Spouse / Dependent

Employment Status:
(1) Full-Time
(2) Part-Time
(3) Irregular
(4) Looking for Work
(5) Not Working
(9) Unknown

Occupation: _____
Code: __ __

If Not Working, What is the Reason:
(01) Disabled
(02) Drinking Problem
(03) Homemaker
(04) Hospitalized
(05) In Jail
(06) Looking for Work
(07) No Skills
(08) Not Looking
(09) Retired
(10) Seasonal
(11) Student
(12) Laid Off
(13) Other _____

Currently in School? (Y) (N)
Highest School Year Completed: __ __
Completed the Following:
(1) High School or G.E.D.
(2) Associate / Bachelors
(3) Advanced Degree
(4) Voc / Bus / Tech
(5) Special Education
(6) None of These

Mental Health Care in the Last 5 Years:
(1) Inpatient
(2) Outpatient/Day Treatment
(3) Both #1 and #2
(4) None
(5) Unknown

Admissions During Last 5 Years: __ __
If any Oregon Hospital / School, Which: _____
Code: __ __ __ __

Date of Last Release: __ __ / __ __ / __ __

Client Citizenship: _____ (8)

Language Preference: _____ (8)

Client Number for Other Organizations:
(1) NIAAA No. __ __ __ __ __ __ __ __ __ __
(2) NIDA No. __ __ __ __ __ __ __ __ __ __
(3) OSH No. __ __ __ __ __ __ __ __ __ __
(4) Dammasch No. __ __ __ __ __ __ __ __ __ __
(5) _____ No. __ __ __ __ __ __ __ __ __ __

Number of Arrests During the Past Year:
(1) DUIL __ __
(2) Drug Related __ __
(3) Other __ __ (Specify) _____

Any Legal Charges Pending? (Y) (N)

If Yes, What: _____

ase Number: __ __ __ __ __

ross Family Income for Last 12 Months: __ __ __ __
ross Family Income Last Month: __ __ __ __

eceiving Welfare? (Y) (N)
Yes, Which Programs? (May specify up to two programs.)
Program 1 Code: __ __ __ __
Program 2 Code: __ __ __ __
elfare Case Number: __ __ __ __ __ __ __ __ __ __

itle XIX (Medicaid) Information
Eligibility Code: __ __
Certification Date: __ __ / __ __ / __ __
Effective Date: __ __ / __ __ / __ __

ealth Insurance Information: (Circle all that apply)
) Medicare
) Medicaid (Title XIX)
) Blue Cross
(4) C.H.A.M.P.U.S.
(5) V.A.
(6) Other Insurance

sured's Name:
(30)

nployer Name:
(30)

surance Co.:
(30)

ddress:
(30)

ty / State / Zip:
(30)

nsured's Group or Plan Number:
__ __ __ __ __ __ __ __ __ __

nsured's ID / Social Security Number:
__ __ __ __ __ __ __ __ __ __

ledicare Number:
__ __ __ __ __ __ __ __ __ __

ledicaid (Title XIX) Number:
__ __ __ __ __ __ __ __ __ __

ient Served by Other Agency: (Y) (N)
ame:

ode: __ __ __

gned Releases for Information? (Y) (N)

ame: _____

ame: _____

ame: _____

Allergies to Medication:

1. _____ Code: __ __ __ __

2. _____ Code: __ __ __ __

3. _____ Code: __ __ __ __

Number of Hospitalizations for Reasons Other than Mental Health:
Last 5 Years: __ __
Last Year: __ __
Reason for Last Hospitalization:

_____

_____

Most Recent Discharge Date: __ __ / __ __ / __ __

If Client is a Minor or Has Legal Guardian, Name of Parent or Legal Guardian:
(30)

Address:
(25)

City:
(16)

State: __ __ Zip: __ __ __ __ __
Phone: (__ __ __) __ __ __ __ __ __ __

Guardian has Signed Consent to Services? (Y) (N)

Relationship to Client:
(1) Parent
(2) Spouse
(3) Sibling
(4) Friend
(5) Other Relative
(8) Court
(9) Other

On Waiting List: (Y) (N) RU: __ __ __ __

Person(s) Completing This Form Sign Below:

Client Signature: _____

Staff Signature: _____

To Be Filled Out by Center Staff Only

Gross Monthly Income: $_____
Number of Dependents (including self): _____
Maximum Monthly Charge: $_____

CONTACT RECORD

e Number: __ __ __ __ __ Reference: __ __ __ __ __ __ __ __ RU: __ __ __ __

te: __ __ / __ __ / __ __ Time: __ __ : __ __ A.M. P.M.

t Name: _____ (16) First Name _____ (10) Initial ____

dress: _____ (20) City: _____ (16)

te: __ __ Zip Code __ __ __ __ __ Census Tract: __ __ __ __ __ __

me Phone: (__ __ __) __ __ __ - __ __ __ __ Other Phone: (__ __ __) __ __ __ - __ __ __ __

thdate: __ __ / __ __ / __ __ Social Security: __ __ __ - __ __ - __ __ __ __ Sex: (M) (F)

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scussed Fees: (Y) (N)
ent Insured: (Y) (N)
mpany
_____ (30)

se Status at Center:
First Contact (3) Prior Client
Present Client (4) Unknown
or Name:
_____ (20)

nic Group:
1) White (07) Puerto Rican
2) Black (08) Cuban
3) American Indian (09) Other Hispanic
4) Alaskan Native (10) Southeast Asian
5) Asian (98) Refused
6) Mexican (99) Unknown

try Code:
) Voluntary (3) Court Supervised
) Emergency (4) Court Committed

ogram Area Assigned:
) Alcohol (2) Drug (3) MED

esenting Problem: (Circle up to three)
) Child Guidance (5) Alcohol
) Adult Problem (6) Drug
) Marriage / Family (7) MR
) Hospital Follow-up (8) In-Patient

arital Status: (Current)
) Never Married (5) Separated
) Married (6) Living as Married
) Widowed (8) Refused
) Divorced (9) Unknown

urce of Family Income: (Circle three primary)
) Wages (5) Dividends
) Social Security (6) Pension
) S.S.I. (7) Alimony
) Welfare (8) Other _____

pe of Contact:
) Emergency Telephone (5) Telephone
) Emergency Walk-In (6) Walk-In
) Emergency Appointment (7) Planned Appointment
) Home Visit (8) Institution

Contact Type:
(1) Direct (2) Informant (3) Referral

Informant Name:
_____ (30)
Phone: (__ __ __) __ __ __ - __ __ __ __
Relationship:
(1) Parent (5) Other Relative
(2) Spouse (6) Legal Guardian
(3) Sibling (7) Unknown
(4) Friend (8) Other

How did Contact Hear about Program?
_____ Code __ __ __

Referral Source
Name:
_____
Code: __ __ __ __ __ __ __
Phone: (__ __ __) __ __ __ - __ __ __ __
Individual Name:
_____ (25)
Follow-up after __ __ __ Days

Disposition:
(1.0) Referred to Intake: RU __ __ __ __
(2.0) On Waiting List
(3.0) Contact Decided Against Service
No Further Service by Center—
(4.1) No Service Required
(4.2) Requested Service Not Available
(4.3) No Space Available
(4.4) Unsuitable for Treatment
(4.5) Institutionalized
(5.0) Problem Resolved
(6.0) Decision Deferred by Contact
(7.0) Decision Deferred by Staff

Staff's Overall Assessment: __
If Admitted to Intake:
Date: __ __ / __ __ / __ __ Time: __ __ : __ __ A.M. P.M.
Staff: __ __ __ __ RU: __ __ __ __

Contact Duration: __ __ : __ __
Staff No. 1: __ __ __ __ Time: __ __ : __ __
Staff No. 2: __ __ __ __ Time: __ __ : __ __

Signature: _____

Abstract

The literature on rural mental health suggests that rural populations are resistant to accepting mental health services. There was no research located describing utilization of rural mental health facilities. This descriptive retrospective clinical investigation describes the users of a county community mental health center's rural satellite clinics in terms of socio-demographic and illness attributes of clinic utilizers.

Sociodemographic and client program data were collected on all of the rural clients seeking services from the rural clinics during the time period of July 1, 1980 through June 31, 1981. A frequency distribution of the sociodemographic and client program variables were compared with findings from utilization and epidemiological research.

Similarities and differences were found between the socio-demographic variables associated with increased clinic use in the rural clinics and utilization literature. Similar variables were a higher use by young unemployed individuals. In this study the most frequent clinic user was a married male while in the utilization literature the most frequent user was a female in marital distress. The variables most often associated with frequency of use in the rural clinics were: young adult status, males, unemployed, low income and referral to an alcohol program. The elderly and the

total rural population served by the clinics were associated with low utilization.

Implications and recommendations are given pertaining to research and program planning for the rural clinics.