Review

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Evidence-Based Social Work Interventions to Improve Client Attendance in Rural Mental Health: An Overview of Literature

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ABSTRACT

A patient's unwillingness to adhere to scheduled appointment affects the patient, the clinic, and the community. Several barriers have been identified that increases the no-show rates among patients. While the rates of no-show have remained about the same throughout history, evidence-based interventions are needed to provide consumer with a continued and steady treatment regimen. Evidence-based interventions are particularly important to increasing attendance in rural mental health. Social workers are an important link between the patient getting adequate mental health services and attending services. Social workers development of evidence-based interventions will assist in breaking down the challenges associated with barrier to no-shows. The results of this study highlight the importance of evidence-based social worker interventions on improving client attendance in rural mental health.

KEYWORDS: No-Show; No-Show interventions; Rural social work.

INTRODUCTION

Client non-attendance has been an issue throughout mental health services for many decades. It is a difficult problem to solve due to the individuality of each person and influencing factors within each life. Some researchers have narrowed their studies to specific populations but still cannot eradicate no-show behaviors. Clients non-attendance of scheduled appointments is an issue among all services within mental health. Missing scheduled appointments can create an array of problems not only for the client but for the facilities as well. When clients miss their appointments, it can "interrupt the patient's treatment which may have serious adverse medical and/or psychological consequences, and they disrupt efficient utilization of staff time".[1] Even more important is that children attend the necessary mental health appointments to prevent their current illness from developing into a more severe, treatment-resistant mental illness later in life. Untreated mental illness in children has also been linked with "school failure, teenage childbearing, unstable employment, early marriage, marital instability, and violence".[2]

While many researchers have focused their studies on one particular population such as HIV positive or African American lower class, few have researched the barriers and interventions specific to rural communities. Before discussing characteristics of social work in rural areas, it is important to define urban and rural areas first. Different countries have differ-

ent criteria for urban/rural classification.[3] According to the 2010 Census of the United States, urban areas must encompass at least 50,000 people in the US, and rural areas encompass all population, housing, and territory not included within an urban area.[4] As of 2010, 51 million US residents, about 1/6 of the total US population, lived in rural areas.[5] This makes up a small portion of the population; however, "rural people should be considered an at-risk or diverse group based on their high rates of poverty, lower life opportunities, and stigmatized social status".[6]

The purpose of this paper is to review evidence-based social work interventions used in rural mental health to improve client attendance. It is important to address this topic because of the lack of research and the unique barriers experienced by residents in rural areas. For example, rural areas have a lower population density which indicates that rural residents must drive further distances to reach others and services. Long distance leads to inadequate access to services and little knowledge of available resources.[7] We hypothesize that distance, lack of resources and lack of knowledge about resources are going to be major barriers determined by previous researchers. If these are the biggest barriers, then interventions for rural services should target these issues. While rural areas have several barriers preventing formal services and client attendance, these communities also have some advantages which can help to improve appointment attendance through community team work, co-ordination, and know-how.

METHODS

In the initial screening stage, we compiled and reviewed 50 articles with titles or abstracts relating to the specific keywords used for this paper, and 12 articles were excluded because they did not meet the specific inclusion criteria, including 1) evidence-based research article, 2) social work interventions, 3) exploring barriers preventing client attendance, 4) having urban and/or rural designation/comparison. These articles were categorized based on their information and year of publication to determine their usefulness in relation to the purpose of the paper. Finally, we included 38 articles published up to 2013 (the year when this study was conducted) that met our search criteria in this review.

Participants

The participants within the studies ranged from adolescents to older individuals and the sample size varied. The participants in the research literature included patients, clinicians, treatment groups, patient with diagnosis, administrative staff, and social workers. One study, for example, included both an urban group of 433 individuals and a rural group of 586.[8] Patients that already had DSM-IV diagnosis were included in six of the articles. Even though the participants changed with the study, many articles identified similar struggles and barriers.

Procedures

The research designs used in the studies were quantitative and qualitative. Several articles used questionnaires, follow-up letters, interviews, and telephone calls to gather their data. Focus groups consisted of referred patients from outsourced agencies. Clients who attended initial appointments were used to identify rates of follow-up appointments. Administrative staff and professional staff made calls to patients to remind them of their appointments. Clinicians responded to open-ended questions as to why participants did not show up for their appointment. Only one study used a new no-show policy to reduce their no-show rates. Interviews were audiotaped and transcribed verbatim. Patients records where used to gather demographic information and assist in identifying barriers.

RESULTS

The literature reports that no-show rates continue to be an issue, and most literature reports interventions that only reduce the rates. Several studies identified multiple socioeconomic and demographic variables as predicts of no-shows. Other studies concluded that differences in socio-demographic characteristics between rural and urban areas come into play when talking about the behavior and attitudes. Literature reports that the most common reason to missed appointments is forgetfulness. Barriers included perception and availability to treatment. Interventions from four studies concluded that a telephone call before the initial appointment was increased the show rates of clients. Studies suggested that importance of the client and therapist relationship in attending appointments, family support and access to transportation impacts a client participation in services. Social workers can be an important keep to increasing client's attendance to appointment. In order for social worker to connect the pieces, they need to understand the individuals and community needs and being part of the family to address needs. In the following sections, we discussed specific findings from literature in regard to no-show, no-show evidence-based interventions, and characteristics of social work in rural areas.[9]

No-show

Different definitions of "no-show" have been used in literature, including failed appointment, noncompliance, nonattendance, and drop-outs.[10] Due to the missed appointments or dropping out of treatment, consumers do not receive enough care to benefit.[11-16] It is estimated that 20-57% of missed appointments occur at the time of intake or the first clinical appointment.[2,17] Fenger and colleagues[17] reported that demographics such as younger age, being unmarried, unemployed, and less educated result in increased predictors of no-shows. Lower socioeconomic status and unemployment are the only demographic variables related to poor adherence when it comes to predictors.[10,18,19] Other predictors of no-show include "substance abuse, psychiatric illness, less knowledge about the disease and treatment, and

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absence of subjective distress".[20,21] Grunebaum and colleagues[20] suggested "environmental factors such as distance from the clinic, weather, time of day, and day of the appointments".

Several different issues affect the client's attendance to treatment. Lacy and colleagues[22] reported that long waiting time for appointments led to the less likeliness a patient attending an appointment. Consumers reported issues such as trouble getting of work, child care, transportation, and cost and reasons why they could not attend appointments.[16,18,19,22] Clinicians reported that client's misconception about therapy and negative attitudes might also result in no attendance.[23-26]

No-Show Evidence-Based Interventions

As indicated in Table 1, many interventions have been studied and discussed over and over again to address the no-show phenomena, including reminders prior to the appointment, engagement groups to increase client awareness, effects of wait time on attendance, issuing a no-show policy, making contact after the missed appointment, orientation letters to raise client awareness, reducing caseloads and improving supervision, and focusing on the client-therapist relationship.

Interventions Tested	Resources	No-show Reduction Rate
Telephone Reminder	12,14,27,28	(difference between control and phone groups) 46%; 24%; 20%; *17%
Orientation Letter	13,14,28	(difference between control and orientation groups) 28%; 21%; 23%
Reminder with an Orientation Letter	14,28	(difference between control and combination groups) 36%; 21%
Letter reminder	13,27	(difference between control and reminder group) 23%; 8%
Engagement Sessions (after missed appointment)	17,29	(difference of no-show percentages before and after intervention)29%; 17%
Motivational Therapy (before appointment)	30	32% reduction in no-shows
Client-Therapist relationship	12	(difference betweenspecific group and the control) Therapist direct contact: 24% reduction Staff direct contact: 9% reduction

*This is an average of the reduction in no-show rates between the staff direct contact and therapist direct contact.

Table 1: Commonly tested interventions among reviewed resources.

The most frequently investigated intervention seems to be before-appointment reminders. These vary depending on the study and seem to have been addressed for decades and continue to be examined. While some tested with telephone contact versus a mailed letter, others compared the time period it was performed, such as one day before the appointment versus three days before the appointment, particularly in rural settings[13,14,27]

The individuals who received some kind of contact one day before their appointments had the highest attendance rate. It is also important to note that those who were informed of what would happen during the appointment also had a high attendance rate. For instance, in a study by Kluger and Karras,[14] 141 adult callers were randomly assigned to one of the following groups: orientation statement only, which describes the plan for the initial appointment, is read over the phone after the appointment is scheduled to the participants; orientation statement and phone prompt; phone prompt only, which is done within in 24 hours of the appointment; and a control group who received no orientation statement and no phone prompts. The lowest no-show rate (20%) was among the participants who received an orientation statement and a phone call 24 hours before the appointment.

A few of our included studies in this review also examined the effectiveness of telephone prompts and orientation letters.[12,28] For example, Shoffner and colleagues[12] examined if a telephone reminder made a day before the appointment would increase client attendance and if it mattered whether the call was made by the staff or the therapist. This study separated clients (N=451) from two rural clinics into three groups; one receiving no phone call, second receiving a phone call from the staff, the third group receiving a phone call from the therapist. The researchers used a random method when assigning the conditions to the clinics. The study lasted nine weeks during which time the clinics applied each condition for three weeks. It was determined that the clients who received a call and spoke directly to the therapist had a high rate of attending their appointments and were significantly more likely to attend compared to those who did not receive any reminders. Similarly, Mooney and Johnson[10] assessed client attendance within a rural mental health center. The researchers reviewed appointments that were kept, cancelled, or failed to be kept within a 30-month period. During this time period, 1509 appointments were scheduled and 17% of those were no-shows. The study also showed there were a greater number of no-shows for the initial appointments than there was for ongoing appointments. The researchers also concluded that the client-therapist relationship might play an important role in attendance.[10,12]

Other interventions[11,30,31] tested patient outreach programs, such as Motivational Therapy and Cognitive Behavioral sessions offered prior to hospital discharge. This was meant to establish a relationship between the client and the therapist and increase client awareness, personal responsibility, and the client's sense of self-efficacy. For instance, the study by Daley and Zuckoff[30] resulted in an increase, from 35% to 67%, in client attendance for the initial outpatient appointments. The researchers also concluded that the client who did attend the motivational therapy session had a 79% rate of treatment compliance. This study further determined those who attended individual sessions were more likely to their initial outpatient appointment than those who attended a small group session.

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Several researchers also reviewed many interventions tested by previous researchers to evaluate which has been studied most often, and what factors have been determined to be statistically significant.[18,23,32] Bostwick[32] reviewed 37 studies that examined why clients were not keeping their appointments, discontinuing during the intake phase, and discontinuing during treatment. At the time of this study, the researchers stated there were actually no studies specifically designed to examine no-shows. Of the studies reviewed, 14 addressed intake dropouts while 32 addressed treatment dropouts. Among the studies, three determined that individual treatment proved better at maintaining clients than group treatment. Several studies focused on setting characteristics such as role induction procedures, like interviews, which have shown to increase the client's likelihood to complete the intake phase, though seemed to have no effect throughout treatment.

Characteristics of Rural Social Work

Weinert and Long stated, "In studying rural health problems, there is no homogeneous rural America and it is reasonable to expect that health differences among various rural areas and subgroups may be pronounced" (as cited in Strickland and Strickland).[33] Rural areas continue to have fewer resources than urban areas, as noted in this article. Barriers to treatment include characteristics such as functional illiteracy, client's negative views of treatment and staff, pride, and stigma within the rural community. Studies also suggest that individuals within rural communities assume the role performance model of health, "the assumption that one is healthy as long as she or he is able to be productive, to work, and to carry out usual roles of functions".[33] The researchers conducted a study including 281 lower-income black rural households to examine the barriers to preventative health services in rural areas for lower-income black families. The results of this study indicated that the most common barrier for rural individuals was the cost of services (53.6% of households). While the participants did not mention a lack of services providers as a barrier, service providers in both public and private systems greatly expressed that programs for lower income individuals were severely underfunded. Transportation and lack of a telephone were also rarely identified by the participants within this study however other studies identify transportation as a more common barrier.

Templeman and Mitchell[7] acknowledged the underemployment of rural residents and that these residents are twice as likely to earn minimum wage as compared to urban residents. Rural children are also more likely to experience long term poverty. Clearly, there is a need for services within rural communities based on this information, though these services are limited and often difficult to access by rural individuals. Public transportation is also rare within rural areas making it more difficult to reach services to meet health, mental health, educational and other social service needs. The researchers directed a focus group of 50 social workers, social work students, and allied helping professional to examine how the needs of rural and urban

children differ in Texas and to develop a plan for change. This forum found that rural communities have several assets including strong family values, voluntary helping networks, resourcefulness, and resilience. Social workers can build on these assets to help communities overcome barriers. Barriers included a lack of economic opportunity, isolation, low population density, and restricted mobility. These barriers can account for inaccessibility of services, increased mileage costs, limited services hours and poor coordination of services. These barriers can lead to a low quality of services, provider burnout, and understaffing. To help overcome some barriers, the focus group suggested building strong communications between the informal helping groups and community leaders to develop information and referral programs. This can help increase awareness of available services to those living in isolated areas.

Mateyoke-Scrivner, Webster, Staton, and Leukefeld[34] define rural areas as an area with a population less than 50,000 residents combined with its adjacent areas. One-fifth of the US population and one-third of the nation's persons in poverty reside in rural areas. This study focused on drug court treatment retention in rural and urban areas to better understand the differences between the clients in each area. The study selected 500 participants from two drug court sites for the comparison. While this article was meant to focus specifically on drug court, it noted a few important characteristics of rural areas which can help when shaping an intervention specifically for this area. Determined from the results, there were no significant differences found between rural and urban participants in relation to completion or termination. It was also noted that rural individual who did not complete the program were more like to have a lower education than those who did complete. Overall, rural participants were more likely to be less educated, with fewer children and a lower employment status than urban participants. On the contrary, this study also documented that rural participants reported a higher income than urban participants even though they were less likely to be employed full-time.

Goins and colleagues[35] examined the barriers reported by rural elders when accessing health care. The study consisted of 101 adults over 60 years of age. Transportation was discussed with traveling to out of town services as a common barrier. Other barriers included a limited number of doctors and long-term care options, lack of quality healthcare, social isolation and financial constraints. Harju and colleagues[8] also discussed some of these rural barriers and share that the barriers tend to discourage compliance. The authors studied the attitudes of rural residents towards healthcare and determine that, "Rural residents' attitudes are particularly salient since this community has comparatively less income, education, and fewer wellness behaviors or healthcare services nearby."[8] Riebschleger[6] stated that, "rural people should be considered an at-risk or diverse group based on their high rates of poverty, lower life opportunities, and stigmatized social status."She gathered information from two focus groups consisting of eleven social workers discussing suggestions for engaging in effective social work practices in rural areas. The

participants suggested for social workers working in rural areas to strive to understand the rural community, it groups, and its individuals, deal with the high rates of poverty and scarce resources, utilize the informal resources within the community and adjust to a slower pace of change. The informal resources within rural communities and clearly noted as important advantages of the rural areas and should be identified within the community addressed. These resources included neighbours helping each other and also stated that the rural social workers may be expected to be involved within the community as well.

Edwards, Torgerson and Sattem[36] studied the issue with providing services to homeless youth within rural areas. The study reported multiple barriers that have been mentioned in previous studies, including low population and population density, a lack of public transportation, and large areas requiring longer driving routes for services. Some service providers in this study attempted to set up services within the largest of the small towns in hopes that the target population would come to them. This did not, however, solve many issues, considering that the smaller towns within rural areas do not typically provide bus transportation and therefore prevented individuals who did not live close to the larger town from attending their appointments.

Furthermore, Kempt and colleagues[37] also acknowledged transportation and distance to clinics as barriers to reaching appointments when they conducted a survey of 40 women in rural areas. Lewis, Scott and Calfee[5] also recognized distance as a barrier as well as waiting time, and lack of child care. They also mentioned informal helping networks, concern for others, and a shared value of self-reliance as some of the strengths of rural communities. Churches have also shown to play a large role in providing support to individuals and families within rural communities and can be very helpful in linking individuals with the resources and services they may need by creating a partnership between the church and formal supports. Schools also can help to provide linkage between services for individuals. The researchers further suggested that the schools could potentially be used as a base for services during the hours that the school building is not being utilized. This provides the rural area with a closer location to receive necessary services, one that is frequented by the local citizens already.

DISCUSSION

Among the interventions reviewed, each one seems to result in a similar rate of no-show reductions which can strengthen the idea that any intervention is better than none at all. It is also critical to carefully develop a positive, appropriate client-practitioner relationship. According to the articles discussing social work practice in rural areas, it is important to build a rapport with the individuals within the community to increase compliance and attendance. Other studies have strengthened this theory by showing that clients are more likely to show for appointments when their therapist contacts them with a reminder instead of contact by the agency staff.

Of the 38 articles, only 13 specifically addressed rural populations, most of which narrowed the focus even more to smaller populations such as HIV-positive women in rural areas, homeless youth in rural areas, drug court participants in rural areas, or rural older adults. While these articles are useful in developing interventions towards each specific group, it may be more cost effective and efficient to determine an intervention that could be effective for rural areas as a whole community. Of the 13 addressing rural areas, three focused on the barriers affecting rural social work and solutions or suggestion for effective rural practice. It is evident that more research should be conducted to expand the knowledge base of practitioners within rural communities. Several articles address the reasons and predictors for individuals who miss appointments and it may be beneficial to use this information to develop an intervention based on the more common explanations.

High no-show rates negatively affect not only the clients but also the agency. Clients miss out on needed treatments when they do not attend appointments and doing so may have strong medical or psychological consequences.[1] These appointments can be seen as "wasted" and leave "less appointments available to other patients".[25] While many reasons for missing appointments have been determined, the most repeated has been forgetfulness and the long wait times between scheduling and the actual appointment time. It is plausible to consider that these two reasons may be connected and suggest that because of the long wait times clients may forget the scheduled appointment. Therefore, reminder contacts, by telephone or letter, could be an effective intervention to reduce the no-show rates based on these reasons. This intervention is one that could be implemented for most agencies, though may not be practical for clients without telephones. Rural individuals may be among those who do not have phone connections because of the high poverty rates; hence rural social workers may require a more creative approach when developing interventions for no-shows. As one participant in Riebschleger's study stated, when working in rural communities, "The community is the client".[6] Others have also noted that rural communities have a higher level of concern for other rural residents with many informal helpers from neighbours to churches. Because of these strong community ties, rural socials workers are encouraged to become involved within the community to better understand the individuals, families, and groups being served.

CONFLICTS OF INTEREST

The authors declare that they have nothing to disclose.

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