Enhancing the Utilization of Outpatient Mental Health Services

Daniel L. Larsen, Ph.D.
Tuan D. Nguyen, Ph.D.
Rex S. Green, Ph.D.
C. Clifford Attkisson, Ph.D.

ABSTRACT: This article describes two sets of field studies undertaken by the program evaluation unit of a community mental health center. These studies analyzed clients' utilization of service and assessed service impact in the process of testing procedural variations in service delivery. In the first set of studies, a procedure for ensuring verbal client-therapist contact prior to the first appointment was developed and tested. This procedure reduced the no-show rate for initial appointments from 22 to 12%. In the second set of studies, a brief pretherapy orientation nearly eliminated dropout during the first month of therapy. Orientation had both short- and long-range impact on the amount of services used by clients as well as on their outcomes. Therapist's global ratings of client functioning reflected more change for oriented clients, who reported greater short-term symptom reduction as well. Non-oriented clients were more likely to drop out early and to impress their therapists less favorably. The results of these studies suggest that a combination of pretherapy orientation and verbal client-therapist contact prior to the initial appointment might greatly reduce the failure to complete treatment.

Evaluations of human service programs all too often produce findings that are seldom used, especially in decisions to modify or eliminate existing programs (Attkisson, Brown & Hargreaves, 1978; Davis & Salasin, 1975; Windle & Volkman, 1973). Greater utilization of evaluation findings can be accomplished by relating evaluation activities directly to policy and administrative issues, as well as by integrating them with program planning (Patton, 1978). Areas where this relevance can be enhanced include the examination of the operations of the service delivery

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system, the identification of potentially beneficial changes in service delivery, and the assessment of the usefulness of these changes before and after their implementation. This article reports a series of such investigations, focusing upon two factors that have a direct impact on mental health service utilization: first appointment no-show and early dropout from treatment.

There are two compelling reasons to reduce the extent of no-show and early dropout. The first reason is client-focused: A reduction in no-show and dropout rates should enhance appropriate service utilization and enable clients to derive greater benefit from existing services. When clients drop out of treatment early, they may have received less than optimal benefit; furthermore, they may retain negative reactions toward the services received. Similarly, when prospective clients request services, but do not arrive to receive them because of barriers to accessibility or procedural problems (e.g., too long a wait), their needs may never be met.

The second reason for reducing no-show and early dropout stems from a consideration of systemic efficiency: No-show and dropout increase the number of unfilled appointment hours, thereby decreasing staff productivity and increasing the per-unit cost of services provided. As an illustration, consider an outpatient clinic that costs $162,000 per quarter to operate and can provide up to 3,600 client visits per quarter, for an average cost per client visit of $45.00. Suppose that in a given quarter 120 no-shows and 180 dropouts occur. Not filling these hours reduces to 3,300 the number of actual client visits provided and increases the cost per visit to $49.09, or a 9.1% increase in per-unit cost compared to the situation when attendance is perfect. Furthermore, if a declining number of new clients requests services, these caseload vacancies may take time to fill, further increasing the per-unit cost (Sorensen & Grove, 1978).

The no-show and dropout problems were studied using a three-phase approach. Phase I consisted of accessing the existing data base to obtain sociodemographic, service utilization, and outcome data, then conducting post-hoc exploratory analyses to relate these three types of data. This “exploration” phase attempted to ascertain whether the service delivery system was in fact experiencing the identified problems. Phase II, “solution generation,” involved integrating the observed findings with relevant theories and research findings in order to identify possible solutions that could be implemented on an on-going basis. Phase III, “impact assessment,” consisted of experimental or quasi-experimental tests of the planned-change procedures in actual service settings to determine whether the identified problem was in fact ameliorated.

At the time of these investigations, the community mental health center (CMHC) under study was highly decentralized. Its clinics were dispersed throughout the catchment area in order to maximize accessibility of services to area residents. Public transportation was excellent and awareness of services within the community appeared to be good. Evening appointments were available, requests for services were usually handled promptly, and treatment was not denied because of inability to pay. Also, special services