Spring 2012

Obstacles to Attending Treatment in an Urban Mental Health Clinic: A Client's Perspective Approach to Identifying Factors Influencing Treatment Attendance

Nicholas M. Delaney
The College at Brockport, ndela1@brockport.edu

Obstacles to Attending Treatment in an Urban Mental Health Clinic: A Client's Perspective

Approach to Identifying Factors Influencing Treatment Attendance

Nicholas M. Delaney

The College at Brockport, SUNY

Abstract

The majority of clients seeking, and participating in, mental health treatment face a variety of barriers to their regular attendance; much of the focus, however, has continued to be centered around the experience of the provider and not on the client. The following research investigates the perceptions held by clients in an urban, low income, mental health setting, about what barriers they face. Clients completed a survey asking them to identify, on a likert scale, the degree to which they experienced barriers in several areas as they pertained to their mental health treatment. Clients also identified ways in which they believed they could be aided by the clinic in circumventing their barriers. The research findings, though descriptive in nature, point towards an institutional blind spot that allows for lower income clients to fall through the cracks of the mental health care industry.

Obstacles to Attending Treatment in an Urban Mental Health Clinic: A Client's Perspective

Approach to Identifying Factors Influencing Treatment Attendance

Literature Review

According to the most recent data available from the census, the United States is home to 308,745,538 people; 234,564,071 of whom are adults, eighteen or older (US Census Bureau, 2011). Of these people, roughly 31,666,149 adults, or 13.5%, are involved in mental health treatment (NIMH, 2008). The statistics are misleading, however, when one considers the information reported by the National Alliance on Mental Illness (NAMI) that indicates that one in four American citizens will suffer from mental illness at some point in their lives (NAMI, 2009). The disparity between the two reports points to the disparity between those who suffer from mental illness and those who actually engage in mental health treatment. Despite a consensus of those in the mental health community that overcoming client barriers is paramount in delivering successful treatment, little is known about the nature of this problem. With mental illness constituting the largest cause of disability in the country, efficiency and effectiveness in treatment must remain of the utmost importance (Mohr et al., 2010). Much of the existing research done on barriers has a strong clinic based focus. Such a focus tends to aim towards increasing institutional profits and efficiency, while neglecting the overall experience of the client. This narrow view limits the variety barriers being identified. For that reason, much of the work will be critically analyzed to better understand the client element.

Developing a better understanding of why clients experience barriers when seeking help is essential to improving their treatment. Client attendance may be one of the most important

factors influencing the effectiveness of the therapeutic process (Coulter, 2007). Client nonattendance, or low kept appointment rates, remains a serious problem facing clinicians, clinics, as well as, clients (Mohr et al., 2006). Client nonattendance and low kept appointment rates are used interchangeably, and both refer to occurrences in which clients have a scheduled appointment and fail to attend, reschedule, or cancel the appointment. The issue of client nonattendance is not new; much of the literature points to a long standing struggle between health care providers and clients around attendance (Mohr et al., 2006). In fact, a search of the literature reveals several other disciplines (i.e. chiropractic, massage therapy, dentistry, optometry) facing the same predicament and striving to find the answer to the same question: how can the problem of client non-attendance be reduced, or even eliminated from the helping relationship?

The most commonly missed counseling appointments are the preliminary engagement session for the client, known as *intakes*. By the time clients reach out for services, they have realized that they cannot manage their symptoms alone (Tambling, Johnson, Templeton, Santilli & Melton, 2007). Once a client finally reaches out for help it is important that the client is seen as soon as possible; clients who experience short wait times between initial contact and their intake appointment are more likely than those who experience a longer wait time to attend their intake appointment (Tambling et al., 2007). A missed intake appointment is particularly troubling when viewed in the larger context of access to mental health care treatment. When intake appointments go unattended, the provider is not meeting the need of the individual seeking treatment. Moreover, missed intake appointments are also the least likely to result in a rescheduled appointment, which often translates to an individual left unsupported (Lester & Harris 2007). Intake appointments that are neither kept nor rescheduled are likely representative

of an individual who has been negatively affected by the intake process (Festinger, Lamb, Marlow & Kirby, 2002; Tambling et al., 2007). Appointments also tend to require more people to be involved (intake worker, benefits staff, etc.); leaving more people negatively affected by an appointment no show.

The Effects of Missed Appointments

The struggle between clinic and client over attending set appointments is much more than an issue of convenience or courtesy. Often, an appointment that is not kept can serve as a meter for the provider's ability to predict and intervene on the barriers faced by his or her clientele (Hampton-Robb, Qualls & Compton, 2003). Clients of a mental health clinic, possibly more than any other area of health care, depend on their providers to aid them in circumventing their barriers to accessing care. Missed appointments often prove detrimental to the mental health of the client. For some clients, a missed appointment could mean more time spent in treatment (Ambrose & Beech, 2006). Ambrose and Beech stressed that by missing sessions a client can halt or regress in relation to the progress that they have made in treatment. The client could also suffer monetarily due to the tendency some clinics and private practices have towards charging for services regardless of whether or not the client attends the session. Although practical for the providers, this billing practice could contribute to a fracturing of trust and effectiveness in the therapeutic process.

The other members impacted by the phenomenon of client non-attendance are the clinicians and clinics that cater to them and the cost of a low kept appointment rate can often times be a heavy burden (Hampton-Robb et al., 2003; Lester & Harris 2007). It is estimated that an average one-hour billable counseling session is worth $124 (Psychology Today, 2011). With

some clinics experiencing as high as a 67% no show rate, there are clinics that are essentially losing more money than they are taking in (Hampton-Robb et al., 2003). The lack of productivity in a clinic equates to fewer occupational opportunities for clinicians and staff at the site (Vujicic, Addai & Bosomprah, 2009). The cost can put many serious restraints on a clinic. Although service providers obviously suffer monetarily due to missed appointments, the costs are not limited to those measured in money. As a result of marginal profits from low productivity, many clinics are operating understaffed. When a business is understaffed, the result is often an increase in worker responsibilities and a decrease in output quality (Swanberg, 2008); this remains true for mental health care providers who become overbooked and less effective in their positions. Standard of care is also often compromised in a setting that is affected by understaffing. The lower standard of care is the result of over worked clinicians and staff members who are unable to maintain self-care, which as a result impacts their effectiveness as professionals (Vujicic, et al., 2009).

For every appointment that is missed, another potential client is kept from being seen; many clinics that have waiting lists that are filled with clients who are waiting to gain access to mental health services (Hampton-Robb et al., 2003). The provider increases the likelihood that a client will not attend their appointment if they place the client on a waiting list. A review of the literature revealed a pattern: clients who are forced to wait for longer than one to two weeks after their initial contact for an appointment are more likely not to attend their therapy sessions (Festinger et al., 2002; Hampton-Robb et al., 2003; Tambling et al., 2007). When clients do not attend scheduled appointments, they not only cost productivity dollars to the site, they also cost another person the opportunity to be seen for services. The end result of missing scheduled appointments creates a cyclical pattern of long wait times and subsequent non-attendance.

The "No-Show" Client

The mentally ill, the poor, or the overburdened seem to be those who are most in need of the support and mental health attention, yet they are the ones who are failing to arrive at their appointments (Ambrose & Beech, 2006). While their lack of treatment is shared, the research indicates that specific barriers faced by each population are unique.

Hampton-Robb et al. (2003) found that client income can have a significant negative impact on client attendance for scheduled appointments. Their research revealed that those in the largest income range (M=70,000+) attended 78% of the time, whereas those in the lowest range (M=11,000) attended only 53% of the time. Mohr et al. (2006) found that those suffering from depression reported a higher incidence of perceived barriers to treatment. They reported that 74% of their clients with depression identified at least one treatment barrier in comparison to only 51.4% of their non-depressed counterparts. Supplemental work done by Mohr et al., (2010) found that depression was associated with a higher likelihood of perceiving barriers to treatment. The work in the above studies supports a notion that mental health diagnoses are, in of themselves, barriers to the therapeutic process. These findings (Hampton-Robb et al., 2003; Mohr et al., 2006) show the ways in which having a mental health condition can contribute to a difficulty in being able to successfully pursue treatment.

In a study performed by Cavaleri et al. (2006) "between one half and three quarters of all children with mental health needs either do not engage in treatment or drop out early" (p. 68). Researchers (e.g., Cavaleri et al., 2006) identified increased hardship for children from low SES (socio-economic status). The circumstances facing these children contribute to an increased likelihood that they will suffer from a mental illness. In addition, many of these factors

(including living in poorer communities, witnessing more crime, and receiving less education) may also become barriers to their seeking treatment. Cavaleri adds that the involvement of guardians in a child's treatment compounds these barriers.

Although the issue of nonattendance is one that is relatively generalized across the medical and helping professions, some research indicates that one can predict the clients most likely to prove problematic in regards to attending their treatment. Lester and Harris (2007) found that certain demographic identifiers were correlated with client nonattendance. Individuals who identified as divorced, unemployed, having a partner between the ages of 18-24 or having children were less likely than their counterparts to attend treatment. Mohr et al., (2010) found supporting results identifying: women, ethnic minorities, and those who were single reported experiencing higher levels of difficulty in attending treatment. Having children was also found to have a direct negative relationship with initial appointment attendance at a university-based family therapy clinic (Lester & Harris, 2007). The results of the study revealed that participants who reported having *no children* showed 60% of the time, whereas participants who reported having *five or more children* only arrived to their appointment 29% of the time. Contradictory evidence was indicated by Benway, Hamrin and McMahon (2003), who found in their review of literature spanning from 1973-2003 that demographic information was an insufficient predictor of appointment attendance. Though the findings of Benway et al. (2003) can be criticized as being outdated, their contradictory results leave questions about the generalizability of demographics and barriers.

Reasons for Nonattendance

Mohr et al. (2006) found that of 209 clients surveyed, nearly 60% of them identified at least one barrier to attending their scheduled appointments. The researchers identified two types of barriers: practical and emotional. They concluded that those barriers that were considered practical in nature (time of appointment, accessibility of clinic, etc.) were over five times more common than the emotional barriers. Research conducted by Mojtabai et al. (2011) found, however, that emotional barriers were much more likely to be the reason for clients to discontinue their treatment prematurely (82% vs. 31%). Though seemingly contradictory, the work of Mohr et al. (2006) and Mojtabai et al (2011) combines to show that where physical barriers may be overwhelmingly more common among clients, the strength of the emotional barriers have a far greater impact on the therapeutic relationship.

Emotional barriers: When considering emotional barriers, one of the most consistently identified by clients is that of stigma. The stigma of mental health treatment is often associated with fearing potential status loss and discrimination by the general public (Becker, Arrindell, Perloe, Fay & Striegel-Moore, 2010; Gulliver, Griffiths & Christensen, 2010). Stigma is overwhelmingly present when considering those in the armed forces. Servicemen and women have been shown to identify the fear of having their treatment and diagnosis recorded on their military record (Gorman, Blow, Ames, & Reed, 2011). Many outside of the armed service have become concerned about similar practices. Much of the fear is associated with the effect that their utilization of mental health treatment could have on their careers. Perceived stigma related barriers, however, decreased since 2003 (28% vs. 63%; Gorman et al., 2011). Related to the barrier of stigma is that of embarrassment. Mohr et al., (2010) indicate that the degree of intimacy found in the therapeutic setting can serve as an obstacle to clients attending their

sessions. This intimacy refers to the strength of the trust and relationship between client and clinician. Findings indicate that a stronger more trusting bond lead to an increase in client participation. Another highly identified emotional barrier to treatment is an attitude of self sufficiency. A desire to help one's self without asking for the assistance of others is a barrier that is highly prevalent across cultures, ages, and genders (Gulliver, Griffiths & Christensen, 2010; Mojtabai et al., 2011).

Researchers (e.g., Gulliver et al., 2010; Mojtabai et al., 2011) discovered that a "low perceived need for mental health services" was the greatest barrier to those with mental health diagnosis receiving treatment. Mohr et al., (2010) stated that, on average, only 20% of clients referred to mental health treatment actually pursue and attend therapy. Hampton-Robb et al. (2003) found that the individual's original referral source was a major factor in determining the likelihood that clients would attend their appointments. The researchers concluded that the more personal the relationship between the client and the referral source, the more likely the client would attend his or her session. Specifically, the study, which was based in a religiously focused counseling center, found that clients who were referred from a religious source were more likely to attend their appointments, particularly their initial appointment, at the similarly focused clinic.

In situations where an individual has a large degree of control over the actions of a client (children, mentally handicapped, etc.) the beliefs of the caregiver can be just as important than that of the client (Cavaleri et al., 2006). Researchers found that the perceptions of parents, not that of the child client, was a decisive factor on entering and continuing mental health treatment.

The client-clinician relationship was found to have a significant impact on client attendance (Ambrose & Beech, 2006; Baumann et al., 2001; Gulliver et al., 2010). Researchers (Gulliver, et al., 2010; Mohr et al., 2010) found that the influence of prior negative experiences

can have an effect on attendance even when it was not the client themselves who had the poor experience. A weak therapeutic relationship was found to be a predictor of early client termination from treatment (Ambrose & Beech, 2006; Baumann et al., 2001; Gulliver et al., 2010). Attrition was attributed to a lack of trust between the client and their provider. Motivation, denial and limited insight on the part of the client was also found to undermine the clinician's ability to detect the symptoms and struggles of their clients (Becker et al., 2010); this can lead to the client lacking trust in the therapist's ability to help.

Practical barriers: One of the most evident barriers in obtaining mental health treatment in the United States is financial (Gorman, et al., 2011; Gulliver, et al., 2010; Mojtabai et al., 2011). Financial barriers include the lack of funds to arrive at the session, to pay for the session, and lack of health insurance coverage. Sareen et al., (2007) conducted a study comparing the effects of financial barriers for low income clients. The study found that clients in the United States suffer significantly more financial barriers than the other subject countries, including Canada. The issue of financial barriers to treatment has been steadily worsening throughout the past decade (Mojtabai et al., 2011).

Hampton-Robb et al., (2003) found, through their review of the literature pertaining to predicting first session attendance, that the only consistent predictor related to non-attendance was the time interval between the date of contact and the scheduled appointment; clients who waited longer were more likely to miss appointments. Research has revealed that even a perceived long wait for treatment can negatively affect the attendance of the client, regardless of how long the wait times actually is (Lacy, Paulman, Reuter & Lovejoy, 2004; Tambling et al., 2007).

Barrier of Classism

Classism, as defined by Smith, Foley, & Chaney (2008), is the assignment of worthiness and ability of a person due solely on their given social class. The impacts of classism can be seen strongly in the context of access to service and missed appointments. The entire structure of the mental health care system reflects a society riddles with the effects of classism. The surgeon general's reports on the state of the mental health care system in America found that minority group need remain largely unmet (Chow, Jaffe & Snowden, 2003). Simply put, the researchers stated that those living in high poverty were significantly more likely to than their middle class counterparts to be referred to mental health treatment, while all together remaining less likely to actually engage in it. Chow et. al (2003) go on explain that attending treatment does not insulate members of the class minority from classism affecting their access to care identifying that minorities that have engaged in treatment are more likely to terminate their sessions prematurely. Research is now beginning to indicate that our mental healthcare system, which already favors those who can spare both capital and time, will be further discriminating against those of lower socio-economic status (Snowden, Wallace, Kang, Cheng, & Bloom, 2007). The researchers point towards capitation, the practice of paying providers according to the number of clients they see, as the culprit for the worsening conditions. A tendency towards this type of payment would increase the likelihood of strict attendance guidelines that will alienate those who do not have consistent expendable income or full control of their transportation.

Low Kept-Appointment Interventions

In the battle against low kept appointment rates, many interventions have been attempted. The interventions that appear most often are reminder letters, reminder calls, and preadmission orientation programs that introduce the clients to the process of counseling and what to expect (Cavaleri et al., 2006; Lefforge, Donohuue & Strada, 2007; Ambrose & Beech 2006). The reminder interventions are geared towards the client that has difficulty remembering their appointments and can benefit from the reminder (Booth & Bennett, 2004). These interventions have also been shown to increase the trust and improve the therapeutic bond between the client and the clinician (Lefforge et al., 2007). The intervention is effective, assuming the client appreciates the contact, is able to receive the contact, and experiences no greater barrier to treatment. It remains least effective with those who are illiterate, not fluent in the English language, have moved, or unable to pay for phone service (George & Rubin, 2003). Reminders are utilized to some degree in many clinical settings. The orientation intervention aids in the education of the client, and any others involved in the treatment explaining what should be expected from treatment (Cavaleri et al., 2006; Lefforge et al., 2007). Orientation intervention is particularly effective with those who suffer from anxiety or misconceptions in regards to the process of counseling.

Some strategies have been as simple as accommodating those with busy lives. Cavaleri, et al., (2006) encouraged clinics to modify their programs to accommodate more clients whose schedules did not allow for 9:00am-5:00pm counseling appointments. The modifications meant the addition of both evening and weekend hours. An expansion of hours is a prime example of identifying a barrier to clients and providing a solution at the clinic level. By staying open later, a clinic is providing access to care for an increased number of clients; not solely for the fact that

there are more operating hours in a day, but because now clients who were previously unable to access treatment due a barrier connected to hours of operation have been offered that ability.

Technology is increasingly becoming a medium of interest for circumventing barriers faced by clients (Mohr et al., 2010). Treatments delivered by both telephone and via the internet have become more common in the mental health care industry (Mohr, Vella, Hart, Heckman, & Simon, 2008; Stretcher, 2007). Tambling et al., (2007) found that using a web-based scheduling system significantly increased the number of kept appointments at a university based marriage and family therapy clinic. Researchers used a scheduling system that allowed all staff to access any workers schedule. The results of the research showed that a total of 74% of clients attended their first session, compared to only 57% of the control group. The web-based system allowed for clinic staff to schedule intakes much more quickly and efficiently, drastically reducing the time that a client had to wait before being seen by a clinician; a factor that has been shown to be associated with an increased no show rate among clients. The research also indicated that immediately offering a client an intake appointment was effective in increasing overall attendance at the clinic, regardless of how far out the date of the scheduled appointment was (Gallucci, Swartz, & Hackerman, 2005; Lacy, et al., 2004). A quick response to client inquiry leads to less attrition, better attendance, shorter treatment time, and better outcomes (Festinger, et al., 2002; Lefforge et al, 2007; Reardon, Cukrowicz, Reeves, & Joiner 2002). Tambling, et al., (2007) also found that those who were scheduled using a web based group waited fewer days to be scheduled, spent less time in treatment, and missed fewer sessions on average. Clinicians who participated in the web based scheduling were able to see an average of 2 more new cases per month. The scheduling intervention was beneficial to strengthening the therapeutic relationship and improving clinician productivity. A related study by Ambrose & Beech (2006)

tested the effectiveness of a *partial booking* procedure on client attendance. Partial booking involves clients requesting their desired intake time. The experimental group had an 18.5% nonattendance rate compared to the 42.9% of the control group. These aforementioned interventions revealed the effectiveness of allowing the client to remain in control and empowering them to remain the expert in their own treatment.

An intervention that seemed especially beneficial for child clients was to maximize the investment that the adult custodian had in the client's treatment (Cavaleri et al., 2006). Researchers found that several factors influenced a guardian's willingness to allow the child to continue to participate in treatment. These factors included life stressors, clinician/guardian bond, competing priorities, child-care availability, and perceived relevance and benefit of the treatment. By engaging the adult custodians in the treatment of their child, the therapist can increase the adult's investment, decreasing the likelihood that the custodian will neglect, or refuse, to bring the child to their appointments (Cavaleri et al., 2006; Minty & Andersong, 2004). Minty and Anderson (2004) suggested telephone communication with the family of a client prior to the date of the first appointment. The purpose of the phone call would be to solidify interest in pursuing treatment and involving the adult in the healing process of the youth. The intervention increases the therapeutic alliance inside and outside of the session.

Coulter (2007) suggested that the best way to reduce nonattendance rates is to spend more time focusing on the initial appointment. Coulter's research suggested that a more detailed understanding of the client at the onset of the therapeutic process would reduce the likelihood of the client losing motivation early in the process. In addition to the relationship building that would take place during these early communications, Coulter suggested that a more detailed and efficient intake process would help to instill a sense of trust and comfort in the clinic and the

clinician. This attention to detail, according to Coulter's research, is more cost effective for the clinic and fair to the client by ensuring their commitment to the process. The work by Gulliver at al. (2010) supported the notion that attention to client needs, and education about the process of counseling at intake, is essential to lowering client nonattendance.

Lefforge et al., (2007) reported *rewards* as being particularly beneficial to increasing client attendance at scheduled sessions. The rewards were described as being "monetary incentive and food coupons." Researchers indicated that these interventions were most useful when used by in-patient treatment where client interaction is more consistent. It is also noted that such an intervention would only be possible assuming the availability of funds. Researchers cautioned that discontinuation of such a system could have an adverse effect on attendance and client progress.

Rationale

There has been a plethora of research conducted on predicting those clients at-risk of canceling appointments, the results of these studies often focus on what can be done to improve client attendance. Although some of the practices that have come from the studies were found to be beneficial (reminder phone calls, client orientations, and quicker clinic response times), other practices remain highly clinic-centered and lacking in therapeutic ethics (double booking, prioritized or triaged clients, and stricter policies on client attendance (Cavaleri et al., 2006; Hampton-Robb et al., 2003). The aspect that has been mainly overlooked has been what can be done to better understand the experience of the client and what their barriers mean to them. In order to truly better clinicians' ability to help clients who are suffering from a low attendance rate, it must first be understood what it is like for the clients to face these barriers to begin with.

It remains unclear if either barrier type (practical or emotional) proves more detrimental to the progress of clients, but with over half of all clients experiencing some sort of obstacle in their journey to obtaining mental health treatment, it becomes evident that the client struggling with barriers is not in the minority. The new charge of mental health providers has become understanding the reasons for nonattendance.

Client barriers are rampant among those attending mental health treatments. It becomes the charge of the clinician and the system to aid their clients in overcoming the obstacles that hinder them from reaping the benefits they are afforded by attending therapy; and considering the breadth of barriers identified by provider and consumer, the clinician must remain cognizant of the needs of each individual client.

Client perceptions and experiences continue to constitute prominent gaps in the knowledge provided by scholarly research. The following research will focus on obtaining and understanding the perceptions and experiences of barriers for clients in an urban mental health clinic. Further the aim will be to begin understanding the desires of the client in how they believe they can be aided by the provider to reduce the impact said barriers will have on them.

Method

The research was based on the utilization of a survey instrument to collect data about client perceptions of barriers to receiving mental health treatment at an urban mental health clinic. The survey was administered over a two week period. The survey was presented to every client who arrived for their appointments during the survey period. For all clients who did not arrive for their scheduled appointments, a letter containing an invitation letter, informed consent, and the survey was sent out along with a prepaid return envelope for participants to send back

their responses. To accommodate mail delivery and completion time, mail in Survey's were accepted for two weeks longer than the survey was available for completion on site.

Participants

A total of 593 clients were eligible to participate in the research. In addition to those clients who were offered the opportunity to participate at check in, a total of 96 clients were offered the opportunity to participate via mail due to appointment non-attendance. Thirty six of those who completed the measure (88%) were adult clients and five were the guardians of a combined six children who were active clients at the clinic. Only one guardian identified being both a client and a guardian of a child client. Age demographics for the survey were compiled using the age of the client utilizing the clinic services. Client age broke down as follows, two (5%) identified as falling in the range of "61+", six (15%) in "51-60", twelve (29%) in "41-50", eight (19%) in "31-40", six (18%) in "25-30", two (5%) in "18-24", three (7%) in "13-17", and two (5%) in "6-12". The majority of those involved were female (58%, N=23) while 42% (N=18) of the clients surveyed were males. An investigation into the payers of those involved in the research found that only five percent of the clients identified any payer that was not associated with state/government funded insurance and that nearly one third of the clients identified that they utilized Blue Choice (32%) and/or Monroe Plan (31%) options of privately managed Medicaid. Further payer information can be seen in appendix A.

Instruments

Clients were asked to complete a survey that was created by the researcher utilizing treatment barrier literature in conjunction with supervisory staff at the test site. The instrument was created to be implemented at the specific site in order to best capture data that could be used

to aid clients in utilizing treatment. The survey was then created in two versions: one aimed towards adults attending treatment at the clinic, and one aimed towards adult guardians of children who are attending the clinic. The question content in both instruments was identical, an extra question added to the survey aimed at guardians to identify their own personal utilization of services at the clinic. The adult and guardian instruments were comprised of twelve and thirteen questions respectively. Nine of the questions were directed at obtaining the clients' perceptions and degree of difficulty experienced due to barriers to therapeutic treatment. The remaining questions were categorized as demographics (age, gender, insurance provider, and guardian client status). Of the nine barrier oriented questions, seven items were two-part inquiries. Part "a" of these seven questions is a "1-4" likert scale asking how frequently they encountered a specific barrier with one signifying a response of "Never" and four signifying a response of "Always." Part "b" offered the client an opportunity to answer the question "How do you believe the clinic can help you with this problem." The remaining questions asked about "no show" appointments and about any barriers not indicated in previous questions. A copy of the adult and guardian survey can be found in appendices C and D, respectively.

Results

From the eligible 593 clients, forty one completed the survey, for a response rate of nearly seven percent. The data collected was split into two types of information, quantitative or qualitative data. Quantitative information was compiled and analyzed using descriptive statistical methods. The qualitative research was analyzed primarily using themes that were formed from the responses received from participants. Themes were identified by recording the central focus of each individual response. Then after all responses for an item were reviewed,

redundancies in themes were combined to ensure for accuracy of reporting. The resulting themes represent prominent messages and commonalities between respondents.

Quantitative Data

The quantitative data was found in part "a" of questions 1-7 as well as in question 8. Figure A1 (see appendix A) shows the frequency distribution of all likert scale items. When compiling the data, any item left unanswered was indicated by a "0." The most striking trend that is shown by the results is the lack of strong response. The majority of participants did not indicate that the items significantly impacted their ability to attend their appointments. An analysis of the item averages shows a generalized impact rating. The generalized impact rating refers to the number that is acquired by finding the mean of all scores on one item, resulting in a score that represents the average perception of difficulty clients rate the barrier in question. Table 1 shows the averages that were compiled from the raw data. Although the participants were asked to commit to a whole number rating, averages are displayed to the nearest tenth to better portray trends. Both the frequency histograms as well as the mean analysis indicated that the strongest trends were in the areas of "I have difficulty remembering my appointments", "Getting a ride is hard for me", and "Receiving bus passes is difficult for me" respectively.

Table 1: Averages gathered from participant responses to likert scale survey questions.

Item	Mean Rating
Getting a ride is hard for me	2
Receiving bus passes is difficult for me	1.8
A family Illness affects my attendance	1.5
The amount of people at the clinic impacts my attendance	1.3
An undisclosed problem influences my attendance	1.2
A person in my life makes it hard to make my appointments	1.1
I have difficulty remembering my appointments	2

Ratings are on a scale of: 1(Never), 2(Occasionally), 3(Most of the time), and 4(Always).

Question 8 of the survey asked clients to identify reasons that they, in the past, had not cancelled appointments that they were unable to attend. For this item answers were multiple choice, including an option for "other" which provided a space for elaboration, and clients were asked to identify as many as were applicable. In Figure B1 (see appendix B) a frequency histogram of the identified barriers to informing the clinic about missing appointment prior to the scheduled meeting time is shown. Most indicated by respondents was "I forgot my appointment" and "I forgot to call" respectively.

Qualitative Data

The qualitative findings were identified using an identical method for all eight questions and each question had a few themes that were strikingly similar. Each question had at least two themes in common "No Response" and "Not a clinic problem/ Clinic can do no more." However many of the items also shared the theme of "Unclear" as well. "Unresponsive" indicates that the participant did not provide an answer to the qualitative question. "Unclear" indicates that the participant provided an answer that was irrelevant to the context of the question. Tables 2-7 show the themes identifies by participants and how often the themes were raised.

Table 2: Identified themes of question 1b and their frequency.

How could the clinic help you with transportation?	Theme Frequency
Give Bus Passes	11
Not a Clinic Problem	9
Help with Medicab	4
Coordinate Transportation	3
Help with Insurance	1
Unresponsive	16

Table 3: Identified themes of question 2b and their frequency.

How could the clinic help you get your bus passes from your provider?	Theme Frequency
Help with Provider	11
Not a Clinic Problem	3
Any	1
Provide Them	1
Unclear	3
Unresponsive	22

Table 4: Identified themes of question 3b and their frequency.

How could the clinic help you when your family is affected by illness?	Theme Frequency
Be Understanding	5
Not a Clinic Problem	3
Allow for Rescheduling	3
Provide Support	2
Unclear	3
Unresponsive	25

Table 5: Identified themes of question 4b and their frequency.

How could the clinic make it easier for you to arrive and wait for your appointments?	Theme Frequency
Not a Clinic Problem	3
Unsure	2
Unclear	2
Unresponsive	34

Table 6: Identified themes of question 5b and their frequency.

How could your clinician help you to feel comfortable sharing personal information?	Theme Frequency
Not a Clinic Problem	4
Be More Accepting/Open	3
Unclear	1
Unresponsive	33

Table 7: Identified themes of question 6b and their frequency.

How can the clinic help you with people who restrict your ability to attend sessions?	Theme Frequency
Not a Clinic Problem	3
Provide Continued Support	3
Unclear	1
Unresponsive	34

Table 8: Identified themes of question 7b and their frequency.

How can the clinic help you to remember your appointments?	Theme Frequencies
Give Reminder Calls	14
Not a Clinic Problem	3
General Reminders	2
Give Reminder Cards	2
Send Reminder Letter	1
Give Out Calendars	1
Be More Understanding	1
Unclear	1
Unresponsive	17

Examination of the qualitative data finds two parallels to trends already identified using the quantitative data. First it is shown that in all questions one of the highest identified themes is that the barriers faced by client do not represent a short coming of the current operations of the site. Another parallel is found in the trend that transportation, bus passes, and remembering appointments are the most common barriers of the sample group.

Question nine of the survey asked clients to identify "Is there anything else the clinic can do to help you attend your appointments?" The responses to this question, seen in Table 9, served as a synopsis of the trends found in the research in its entirety. Participants identified in a majority that they did not feel anything else needed to be attended to by the site. However the next most likely response was to identify either Transportation issues or appointment reminder

issues. It is worth noting that the qualitative items showed a much greater "unresponsive" rate than their quantitative counterparts.

Table 9: Identified themes to question nine and their frequencies.

What else can the clinic be doing to help you with you treatment barriers?	Theme Frequencies
Clinic Can Do No More	11
Provide Transportation	3
Call and Remind me of Appointments	3
Give out Business Cards	1
Stress Importance More	1
Provide Childcare	1
Unresponsive	22

Participant's Voice

Due to the fact that the participant response rate to the qualitative based items was relatively low, it was difficult to compile a large spread of consistent feedback each of the items. However, as was true for the majority of the research, the client voice rang clearest in reference to the barriers of transportation, bus passes, and remembering appointments. When addressing the issue of transportation, clients voiced a desire to have clinic support when attempting to make their sessions. One client stated "[the clinic should] have a person with the job of 'transportation services." Another focused more heavily on what ways current staff might be able to aid them with their needs stating; "[the clinic should] provide a few bus passes" and "it would be helpful if they could approve a medi-cab." When discussing the barrier of bus pass acquisition, some were rather straight forward, "getting bus passes for me", but much of the discussion focused on the difficulty of navigating the use of a third party payer system. One participant's frustration was clearly evident in their response of "[Communicating] the importance of attending the clinic with depression and anxiety [would be helpful]", while another has seemingly accepted their

unfortunate situation by simply exclaiming "[my] insurance does not allow the clinic to give me a bus pass." The responses around forgotten appointments were the most straightforward evidenced by statements such as "Calling me would be wonderful", "Reminder calls", and "Call me to confirm."

Although the remainder of the questions/barriers did not appear to show as strong a trend as those discussed above, there were individual responses that warranted thought and mentioning. When asked about how the clinic could aid the client in navigating difficulties with a family illness, one participant indicated "They can be more understanding and less rude." A response of "She could help me feel better instead of the same or worse after our session" was made by one participant in regards to the question "how could your clinician help you to feel comfortable sharing personal information?" Both of these participants highlight a possible lack of compassion and understanding on the part of the clinic staff. A third participant also indicated a shortcoming of the clinic when it came to meeting their needs giving a response that "Work sometimes makes it hard for me to make it on time", indicating that longer or more flexible hours may be helpful for her ability to attend appointments.

Discussion

Client attendance remains an integral piece of unlocking the formula for best client care. The statement holds even more truth when speaking about underprivileged and low income clients, as were the focus of this research. The majority of the research has neglected to take into consideration the perceptions and experience of this population, leaving a general hole in the professions collective knowledge. This preliminary investigation helps to voice the unique and elementary needs of the impoverished and minority populations.

Implications

The trends identified in the research have begun to identify an area of weakness in the delivery of treatment. Research has shown that the strongest barrier type is emotionally based (fear, sadness, lack of interpersonal trust, etc.), but this study has shown that majority of participants have the most difficulty with more tangible barriers. Assuming that these trends are fact, clinics that service low income clients need to focus more heavily on providing supportive services that will allow their clients to attend treatment on a regular basis. The study findings highlight the issue of transportation and reminder calls as most prominent, however it is likely that the addition of case management services would improve client attendance. This assumption can be supported by Maslow's hierarchy of needs, a theory that states that an individual will focus on the most essential needs that are not being met while ignoring needs that are less essential to their own functioning/wellness. If the clinic provided clients with services that aided them in attending to their basic needs, it would increase their ability to attend to their mental health.

Limitations

There are several limiting factors associated with the research presented. Primarily the results found from the research is simply descriptive, and thus no concrete conclusions can be made as to cause and effect, nor significance be calculated due to lack of experimental design and adequate information. For these reasons it is not possible to truly suggest any solutions or interventions with any confidence. Another area of weakness is the non-standardized instrument used for data collection. In this study the use of an original, site focused, instrument was opted for to aid in obtaining specific information desired by site directors. Upon reviewing the

completed surveys, it was apparent that the instrument had flaws in regard to ease of understanding and clarity. This was evidenced by the fact that many a handful of participants utilized space for meant for other questions when answering certain items. It was also seen that some clients provided incoherent responses to items. Due the faults in the instrument, there is little if any reliability inherent in the findings. Time was also a factor limiting the study. Time constrained the ability to properly test the instrument prior to its utilization, and it also limited the amount of clients eligible to complete the instrument. Finally the low response rate is a significant limitation for the ability of the work to be generalized.

Future Research

Further research should utilize an experimental design to supplement the descriptive findings of this study. It is integral that the research utilizes a well tested, and standardized instrument to ensure for better reliability and more quality participant responses. Future research should also have a solution focus, utilizing treatment variables to measure impact of interventions. It is important that the issue of client attendance is investigated on a broader scope. Research should examine both a broader income range and multiple settings. It would also be advisable that future research consider a much heavier focus on qualitative research. Taking such an approach to the work would allow not only aid in the depth of insight gained from clients in regards to their experience, but it would also aid in the alleviation of limitations to the study due to poor education of the participant.

Conclusion

Ultimately, the findings of this study have added insight into an area that is largely unknown. Though the general consensus among respondents is that the clinic is performing well

and the barriers the clients face are just that, their own, the question remains how much of it should be client owned. In a clinic like the one utilized in this work the targeted clientele is the underprivileged and poor; does such an orientation not include the responsibility of barrier circumvention? This is the question that is left largely unanswered by the current work. For now the site will be left with insight gained from the client population about how services can be enhanced.

References

Ambrose, J. & Beech, B. (2006, February). Tackling non-attendance for outpatient appointments. *Mental Health Practice, 9*(5), 22-25.

Baumann, B. D., Hilsenroth, M. J., Ackerman S. J., Baity, M. R., Smith C. L., Smith S. R. (2001). The capacity for dynamic process scale: An examination of reliability, validity, and relation to therapeutic alliance. *Psychotherapy Research, 11,* 275-294. doi: 10.1093/ptr/11.3.275

Becker, A. E., Arrindell, A. H., Perloe, A., Fay, K., & Striegel-Moore, R. H. (2010). A qualitative study of perceived social barriers to care for eating disorders: Perspectives from ethnically diverse health care consumers. *International Journal of Eating Disorders*, *43*(7), 633-647.

Benway, C. B., Hamrin, V., & McMahon, T. J. (2003). Initial appointment nonattendance in child and family mental health clinics. *American Journal of Orthopsychiatry*, *73*(4), 419-428. doi: 10.1037/0002-9432.73.4.419

Booth, P. G., Bennett, H. E. (2004). Factors associated with attendance for first appointments at an alcohol clinic and the effects of telephone prompting. *Journal of Substance Abuse, 9(6),* 269-279.

Cavaleri, M. A., Gopalan, G., McKay, M. M., Appel, A., Bannon, W. M., Bigley, M. F., & Fazio, M. H., et al. (2006). Impact of a learning collaborative to improve child mental

health service use among low-income urban youth and families. *Best Practices in Mental Health, 2*(2), 67-79.

Chow, J. C., Jaffee, K., & Snowden, L. (2003). Racial/ethnic disparities in the use of mental health services in poverty areas. *American Journal of Public Health, 93(5),* 792-797. doi: 10.2105/AJPH.93.5.792

Coulter, S. (2007). The impact of engagement processes on the first-appointment attendance rate at a regional outpatient psychological trauma service. *Child Care in Practice*, *13*(2), 117-123. doi: 10.1080/13575270701204189.

Festinger, D. S., Lamb, R. J., Marlowe, D. B., & Kirby K. C. (2002). From telephone to office: Intake attendance as a function of appointment delay. *Addictive Behaviors, 27,* 131-137. doi: 10.1016/S0306-4603(01)00172-1

Gallucci, G., Swartz, W., & Hackerman, F. (2005). Brief reports: Impact of the wait for an initial appointment on the rate of kept appointments at a mental health center. *Psychiatric Services, 56,* 344-346.

George, A., Rubin, G. (2003). Non-attendance in general practice: A systematic review and its implications for access to primary health care. *Family Practice 20(2),* 178-184. doi: 10.1093/fampra/20.2.178

Gorman, L. A., Blow, A. J., Ames, B. D., & Reed, P. L. (2011). National guard families after combat: Mental health services and perceived treatment barriers. *Psychiatric Services*, *62*(1), 28-34. doi: 10.1176/appi.ps.62.1.28

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry, 10,* 113. doi: 10.1186/1471-244X-10-113

Hampton-Robb, S., Qualls, R. C., & Compton, W. C. (2003). Predicting first session attendance: The influence of referral source and client income. *Psychotherapy Research, 13*(2), 223-233. doi:10.1093/ptr/kpg020.

Lacy, N. L., Paulman, A., Reuter, M. D., & Lovejoy, B. (2004). Why we don't come: Patient perceptions of no-shows. *Annals of Family Medicine, 2 (6),* 541-545. doi: 10.1370/afm.123

Lefforge, N. L., Donohue, B. & Strada, M. J. (2007, June). Review identifies effective strategies to improve attendance among mh and sa patients. *The Brown University Digest of Addiction Theory and Application, 26*(6), 1 & 5-6.

Lester, S., & Harris, S. M. (2007). Factors associated with first session nonattendance at a university-based family therapy clinic. *The American Journal of Family Therapy, 35,* 363-376. doi: 10.1080/01926180600814718.

Minty, B., & Anderson, C. (2004). Non-attendance at initial out-patient appointments at a hospital based child psychiatric clinic. *Clinical Child Psychology and Psychiatry, 9(3),* 403-418. doi: 10.1177/13591045043923

Mohr, D. C., Hart, S. L., Howard, I., Julian, L., Vella, L., Catledge, C., & Feldman, M. D. (2006). Barriers to psychotherapy among depressed and nondepressed primary care

patients. *The Society of Behavioral Medicine, 32*(3), 254-258. Doi: 10.1207/s15324796abm3203_12

Mohr, D. C., Ho, J., Duffecy, J., Baron, K. G., Lehman, K. A., Jin, L., & Reifler, D. (2010). Perceived barriers to psychological treatment and their relationship to depression. *Journal of Clinical Psychology*, *66*(4), 394-409. doi: 10.1002/jclp.20659

Mohr, D.C., Vella, L., Hart, S., Heckman T., & Simon, G. (2008). The effect of telephone administered psychotherapy on symptoms of depression and attrition: A meta-analysis. *Clinical Psychology: Science and Practice, 15(3),* 243-253. doi: 10.1111/j.1468-2850.2008.00134.x

Mojtabai, R., Olfson, M., Sampson, N. A., Jin, R., Druss, B., Wang, P. S., Wells, K. B., … et al. (2011). Barriers to mental health treatment: Results from the national comorbidity survey replication. *Psychological Medicine, 41*, 1751-1761. doi: 10.1017/S0033291710002291

National Alliance on Mental Illness. (2009). *Grading the states 2009: A report on America's health care system for adults with serious mental illness*. Retrieved from http://www.nami.org/gtsTemplate09.cfm?Section=Overview1&Template=/ContentManagement/ContentDisplay.cfm&ContentID=75106

National Institute of Mental Health. (2008). *Use of mental health services and treatment by adults*. Retrieved from http://www.nimh.nih.gov/statistics/3USE_MT_ADULT.shtml

Psychology Today. (2011). *Ins and outs of mental health insurance*. Retrieved from http://therapists.psychologytoday.com/rms/content/therapy_insurance.html

Reardon, M. L., Cukrowicz, K. C., Reeves, M. D., & Joiner, T. E. (2002). Duration and regularity of therapy attendance as predictors of treatment outcome in an adult outpatient population. *Psychotherapy Research 12(3),*273-285. doi: 10.1093/ptr/12.3.273

Sareen, J., Jagdeo, A., Cox, B. J., Clara, I., Have, M., Belik, S. L., Graff, R., Stein, M. B. (2007). Perceived barriers to mental health service utilization in the united states, Ontario, and the Netherlands. *Psychiatric Services, 58,* 357-364.

Smith, L., Foley, P. F., & Chaney, M. P. (2008). Addressing classism, ableism, and heterosexism in counselor education. *Journal of Counseling and Development, 86,* 303-309.

Snowden, L., Wallace, N., Kang, S., Cheng, J., & Bloom, J. (2007). Capitation and racial and ethnic differences in use and cost of mental health services. *Administration and Policy in Mental Health and Mental Health Services Research, 34,* 456-464. doi: 10.1007/s10488-007-0126-y

Stretcher, V. (2007). Internet methods for delivering behavioral and health related interventions. *Annual Review of Clinical Psychology, 3,* 53-76.

Swanberg, J. (2008, May 16). Do you overwork? more production but at what cost?. *Business Lexington,* http://www.uky.edu/Centers/iwin/publications/published_finals/overwork%205.16.08.pdf

Tambling, R. B., Johnson, L. N., Templeton, G. B., & Santilli Melton, M. (2007). Using web-based technology to facilitate client engagement. *Contemporary Family Therapy, 29,* 177-183. doi: 10.1007/s10591-007/9037/z

United States Census Bureau. (2011, June 29). *United states population clock*. Retrieved from http://www.census.gov/population/www/popclockus.html

Vujicic, M., Addai, E., & Bosomprah, S. (2009). Measuring health workforce productivity: Application of a simple methodology in ghana. *The World Bank*, Retrieved from http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/MeasuringHlthWorkforce.pdf

Appendix A

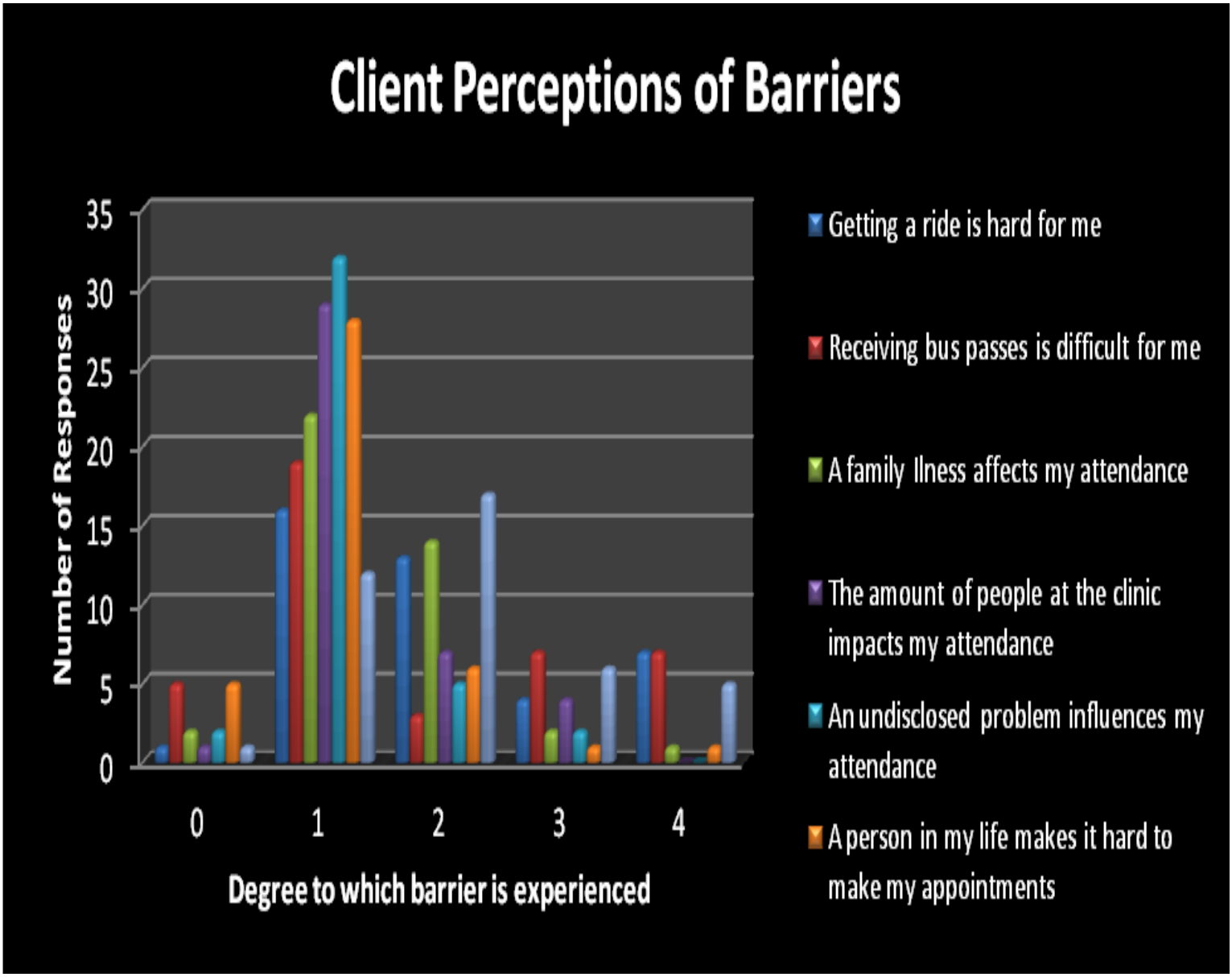

Figure A1: Frequencies of likert scale questions ("a" portion of questions 1-7). Numbers indicate answers on a scale from 1(Never) to 4(Always) while 0 indicates an item left unanswered.

Appendix B

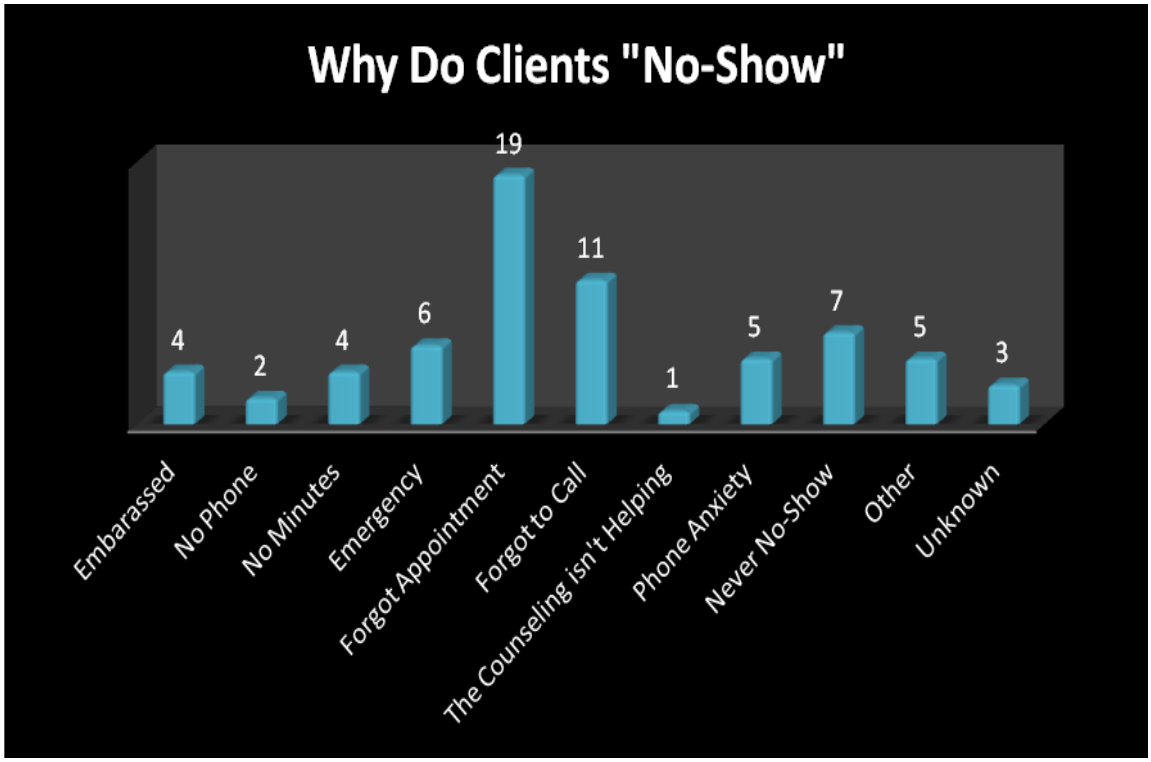

Figure B1: The above frequencies were gathered from client responses to question 8 of the survey. "Other" refers to responses indicated by the responder through circling of "other_____" option without further elaboration. "Unknown" refers to the writers inmability to identify reasoning.

Appendix C

Adult Survey

This survey is meant to be a way to help us find out what makes it hard to attend appointments. So please let us know how we could be of help.

For the following questions, please indicate on a scale from 1-4 how much each of the following affect your ability to make your appointments at the clinic. A response of 1 meaning "Never prevents me from making my appointments" and 4 meaning "Always prevents me from making my appointments."

1_____2_____3_____4

Never Occasionally Most the Time Always

1. Getting a ride/catching the bus is a problem for me.

1_____2_____3_____4

Never Occasionally Most the Time Always

1a. How could the clinic help you with transportation?

_____

_____

2. Getting bus passes from my insurance provider is a problem for me.

1_____2_____3_____4

Never Occasionally Most the Time Always

2a. How could the clinic help you get your bus passes from your provider?

_____

_____

3. A family illness affects my attendance at my appointments.

1_____2_____3_____4

Never Occasionally Most the Time Always

3a. How could the clinic help you when your family is affected by an illness?
_____
_____

4. The amount of people around when entering and waiting at the clinic is a problem for me.

1_____2_____3_____4

Never Occasionally Most the Time Always

4a. How could the clinic make it easier for you to arrive and wait for you appointments?
_____

5. A problem I have not yet told my clinician makes me not want to attend my appointments.

1_____2_____3_____4

Never Occasionally Most the Time Always

5a. How could your clinician help you to share this information?
_____
_____

6. A person in my life makes it hard for me to make all of my appointments.

1_____2_____3_____4

Never Occasionally Most the Time Always

6a. How can the clinic, or your clinician help you this person/these people? _____
_____

7. I have a hard time remembering when my appointments are.

1_____2_____3_____4

Never Occasionally Most the Time Always

7a. How can the clinic help you to remember your appointments? _____
_____

8. If you have ever missed an appointment and did not call to cancel it beforehand, what if any of the following played a part in your not calling. *Please circle all that apply*

(Embarrassed)	(No access to a phone)	(No minutes on cell phone)
(Emergency)	(Didn't think it was expected)	(Forgot my appointment)
(Forgot to call)	(The counseling isn't helping)	(Phone anxiety)
	(Other_____)	

9. Is there anything else the clinic can do to help you attend your appointments?
_____
_____
_____

Please answer questions 10-12 by circling the response that best describes you.

10. What is your age?

(18-24) (25-34) (35-44) (45-54) (55-60) (61+)

11. What is your gender?

(Male) (Female) (Transgender)

12. Who is your insurance provider/payer? *Check all that apply.*

(Medicaid)	(Monroe Plan/Blue Choice Option)	(MVP Option)
(Fidelis Care)	(Medicare)	(Other Insurance_____)
	(None/Self Pay)	

Appendix D

Guardian Survey

This survey is meant to be a way to help us find out what makes it hard to attend appointments. So please let us know how we could be of help.

For the following questions, please indicate on a scale from 1-4 how much each of the following affect your ability to make your appointments at the clinic. A response of 1 meaning "Never prevents me from making my appointments" and 4 meaning "Always prevents me from making my appointments."

1_____2_____3_____4

Never Occasionally Most the Time Always

1. Getting a ride/catching the bus is a problem for me.

1_____2_____3_____4

Never Occasionally Most the Time Always

1a. How could the clinic help you with transportation?

_____

_____

2. Getting bus passes from my insurance provider is a problem for me.

1_____2_____3_____4

Never Occasionally Most the Time Always

2a. How could the clinic help you get your bus passes from your provider?

_____

_____

3. A family illness affects my attendance at my appointments.

1_____2_____3_____4

Never Occasionally Most the Time Always

3a. How could the clinic help you when your family is affected by an illness?
_____
_____

4. The amount of people around when entering and waiting at the clinic is a problem for me.

1_____2_____3_____4

Never Occasionally Most the Time Always

4a. How could the clinic make it easier for you to arrive and wait for you appointments?
_____

5. A problem I have not yet told my clinician makes me not want to attend my appointments.

1_____2_____3_____4

Never Occasionally Most the Time Always

5a. How could your clinician help you to share this information?
_____
_____

6. A person in my life makes it hard for me to make all of my appointments.

1_____2_____3_____4

Never Occasionally Most the Time Always

6a. How can the clinic, or your clinician help you this person/these people? _____
_____

7. I have a hard time remembering when my appointments are.

1_____2_____3_____4

Never Occasionally Most the Time Always

7a. How can the clinic help you to remember your appointments? _____
_____

8. If you have ever missed an appointment and did not call to cancel it beforehand, what if any of the following played a part in your not calling. *Please circle all that apply*

(Embarrassed)	(No access to a phone)	(No minutes on cell phone)
(Emergency)	(Didn't think it was expected)	(Forgot my appointment)
(Forgot to call)	(The counseling isn't helping)	(Phone anxiety)
	(Other_____)	

9. Is there anything else the clinic can do to help you attend your appointments?
_____
_____
_____

Please answer questions 10-13 by circling the response that best describes you.

10. What is your child's age?

(5 years or less) (6-12) (13-17)

11. What is your child's gender?

(Male) (Female)

12. Are you a client at the clinic, the parent of a client, or both?

(Client) (Parent) (Both)

13. Who is your insurance provider/payer? *Check all that apply.*

(Medicaid)	(Monroe Plan/Blue Choice Option)	(MVP Option)
(Fidelis Care)	(Medicare)	(Other Insurance_____)
	(None/Self Pay)	