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NOTES AND COMMENTS II

The Psychiatric Walk-In Clinic Service

An Interim Report of Experience at Henry Ford Hospital

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In the time since the first Walk-In Psychiatric Clinic was conducted at Henry Ford Hospital on January 14, 1970, to May of 1972, 1,254 cases have been seen. Of this number, the authors and a resident physician working directly with us handled 104 cases registered in the year from May 1971 to April 1972. Our series will be described in this paper.

The outline and philosophy of the clinic has been described in detail.[1] In essence, important reasons for establishing the clinic had to do with eliminating the long waiting list (up to as much as six weeks) and to assist in dealing with "emergencies". An added problem was that up to one third of the new patients on the long waiting list failed to appear for appointments. This constituted a significant waste of professional time.

We set aside Wednesday, between the hours of 9:00 and 3:00 p.m., for patients to be seen without any appointment in the Walk-In Clinic. When they arrive, they are seen first by the clinic nurse, who completes a rather detailed formal questionnaire; then, a counselor, and then a psychiatrist. Prior to the interview, the psychiatrist has a conference with the counselor and, in some cases, the nurse to share information.

Disposition is made by the psychiatrist in conjunction with the opinions of the counselor. The disposition is completely open-ended and is unlike that described by Paul and Normand[2,3] for certain walk-in clinics. Nor is it like the psychiatric emergency clinics described by Coleman and Zwerling in 1959[4] and Coleman and Rosenbaum in 1963.[5] These authors have outlined clinics wherein disposition has consisted of brief psychotherapy lasting no more than five to six visits which is described to the patients at the time of initial evaluation. At Bronx Municipal Hospital Center[4] a psychiatric emergency clinic functioned as a 24-hour service. That clinic and many others serve not only as evaluatory and disposition agencies, but offer return visits as a significant part of their ser-

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vices, particularly of chronically ill patients.

At our clinic, disposition may consist of recommendations for admission to in-patient psychiatric care, psychotherapy (long or short-term with either a counselor or a psychiatrist), group therapy, marital counseling, individual counseling, further diagnostic interviews, referral to other departments, psychological testing, or referral to agencies outside the hospital, including a public hospital or clinic, or an alcoholism or drug abuse treatment program. It is our opinion that nothing would be gained by attempting to restrict disposition to certain treatment modalities.

The walk-in clinic at Henry Ford Hospital functions solely as an intake evaluation and disposition service. For practical purposes, all patients seen are new to the psychiatric department, with the exception of a few former patients whose therapists have left the staff. For many patients, revisits occur to the department, but these are not considered open clinic visits. Emergency psychotherapy is done in our setting, but not as mentioned in the walk-in clinic parameters.

Tables 1 and 2, respectively, give a breakdown of diagnosis and disposition by referral source of the 104 cases we handled. Table 2, additionally, shows the number of patients who are designated as "no returns". These patients had a course of treatment recommended to them, made an appointment, but never kept it. To some extent, they are analogous to the "dropouts" described by Salzman[6] yet not as restrictive in definition. Of the 17 patients in this group, 15 had been referred for further out-patient psychiatric visits and two to other departments. Twelve patients in the study were referred from the hospital emergency room. Of these, five were later referred to public clinics, five others were referred for further out-patient visits in our clinic, and two had no return recommended. Two patients from our group entered counseling, the other three were "no returns". It is noteworthy that 43 patients, or 42.2%, were referred for either counseling or psychotherapy on an out-patient, individual basis. Only eight patients, 7.3%, were recommended for admission. This re-inforces the impression that hospitalization can be prevented by early intervention. We will present two cases as illustrations.

We plan to follow up the 17 "no returns" by phone or mail to attempt to determine the stated reason or reasons for not continuing. The high number of referrals to public agencies is directly related to the fact that psychiatric services are not covered by Medicaid.

While our clinic has no eligibility requirements and payment is not a requirement for evaluation, only five patients with primary symptoms of drug addiction were evaluated in this group. Two patients were given return appointments which they failed to keep. Two patients were referred out to drug treatment programs and one of these followed through. The fifth wanted to be on an out-patient methadone program which we do not operate.

Case Reports

The following case reports illustrate that early short-term intervention can

TABLE I. By Diagnoses

Referral Source	Number of Cases	Neurotic	Psychotic (Functional)	Character Disorder	Organic Brain Syndrome	Psycho-physiological Disturbance	Adjustment Reaction	No Diagnosis
Other Departments in the Hospital	42	15	5	5	3	5	8	1
Self or Family	31	7	7	3	3	2	8	1
Emergency Room	12	4	2	2	1	0	3	0
Former Patients	7	1	6	0	0	0	0	0
Physicians or Other Agencies in the Community	6	2	0	2	0	0	0	2
Miscellaneous . . . Courts or not Recorded	6	1	0	1	0	0	2	2

TABLE II. By Disposition

Referral Source	Individual Psychotherapy or Counseling	Group Therapy	Marital Counseling	Admission	Referred Out	No Referral	Extended Diagnosis	No Return
Other Departments in the Hospital	19	2	1	2	10	7	1	5
Self or Family	13	1	3	4	5	2	3	7
Emergency Room	5	0	0	0	5	2	0	3
Former Patients	5	0	0	2	0	0	0	0
Physicians or Other Agencies in the Community	1	1	0	0	1	3	0	1
Miscellaneous . . . Courts or not Recorded					2	2	2	1

significantly alter the course of very severe psychopathology.

Case I. This 35-year-old single tax analyst came with a complaint of difficulty in concentrating at work and vague paranoid ideas regarding co-workers. He had a history of similar complaints in 1966 which were resolved in a short time. During the interview, he was inappropriately angry and showed an obvious thought disorder. He was given medication, re-assurance, and an early return appointment. In the second and third interviews, it became apparent that he was angry and frustrated at co-workers. These included especially subordinates but also his supervisor whom he felt organized the office in an inefficient way, leaving him with an excessive work load. He was unable to express these concerns to anyone and, hence, the symptoms developed. With direct advice and re-assurance that expressing his feelings would not be inappropriate plus the medication, he quickly improved. At the time of the third visit, he and the therapist both felt no return was necessary except on a p.r.n. basis and treatment was discontinued.

Case II. A 33-year-old married administrative clerk with ulcerative colitis was referred because he felt he was being followed. He described what he believed was an elaborate system of cars and radios which kept surveillance on him. It was soon apparent that his paranoid projection was related to his wife's gynecologic problems which had caused much sexual abstinence. Underlying homosexual fears were threatening to break through. With medication and after two more psychotherapeutic visits after the initial evaluation, he stated that he was sure he had been wrong about being followed. His agitation had gone and he described himself as being well. Return was advised on a p.r.n. basis only.

In both of these cases, a knowledge of psychodynamics in a short-term setting proved highly meaningful in returning emotional homeostasis.

Comments

We believe the most significant features of a walk-in clinic are the absence of any wait and the ability to refer a specific case to the appropriate treatment modality. The 16.3% of "no returns" compared to the figures of Salzman[6] and Lief[7] is probably too high and these will be evaluated via direct contact with each patient. Emergency room referrals were those least likely to return for treatment, either due to ineligibility for insurance coverage, or lack of need for or interest in treatment, as expressed at the time of evaluation.

The psychiatric walk-in clinic is a part of the recent trend toward "community psychiatry" which aims to make more treatment available to larger groups of people. In the absence of greater manpower availability, innovation in treatment technique is its hallmark. Some have described it as the third revolution in psychiatry, the first being the recognition by Pinel and others that illness was not caused by demon possession; the second being the dynamic insights of Freud. In this interim report and more detailed ones to follow, we hope to aid in evaluating how and where walk-in clinics best fit into this trend.

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