An Evening Mental Health Clinic Established in a County Hospital Reaches an Underserved Population

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IN A PERIOD CHARACTERIZED by close scrutiny of mental health expenditures, use of mental health facilities to their fullest extent becomes an important issue. My focus in this report is on the expansion of the psychiatric facilities at Cleveland Metropolitan General Hospital, a county hospital that is affiliated with a university. The expansion was accomplished by the establishment of an evening mental health clinic to provide mental health services to a segment of the population that was considered to be underserved in this regard.

Among the most frequently cited concerns about the provision of mental health services to underserved persons is the response of mental health professionals to persons in the lower socioeconomic classes. Numerous authors have commented on the lack of adequate services to such persons (*1–4*). These authors have summarized the results of research which indicate that lower class persons are not accepted for psychotherapy as frequently as are middle class persons, and when lower class persons are accepted for psychotherapy they are assigned to less experienced therapists. Also, the lower class patient, compared to the middle class patient, remains in therapy for a shorter period and is rated as less improved at termination. Garfield (*5*) made an in-depth review of patient variables in psychotherapy and concluded that psychotherapy as traditionally conceived—long term and dynamically oriented—generally is not effective with lower class patients. In contrast, Jones (*3*) summarized the results of other work which suggest that lower class patients are more psychologically minded and verbally expressive and are better therapy risks than commonly assumed.

A number of new methods have been tried—including varying the kinds of therapy offered (*3*), focusing on the patient as a "customer," clarifying and then working on the patient's specific request (*6*), and developing inner-city centers and using indigenous personnel (*7,8*)—to provide more satisfactory mental health services to lower class patients.

Another segment of the population regarded as underserved in mental health services was defined by the administrators of the department of psychiatry at Cleveland Metropolitan General Hospital and the local county mental health and mental retardation board. The characteristics of this segment of the population were defined with a somewhat different emphasis than that usually implied by the term "underserved." These administrators considered the possibility that a significant number of persons were being excluded from public mental health services because most mental health clinics were open primarily in the daytime. A prime example of this potentially excluded group is employed persons who cannot attend clinics because the clinic hours conflict with their work hours.

As a result of this consideration, the Evening Mental Health Clinic was established in 1971. The clinic has its own director and its own staff, but it is administered by the department of psychiatry of the county general hospital. The clinic combines a number of features not found in other clinics. First, it uses the same facilities that the hospital's outpatient psychiatry clinic uses during the day. Second, the clinic functions only during evening hours, from 6 to 10, each week night. And third, the evening clinic is staffed by five interdisciplinary teams of mental health professionals who are employed elsewhere during the day. The clinic has been described in detail elsewhere (*9*).

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It was anticipated that patients of both the day and evening clinics would be primarily from social classes IV and V (*10*). However, the evening clinic's purpose was not simply to offer extended hours for the patients who were being seen at the day clinic; rather, it was intended to provide services to a different group of patients. If, as a result of the evening hours, the clinic were to attract a larger percentage of employed patients than the day clinic, men could be expected to comprise a larger percentage of the patients. This expectation was based on the assumption that many working men will not, or cannot, take time off from work to seek mental health services. Consistent with this expectation, one could reasonably anticipate that the evening clinic would attract patients who were in somewhat higher education, income, and social class levels than the day patients.

Because both clinics use a computerized data collection system, it was possible to determine if the evening clinic was fulfilling its purpose of serving a population that was different from the day clinic's population. In addition, the availability of data on a few selected treatment variables made it possible to determine if any of the anticipated differences in the characteristics of patients in the two clinics were associated with differences in any of the treatment variables.

Methods

The county general hospital is situated near the downtown area of Cleveland, a large, heavily industrialized city. Before their first interview in either clinic, patients were asked by clinic secretaries to provide demographic information, which was entered on the patient information form (PIF). This form, used for the department of psychiatry's review and evaluation system, has been described in detail by Miller and Schlachter (*11*).

After a patient was terminated, the therapist entered on the PIF the number of times the patient was seen. The number of visits was grouped into the following categories: 1–2, 3–5, 6–8, 9–11, 12–14, and 15 or more. The therapist also made two subjective outcome judgments and indicated whether the termination was planned or unplanned, that is, if the patient had dropped out from treatment. Regarding outcome judgments, the therapist made two ratings—one pertained to the outcome for the patient's specific initial problem, and the other was made for the treatment outcome concerning the patient's overall adjustment. Each outcome rating was made on a 5-point scale with the following designations: much improved, improved, unchanged, somewhat worse, worse.

The computerized PIF system is still being used in the department of psychiatry. The information on the PIF is entered into the hospital computer by the secretarial staff. Printouts of the data are received by the department of psychiatry monthly, and it also receives a yearly tabulation at the close of each calender year. Data are printed out for the day and evening clinics separately.

To make the data as representative as possible, the data were combined for the years 1974 and 1975, thereby providing information on a potential of 1,549 evening clinic patients and 1,490 day clinic patients. The numbers of patients in the analyses and comparisons differ because some data were recorded on the PIF and entered into the computer at the time of the initial visit (demographic information), and other data were recorded and entered into the computer at the time of termination (treatment data). During 1974 and 1975, it usually took a minimum of 3 to 6 months after a patient's last visit before the closing information was entered on the PIF. This delay was partly to prevent duplicating information on patients who returned to the clinics a short while after terminating treatment.

Other factors contributing to the varying numbers of patients in the analyses included clerical errors, omissions, and difficulty in obtaining information from some patients. It was hoped that the relatively large sample would help to lessen the impact of any potentially confounding influences. Also, there did not appear to be any biases in the data that were operating unilaterally for either clinic; that is, any unwanted influences in the data should have been operating relatively equally for both clinics and therefore should not have influenced the results or their interpretation significantly.

Results

Patients' characteristics. The percentages of patients in the various age groups were as follows:

Age group (years)	*Day clinic (N=1,490)*	*Evening clinic (N=1,549)*
11–20	11.6	11.8
21–30	35.3	50.7
31–40	20.8	21.7
41–50	14.3	9.9
51–60	11.5	4.5
61–70	5.1	1.0
71 and over	1.3	0.4

As the percentages show, the evening clinic generally had a younger patient population than the day clinic ($\chi^2=150.57$, $df=6$, $P<.001$).

Both clinics saw a substantially larger percentage of female patients. However, the predominance of female patients was greater in the day clinic (26 percent males, 74 percent females) than in the evening clinic (37 percent males, 63 percent females). The difference in the numbers of male and female patients

seen at the clinics was significant (χ^2=45.21, df=1, P <.001). This analysis was based on data for 1,483 day clinic patients and 1,538 evening clinic patients.

A substantially larger percentage of white than black patients was seen at both clinics. However, the percentage of black patients seen at the day clinic (27 percent black, 73 percent white) was larger than the percentage seen at the evening clinic (14 percent black, 86 percent white). This difference between clinics was significant (χ^2=81.39, df=1, P <.001). This analysis was based on data for 1,440 day clinic patients and 1,533 evening clinic patients.

The percentages of patients in the various marital categories were as follows:

Martial status	*Day clinic (N=1,448)*	*Evening clinic (N=1,494)*
Married	36.6	45.8
Single	33.4	31.3
Widowed	5.5	1.5
Divorced	11.5	12.9
Separated	11.5	5.9
Unknown	1.5	2.6

The clinics differed significantly in the distributions of patients according to marital status (χ^2=83.56, df=5, P <.001). As shown, the evening clinic treated a larger percentage of married patients, and the day clinic treated more widowed or separated patients.

According to family income, the percentages of patients were: less than $4,000, 79 percent day clinic and 42 percent evening clinic; $4,000–$8,000, 15 percent day clinic and 36 percent evening clinic; more than $9,000, 6 percent day clinic and 22 percent evening clinic. In general, patients at the evening clinic had considerably higher family incomes than the patients at the day clinic (χ^2=353.75, df=2, P <.001). This analysis was based on data for 1,186 day clinic patients and 1,227 evening clinic patients.

Only 39 percent of the day clinic patients completed high school, but 64 percent of the evening clinic patients attained this educational level (χ^2=157.99, df=1, P <.001). This analysis was based on data for 1,185 day clinic patients and 1,225 evening clinic patients.

The percentages of patients of various social classes for the two clinics were as follows:

Social class	*Day clinic (N=1,246)*	*Evening clinic (N=1,224)*
I	0.03	0.04
II	2.4	3.1
III	7.0	16.2
IV	35.7	40.8
V	54.6	39.5

Considered on a group basis, the social class of evening clinic patients was higher than that of day clinic patients (χ^2=80.19, df=4, P <.001).

Treatment variables. The percentages of patients who were seen for various numbers of visits were as follows:

Number of visits	*Day clinic (N=1,002)*	*Evening clinic (N=1,175)*
1–2	51.7	51.6
3–5	23.2	26.9
6–8	10.6	10.5
9–11	4.7	5.1
12–14	3.3	2.5
More than 14	6.6	3.4

Although the clinics were significantly different in respect to the actual numbers of visits (χ^2=15.75, df=5, P <.01), the absolute differences were quite small. It is interesting that at each clinic slightly more than half of the patients were seen only once or twice. At the evening clinic 3.7 percent more patients were seen for 3 to 5 sessions than at the day clinic, while at the day clinic 3.2 percent more patients were seen for more than 14 sessions than at the evening clinic. In the categories of 6–8, 9–11, and 12–14 sessions, similar percentages of patients were seen at the clinics.

Concerning the numbers of planned versus unplanned terminations, the difference between the two clinics was statistically significant (χ^2=6.45, df=1, P <.015), based on data for 999 day clinic patients and 1,159 evening clinic patients. Both clinics had more planned than unplanned terminations, but for the evening clinic the percentage of planned terminations was greater (planned, 59.9 percent; unplanned, 40.1 percent) than it was for the day clinic (planned, 54.5 percent; unplanned, 45.5 percent).

The therapists' ratings of outcome, although subject to the shortcomings of any evaluation made by a participant, were intended to provide at least a suggestion of the perceived success of treatment. The percentages of patients in both clinics who were rated according to their presenting problem and overall adjustment are shown in the following table. Because of the small number of patients rated as "somewhat worse" or "worse," these two categories were combined.

	Day clinic (N=985)		*Evening clinic (N=1,155)*	
Outcome category	*Presenting problem*	*Overall adjustment*	*Presenting problem*	*Overall adjustment*
Much improved	8.5	5.4	7.9	4.8
Improved	38.1	33.1	42.4	35.5
Unchanged	51.8	59.8	49.2	58.9
Worse	1.6	1.7	0.5	0.8

For presenting problems, the evening clinic staff rated a slightly higher percentage of the patients as "improved" and a slightly smaller percentage as "unchanged" than did the day clinic staff (χ^2=9.49,

$df=3$, $P<.025$). The therapists' ratings of overall adjustment did not differ significantly for the two clinics ($\chi^2=5.24$, $df=3$, $P>.10$).

Discussion

The primary purpose of this study was to determine if the evening clinic was attracting a population that was not being reached by the day clinic. The data indicate that compared to the day clinic the evening clinic patients tended to be younger, to include more males, to be more predominately white, to be more likely to be married, to have higher family incomes and more education, and to be higher in social class. Overall, the results indicate that during 1974–75 the evening clinic was indeed serving a population that was different from the population being served by the day clinic.

It is noteworthy that the evening clinic served 11 percent more males than the day clinic. This finding suggests that the predominance of females who attend mental health clinics can be reduced if psychiatric services are offered at a time when males will use the services. Unfortunately, data concerning patients' employment status were not available because of programing omissions; however, the differences between patients' characteristics in the two clinics were consistent with the expectation that more employed persons would attend the evening clinic than the day clinic.

Given that the characteristics of the patients who attended the two clinics differed, the next issue was whether these differences were associated with differences in number of visits, type of termination, and therapists' views of outcome. Concerning the number of visits, the most striking aspect of the data is that for both clinics slightly more than half of the patients were seen only one or two times. Nevertheless, the difference between the two clinics was statistically significant for the number of visits. Although a few more patients were seen in longer term therapy (more than 14 visits) in the day clinic than in the evening clinic, a few more patients were seen for 3 to 5 sessions in the evening clinic than in the day clinic. These data were probably influenced somewhat by the philosophy of the evening clinic, which is to limit the number of visits of any patient to approximately 12. At the day clinic, the philosophy is that long-term therapy is a possible treatment alternative.

Regarding termination, the evening clinic had a somewhat greater percentage of planned terminations than the day clinic. The evening clinic patients also were rated as evidencing more improvement than the day clinic patients. However, one issue that must be considered is whether the differences in types of termination and therapists' views of outcome could be accounted for in terms of differences between the day and evening clinics' staffs, as well as differences between patients seen in the clinics. The current data do not allow definitive conclusions about this issue, but some reasonable speculations can be made.

The day clinic had 6 staff members—2 psychiatrists, 2 psychologists, and 2 social workers; the evening clinic had 24 staff members (each of whom worked 1 night a week)—5 psychiatrists, 5 psychologists, and 14 social workers. The staff of the day clinic generally appeared to be dealing with a population of patients similar to that which the evening clinic staff was serving in their full-time jobs. Only one member of the evening clinic staff was in full-time private practice; two others were associated (during the day) with agencies or hospitals in which they dealt with a population that was similar to the lower class population served by the day clinic. Therefore, it seems that the data on the types of termination or outcome ratings were not greatly influenced by differences in the staffs of the two clinics.

The differences between the two clinics in planned terminations and rated improvement bring to mind the relatively widespread contention that persons who are more educated and of higher socioeconomic status are more suited to psychotherapy (*3*). Some recent work, however, has challenged this contention (*4*). Nevertheless, if a planned termination is partly indicative of following a treatment plan through its conclusion, then the higher percentage of planned terminations in the evening clinic is consistent with the notion that the more educated, higher socioeconomic status patients in the evening clinic were more likely to be successful candidates for psychotherapy than the day clinic patients. Consistent with this conclusion, the data indicated that evening clinic patients were rated as showing greater improvement than the day clinic patients. These speculations should be considered as highly tentative, since the study did not control for factors such as severity, duration, or types of problems experienced by the patients seen at the two clinics.

Despite differences between the two clinics, the data indicate substantial percentages of unplanned termination for both clinics (45.5 percent day clinic and 40.1 percent evening clinic). Although the data do not indicate at which point in the therapy process these unplanned terminations occurred, they do indicate that a great majority of patients at both clinics were seen for 5 or less visits (79 percent day clinic patients and 78.5 percent evening clinic patients) and that substantial numbers of patients terminated prematurely.

The issue of the high frequency of premature terminations among patients in the lower socioeconomic class has been addressed by Lazare and associates (*6*). These authors used a treatment orientation in which

patients were considered as "customers" who were making various requests, such as for ventilation of their problems and for reality contact, as well as for self-understanding. These were considered to be legitimate requests, but they required different kinds of professional response. In both the day and evening clinics continuing efforts are being made to clearly identify patients' requests and to respond to them appropriately.

Since the results of this study demonstrate that the Evening Mental Health Clinic is reaching a population not served by the day clinic, it is well to consider some implications of mental health service delivery at an evening clinic. First, it should be emphasized that the evening clinic operates in the same physical location as the day clinic of the hospital's department of psychiatry, thus making maximum use of the hospital's psychiatric facilities and eliminating the need for a separate physical structure. The same psychiatric facilities, used at different times, serve different populations. Another advantage is the accessibility of the hospital's vast resources. Since all persons attending the evening clinic are registered as hospital patients, referrals for other hospital services, such as physical examinations, vocational rehabilitation, or specialty clinics, are easily carried out.

Another important aspect of the evening clinic is its staff, which consists of a contingent of part-time consultants (with the exception of the full-time director and two secretary-receptionists), each working 1 night a week. To the best of my knowledge, this staffing pattern is unique for a mental health clinic, and it results in a working environment that differs in some important respects from those of many other mental health clinics. For one thing, staff members come to the clinic once a week for 4 hours, and this time is spent almost solely in providing therapy. Continuity for the clinic is provided by the director and the secretary-receptionists, who deal with administrative matters and issues such as making referrals, obtaining additional information from patients, and obtaining concrete services for patients when necessary (for example, welfare and related services). Thus, the evening clinic provides an environment in which staff members can focus their attention almost exclusively on the direct delivery of clinical intervention, unencumbered by administrative and other details. The satisfaction of the staff with this work environment is apparent from the fact that between July 1975 and March 1979 only three staff members left the clinic—one died and two moved out of the State after changing their full-time jobs.

The high proportion of staff time available for direct service is also desirable from the point of view of administrative accountability; 3½ hours of the 4-hour nightly clinic are devoted to direct service—a team conference is held during the first half hour. The high proportion of time spent by the staff in direct service provides a high return for funding sources in terms of staff time devoted to patient contact.

Another noteworthy characteristic of the evening clinic is that since it is staffed by persons who have full-time jobs elsewhere, a great variety of agencies and mental health and social service resources are represented. At the time this paper was written, the 24 staff members of the evening clinic represented 17 such resources. This diverse staff also results in a wide range of therapeutic skills, approaches, and orientations, which make possible a broad range of services from a group of highly experienced professionals.

In conclusion, the results of this study attest to the utility of a relatively self-contained mental health clinic that functions in the evening and uses the psychiatric facilities of a large general hospital. The findings also delineate some important differences between patients who might use evening clinics as opposed to day clinics. Investigation and delineation of such differences and of new ways to provide mental health services, such as the evening clinic, should facilitate planning for mental health funding and for the kinds of services offered in the mental health field.

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