Best Practices for Improving Engagement of Clients in Clinic Care

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Mental health clinicians and program administrators must implement effective strategies for engaging and retaining clients in care. At a recent series of forums open to providers from clinics in New York City that was sponsored by the city and state public mental health authorities, high-performing providers described their client engagement strategies. In this column the effective strategies reported are summarized in four areas: the first session, staff training and expertise, productivity measures, and engaging families and support persons. The approaches should be of use to administrators to improve programs' ability to engage and retain clients in community-based clinic care. (*Psychiatric Services* 61:343–345, 2010)

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Introduction by the column editor: What happens once best practices have been identified? How can they be best communicated to the relevant parties? This column describes efforts of public mental health administrators to disseminate information about best practices to the provider community. It is unfortunate that tragedies are often the driving force for initiatives like these, but it is fortunate that stakeholders from New York City and State took the initiative to gather this useful information.

Engagement in care has been defined as "developing a trusting relationship between the treatment team and the individual" and has been described as successful "when an individual identifies the program as his or her service provider" (1). Engagement leads to a sense of partnership, adherence to treatment recommendations, and lower rates of adverse outcomes, including suicide, violence, hospital admission, and housing instability.

Surveys suggest that engagement is facilitated when treatment providers are committed and dedicated, listen and encourage, and use a partnership model involving problem solving and shared decision making (2–4). In this approach, the treatment provider offers information and learning aids that allow the client to be actively involved in reviewing treatment options and making decisions. There are important ethical, clinical, and economic rationales for this approach, which provides a strong theoretical perspective for a recovery orientation in mental illness (5–7).

In 2007–2008 three violent episodes received notable media attention in New York City because they involved individuals with serious mental illness. In response, city and state mental health administrators convened a panel of experts to review the incidents and make recommendations regarding strategies to enhance care for high-need clients at risk of violence and other adverse outcomes. The New York State/New York City Mental Health–Criminal Justice Panel reported that providers made minimal efforts at outreach to and reengagement of high-need clients who discontinued services (8). The panel recommended the development of standards of care for clinics that included requiring providers to have procedures for engaging and retaining high-need clients in care.

As a follow-up to the panel report, the New York State Office of Mental Health held seven provider forums throughout the state to present the standards and examine current practices. In two New York City forums, administrators from four highly regarded agencies described practices to engage and retain clients. Two are large agencies with networks of clinic, housing, and intensive outreach programs. Another is a victims' assistance organization that manages a domestic violence hotline, shelters, and child advocacy, clinic, and rape crisis programs. The fourth, a smaller agency, provides clinic services to the Latino community.

The program directors from these

"best-practice providers" described practices and procedures that in their experience best supported engagement in care. Their responses are summarized below and grouped into four categories: the first session, staff training and expertise, productivity measures, and engagement of families and support persons.

The first session

All of the program directors agreed that the first meeting is critical in determining successful engagement. Studies indicate that 30% to 40% of clients fail to attend their first scheduled visit at outpatient mental health clinics (9–11). Drug and alcohol abuse, severity of illness, and longer wait times are known to increase no-show rates (12,13), and outreach and prompting procedures have been suggested to improve attendance (11,13,14).

Before the first appointment, one New York City best-practice provider uses scripted confirmation phone calls during which staff members anticipate and address potential obstacles, including transportation and child care. Another provider does not allow intake phone calls to transfer to voice mail and instead uses a phone coverage system to ensure that all calls are answered by a clinician. Whenever possible, treating clinicians conduct initial assessments to minimize the number of new staff that clients encounter. Discussions about preferred appointment times, typical duration of treatment, and specific client preferences in regard to treatment occur at the initial client meeting.

One provider sends personalized letters to clients summarizing treatment recommendations after the initial visit and follows up with phone calls to confirm the second appointment. At another program, clients receive a "contract for services" that stipulates the rights and responsibilities of both the client (keep appointments, pay fees, and participate in goal setting) and the staff member (see the client at the scheduled time, treat the client with respect, and view treatment as a partnership). The best-practice providers reported that when these approaches were used, 70%–80% of clients attended initial scheduled sessions and two-thirds attended at least six sessions.

Staff training and expertise

The program directors noted that it is critical to develop well-trained staff and that experienced, committed staff are more effective at engaging and retaining clients in care. Best-practice providers offer clinical supervision for staff along with opportunities to participate in on- and off-site continuing education activities. Providers stressed the importance of adopting evidence-based practices, including measurement of treatment adherence and outcomes. Learning collaboratives, based on a model of continuous quality improvement developed by the Institute for Healthcare Improvement (15), are used as a highly efficient mechanism for enhancing staff expertise. These collaboratives bring together stakeholders to review concerns related to quality and practice. Clinicians and administrators brainstorm and problem solve regarding evidence-based practices that can be implemented to enhance quality, with the goal of integrating multiple viewpoints into a consensus strategy for changing practice patterns. One program noted that clinician-identified rates of co-occurring substance use disorders increased from 10% to 30% after adoption of an evidence-based assessment strategy.

Despite the ubiquitous pressure to increase "face time" with clients, best-practice providers were in agreement regarding the importance of staff supervision and educational opportunities. One program employs both salaried and fee-for-service clinicians and pays staff (including fee-for-service clinicians) to attend off-site supervision and training to obtain specific technical expertise. The benefits of this commitment to staff development include improved recruitment and retention as well as enhanced staff morale and individual productivity. One provider noticed interest from new funding sources after the agency adopted evidence-based approaches. This provider had a heavy reliance on government funding sources but found that private foundations (nonpharmaceutical) and corporate philanthropies expressed greater interest in funding services that used evidence-based practices because the provider agency was able to draw a straight line from funding dollars to improved outcomes. The benefits of enhanced funding outweighed concerns regarding the cost of staff training activities and loss of face time with clients.

Productivity measures

Preventing staff burnout was an important theme. Best-practice providers were able to avoid the destructive cycle of increased expectations for client face time, clinician fatigue and burnout, and subsequent resignations and staff turnover. This cycle contributes to programs' inability to develop the staff experience and technical skills necessary to facilitate engagement and retention of clients in care. Providers described addressing burnout with open and equitable productivity expectations. One provider sets an expectation of six individual visits per day averaged over 44 weeks a year per clinician. Another provider sets an expectation that 57% of each clinician's time will be face to face, with 27 visits per week expected for a clinician working 35 hour per week. New cases are assigned based on actual visits and not scheduled appointments, which rewards clinicians for engaging clients in treatment by assigning them fewer new cases and lowering the associated administrative burden. The conference and meeting time described above are included in productivity formulas.

The need for "real-time" encounter data was emphasized. Providers described using productivity reports in clinician supervision to establish trends and identify opportunities for efficiency. The program directors are careful to avoid absolute adherence to productivity targets, understanding that unforeseen circumstances and individual variability are unavoidable and that a rigid approach undermines staff morale. Supervisors reviewed and modified productivity targets at their discretion.

Engaging families and support persons

One program director described efforts to focus on families and support persons by soliciting staff opinions regarding characteristics and techniques that enhance engagement of their ethnically diverse population. Ability to speak the same language as the client and family and cultural sensitivity were identified as "universal engagers." Other key principles include a relationship-centered approach that sees the client in the context of his or her family and larger cultural group; "beginning within," which is the capacity of clinicians to manage their emotions so that they can project calmness to the client, family members, and support persons; use of curiosity to elucidate client and family strengths that will enhance healing; respect, or holding the client's culturally based feelings, beliefs, and thoughts in high regard; empathy, or the realization that others' emotional needs are similar to one's own; and a focus on solutions that begins with an explicit recognition that the client is the expert and the family is the key support system.

Conclusions

This column highlights engagement practices adopted by mental health programs that are highly regarded by their peers. Although it is not a comprehensive review or based on a representative sample of providers, it describes the procedural strategies (such as reminder calls) and administrative strategies (such as assignment practices) used by four provider agencies in a large metropolitan area. Several of the practices described have an evidence base supporting their effectiveness. It is beyond the scope of this report to summarize the evidence base; however, a recent review examined literature in this area (16). Other practices described here represent the unique experiences of agency leaders with engagement strategies. Systematic research is required to establish the utility and generalizability of these approaches.

Feedback from providers attending the forums was positive. Many had not attempted to use the procedures and practices discussed, and it was noted repeatedly that many strategies for enhancing engagement could be considered and implemented without extraordinary commitment of resources. All agreed that further efforts to identify the relative extent to which such "promising practices" improve engagement, retention, and client outcomes will be of immediate practical significance to a wide range of clinic providers.

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