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The Role of the Frontline Clinician

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A walk-in client is screened, assessed, needs an appendectomy and is sent out for a referral.

A client with a ruptured spleen needs emergency care. She says she'll be fine before she leaves to make arrangements for her children and return the next day for admission.

The next revolution in behavioral healthcare must involve a drastic overhaul of front-end systems that will foster greater clinical responsibility.

Most individuals would react with horror, disgust or confusion if they witnessed or heard about either of these scenarios. However if "appendectomy" were replaced with "chemical detoxification" or "suicidal ideation" instead of "a ruptured spleen," the situations would be judged as more palatable. Why? The prevailing attitudes toward behavioral medicine and psychiatry indicate that they are "soft" sciences and persons suffering with mental illness or chemical dependency "just need to snap out of it." At the same time, clients are tossed into limited treatment slots and others in need are placed on a "waiting list."

Costly services such as inpatient programs are initiated without proper attention to precipitating circumstances. Current methods of clinical evaluation focus primarily on symptoms and dysfunctions rather than competencies and resources. Little emphasis is placed on identifying client resources or involving clients in meaningful interaction before treatment is started.

Reimbursement for treatment services requires a necessary amount of data collection and documentation. Verifying benefits and completing admissions consume the energies of many frontline clinicians in public and private settings. Identifying chaotic systems, prioritizing interventions and empowering clients should begin during pretreatment while moving the focus from pathologizing to facilitating growth and self-sufficiency.

The next revolution in behavioral healthcare must involve a drastic overhaul of front-end systems that will foster greater clinical responsibility through: 1) improved relations with referral sources; 2) strategic involvement of significant others; 3) coordinated efforts with primary care and; 4) consistent methods of clinical evaluation, crisis intervention, and service coordination.

Engaging clients in central intake sets the stage for effective intervention and improves treatment outcomes.

Intake workers have a responsibility to probe further than client self-reports. It is not uncommon for clients to report an uncharacteristic use of cocaine to avoid a court hearing or specifically request a "28-day" residential drug rehabilitation program despite eight months of sobriety and compliance in outpatient programming. These clients remain in treatment only as long as they get what they want. If the unidentified primary needs are not met, the client leaves treatment prematurely or the crisis exacerbates until another setting is required for stabilization. This is especially challenging when clients with co-existing mental illness go unnoticed for several days in chemical dependency programs. Primary psychiatric issues such as depression, anxiety and personality disorders are prevalent in the chemically dependent population and, if not addressed, the clients will more than likely fail treatment (McLellan et al., 1983). Homelessness, criminal warrants, abuse, or financial problems could also be primary reasons for seeking treatment. When these issues are identified and addressed initially, the results are much better (McLellan et al., 1983).

It is not surprising for a client to report a daily drug habit for several months, but claim no use for several days prior to intake. Clients tend to report information

consistent with their purpose for seeking treatment. It is not the task of the frontline clinician to expose deception. In fact, many alcohol abusers "engage in extreme levels of deception regarding their drinking in attempting to manipulate a more positive image of themselves" (Caddy, 1985). Rather, the goal for frontline clinicians is to highlight discrepancies to help the client view their reporting and behaviors as contradictory with their stated goals and provide clues to the client's motivations for seeking treatment.

Improved relations with referral sources

Service providers often track referral sources as program feeders but frequently miss their benefit in treatment coordination prior to client enrollment. Referral sources can provide much of the critical data necessary for treatment planning. As a habit, frontline clinicians should inquire about referral circumstances and, with the client's consent, clarify any treatment expectations with the referral agent. Common referral sources tend to have expectations that may or may not fall within the service provider's ability to intervene or treat as outlined in Table 1, below.

Strategic involvement of significant others

Few clients seek out treatment on their own. Significant others such as family, church members, friends, or neighbors often make the first move for minors or clients who are chemically or cognitively impaired, heavily medicated, or resistant to treatment. With the client's explicit consent, significant others can provide reliable and accurate information to establish a framework for success and possibly influence the client's readiness for treatment. Studies have shown that clients tend to report more accurately during assessment if they are aware that collateral sources will be involved (Caddy, 1985) and are associated with more positive outcomes. In addition, a serial diagnostic interview involves review of client discrepancies, further assessment of client strengths and development of personal goals that "actually increase self-efficacy and general motivation for

Table 1 - General expectations from common referral agents

	Concerns	Requests	Cautions	Responses
Child Welfare	Child safety, abuse and neglect, treatment mandates	Psychological evaluations, parental interventions, inpatient treatments	Determination of parental fitness, disclosure of abuse or neglect, resistance in engaging parents	Offer assessment, secure release, clarify any treatment mandates, follow-up with disposition
School	Safety of school grounds, attendance, classroom disruptions	Psychiatric evaluations, after-school programming, medication	Determination of eventual risk to others	Offer assessment, secure releases, recommend intervention based on imminent risk, follow-up with disposition
Corrections/Criminal Justice	Legal mandates, parole or probation conditions	Drug screens, involuntary treatments, 28-day programming	Insufficient clinical support for treatment mandate	Offer assessment, secure releases, request documentation of court order or treatment mandate, follow-up with disposition
Ambulatory Health	Psychiatric and substance abuse stabilization	Immediate assessment, transportation, pre-certification	Insufficient documentation	Offer assessment, secure releases, request contact for additional information, follow-up with disposition
Managed Care	Case coordination, cost savings	Level-of-care assessment	After-hours inaccessibility, refusal to authorize use of benefits	Offer assessment, secure releases, advocate for client if authorization refused, follow-up with disposition
Hospital Emergency Department	Clearing emergency department beds	Patient transfers	Medical instability, inadequate documentation, inappropriate transfer	Offer assessment, secure releases, request documentation by fax, review with medical personnel
Intermediate Care/Nursing Home	Resident safety, zero tolerance of alcohol/drug use	Involuntary treatment, day programming	Insufficient criteria for treatment	Offer assessment, secure releases, clarify expectations for intervention, follow-up with disposition

treatment" (Milby and Rice, 1985). Many providers routinely utilize the Addiction Severity Index (ASI) or similar tools to identify core issues, highlight inconsistencies in reporting, and monitor improvements in treatment.

At the New York University School of Medicine, psychiatric residents without prior experience in chemical dependency treatment were taught Network Therapy, a cognitive-behavioral technique of addiction treatment augmenting individual work with support from family, friends, and significant others. After six months of working with cocaine-dependent individuals in outpatient treatment, clients produced negative cocaine screens at statistically similar levels to the control group treated by addiction professionals (Galanter et al., 1997) demonstrating that input from significant others can bolster treatment efficacy. Family members of alcoholics and drug addicts were introduced to the Community Reinforcement and Family Training (CRAFT) approach; a positive reinforcement based family intervention developed to engage addicts in treatment. In a series of studies, CRAFT proved to be three times more effective than Al-Anon or the Johnson Institute intervention in a much higher rate of engagement into treatment (Meyers et al., 1995). If the client is unwilling to involve significant others, the frontline clinician should address the resistance and stress to the client the greater risk for relapse from excluding social supports in the recovery process.

Coordinated efforts with primary care

Another major source of referrals to behavioral health intake originates from primary care systems. Referring physicians can be a vital source of information about medical history, treatment compliance, and presenting problems among other issues. With the client's understanding and explicit consent, primary care involvement is advantageous to fully integrate the intervention.

In general, few physicians incorporate screening for psychiatric or substance abuse issues during routine office visits. Out of 223 persons identified in a study in England as having substance abuse disorders, about 50 percent of the patients with alcohol comorbidity never consulted their primary care physician and only half of those were identified with alcohol addiction. In spite of this, the main filter for accessing specialty addiction services came from primary care referrals (Commander et al., 1999). And for those physicians who do refer to behavioral health specialists, they can be highly influential in getting patients to treatment (Weaver et al., 1999).

From a sample of 298 screened patients in Germany, those referred by physicians more often: 1) were alcohol dependent; 2) rated higher with alcohol-related illness; 3) were motivated to change; 4) exhibited improvements and; 5) participated at a higher level in remedial programs (Hapke et al.,1998). It is clear that primary care involvement in the behavioral healthcare setting is essential in reinforcing follow-up for optimal benefit.

Consistent methods

Gathering indirect but relevant information from referral sources and significant others helps to set the stage for the client interview. Although much information can be acquired through written documentation and telephone contact, timely medical and clinical data can only be collected in face-to-face contact with a trained professional.

The process should take anywhere from 20 to 50 minutes and the data gathered contain elements of both clinical evaluation and service coordination. If a client is suicidal or going through severe withdrawal, it does not matter whether he/she is indigent, under managed care, on disability, or independently wealthy.

The dimension of primary importance to the frontline clinician is the clinical evaluation of the client's *medical* conditions that includes acute and chronic biophysical symptoms. A client experiencing acute pain may not be able to benefit from an intensive outpatient program. Many programs establish exclusionary criteria for varied medical conditions. It is important to assess the severity and acuity of an illness to determine medical stability for program admissions. The *clinical* conditions generally includes all other nonmedical data. A *biopsychosocial* assessment would include information about the client's housing, finances, physical and mental health, vocational and educational issues, family dynamics, social supports, recreational, spiritual and transportation resources (Wallace, 1990). Minimal information would include:

- pattern of drug/alcohol use in past 24-48 hours, last week and last 30 days;
- means of supporting alcohol/drug habit;
- prior treatment attempts as well as outcomes;
- identified sober support;
- composition of household and immediate neighborhood;
- last office visit with a medical professional and purpose of visit;

- involvement with legal systems, current and past;
- history of most recent employment experience and/or contact with payee.

Once the medical and clinical data is collected and treatment issues identified, the clinician prioritizes the interventions. Although screening and assessment are viewed as continuous processes, many interventions are time-sensitive and require intervention within a short period of time. In 1975, the U.S. Department of Defense developed the *triage model of crisis management* as distinguished by:

1. Those who were so severely wounded that they have little hope of survival even with treatment (*emergent*).
2. Those whose chances of survival will be significantly improved by timely treatment (*urgent*).
3. Those who are so well off they do not need treatment or can wait to be treated (*routine*).

In the managed care arena, it is generally noted that *emergent* situations require intervention immediately or not beyond two hours from the onset of the crisis, *urgent* situations handled within 48 hours and *routine* situations resolved in no more than two weeks or 10 business days. Each client should be triaged to determine the required response. Safety and security for clients and others are of utmost importance. Clinicians have ethical and legal responsibilities to report child and elder abuse or neglect, duty to warn and sometimes admit or transfer patients against their will. This does not negate the clinician's responsibility to clarify the legal obligations as well as explain the client's legal rights. This includes educating the client about the intervention and what to expect after the crisis has subsided. Each medical and clinical condition should be identified as emergent, urgent, or routine and treated accordingly. The settings for specific interventions are administrative and financial functions within service coordination. The *administrative* function includes information specific to providers or settings such as admission criteria, available treatment slots, procedures and policies. Predetermined program eligibility and exclusionary criteria consistent with the provider's purpose, goals and mission statement are most effective.

Ultimately, the responsibility and decision to treat is to ensure the safety and security of clients and staff and to stabilize any medical or clinical emergent issues as consistent with the provider's mission statement regardless of income or status. Once the client has stabilized and no longer has emergent needs, the provider can then determine the most appropriate follow-up based on the client's financial resources.

The *financial* function includes the client's insurance, income, family income, available credit and any other benefits or resources available to apply toward payment for treatment. *In the healthcare setting, there are no financial emergencies!* The client's finances only dictate the setting in which emergency treatment is delivered but not whether or not treatment is provided. Determination of a client's ability to pay for treatment is never more than an urgent matter. Clients have rights to emergency care regardless of financial status.

The *benefit* is the client's financial resources available to pay for treatment. Clients who are not indigent or uninsured are responsible for furnishing information about their benefits. The *authorization* is the agreement of the payor source, usually through a gatekeeper, that the clinical information presented by a treatment provider meets medical necessity for reimbursement for a recommended level of treatment. The authorization is usually granted after clinical information is presented to the gatekeeper. The *treatment provider* is responsible for seeking authorization to use the client's benefits to cover certain treatment expenses. Informing clients about their benefits plays a major role in the engagement process and influences motivation to comply with any medical and/or clinical recommendations. There is much work to be done in bolstering the image of mental health and behavioral care as a viable, evidence-based and effective intervention. For many clients, the frontline clinician is their one and only contact with treatment services. As providers shift the role of front-end systems from program feeder to pretreatment intervention or initial case management, clients who may not be prepared to benefit from traditional treatment services can grow closer to treatment readiness. As central intake programs consistently work with referral sources, integrate primary care, provide time-sensitive intervention, coordinate with outside agencies and involve clients and significant others in recovery, providers will see results and demonstrate treatment success.

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