

## Psychiatric out-patient non-attenders: a cause for relief or concern?

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In daily clinical practice, out-patient non-attendances are, unfortunately, regular occurrences. With the current trend towards community based care, out-patient facilities have become increasingly important, and the failure of patients to attend is both disruptive and worrying for professionals in this area. It is difficult to predict which of the non-attenders will progress to join the ranks of those "lost to follow-up". This study was conceived in an attempt to clarify this question, in the setting of adult general psychiatric out-patient services.

Previous studies of out-patient non-attendance have examined failure to attend first appointments (Burgess & Harrington, 1964; Skuse, 1975) and attrition rates in adult psychotherapy and addiction services (Baekland & Lundwall, 1975). Planning of services and analysis of resources in the USA have given impetus to more recent attempts to clarify attendance patterns. Friedman & West (1987) compared "high" and "low" users and found little correlation between utilisation and severity of illness, clinical change and demographic variables.

We are not aware of any study in the UK describing the non-attendance patterns of patients established with an adult general psychiatric out-patient service. We surveyed these patterns for all non-attenders (excluding first appointments) over a maximum of six years, in order to identify the characteristics of patients who get lost to follow-up.

### *The study*

The study was carried out in the out-patients department (OPD) of Highcroft Hospital, Birmingham which serves the entire District of North Birmingham Area Health Authority. All non-attenders previously known to the service (NA) over the six months January–July 1984 were included in the study; those who failed to attend their first appointment were not included. Case-note review and OPD records for a period of three years before and three years after the identified NA provided the following data:

- (a) demographic: age, sex, marital status, employment status

- (b) diagnosis: a diagnosis was made from the case notes according to ICD-9 criteria  
(c) medication prior to NA  
(d) the rank of psychiatrist who last saw the patient before the NA  
(e) tabulation of admissions, attendance and non-attendance over the entire study period.

### *Findings*

There were 240 NAs in the six months. Fifty-one patients were excluded, 39 because of insufficient data to make an ICD-9 diagnosis, and 12 had died during the study period. The sample size was therefore 189. Four categories of patients were identified, based on their status at the end of the study (three years after the NA): still in attendance; not in attendance, but formally discharged or transferred to another catchment area; lost to follow-up immediately after the identified NA; and lost to follow-up during the subsequent three-year period. The sample consisted of 79 male (42%) and 110 female patients (58%). Their age range was 16–70 and was normally distributed. One hundred and thirty-three (70%) were unemployed, 41 (22%) were employed, and 15 (8%) had retired. Eighty-two were married, 78 were single, 21 were separated or divorced, and eight were widowed.

One hundred and three (55%) of the subjects were still in attendance at the end of the study period, while 22 (11%) had been either discharged or formally transferred. The remaining 64 (34%) were lost to follow-up immediately after the identified NA, 42 (22%) or subsequently 22 (12%).

The diagnostic categories were represented as follows: schizophrenia (ICD-9 code: 295) 96 (51%), affective psychosis (manic type (ICD-9 code: 296.0, 296.2, 296.3 and 296.5) 13 (6.9%), affective psychosis (depressive type ICD-9 code: 296.1) 26 (13.8%), neuroses (ICD-9 code: 300) 26 (13.8%), personality disorders (ICD-9 code: 301) 16 (8.5%), and other 12 (6%) cases. The category 'other' comprised isolated cases of alcohol dependence (four cases) (ICD-9 code: 303), drug dependence (two cases) (ICD-9

code: 304), adjustment reaction (two cases) (ICD-9 code: 309), and organic brain damage (four cases) (ICD-9 code: 310).

Diagnosis was the strongest predictor of attendance ( $\chi^2=61.74$ ; d.f.=5;  $P<0.001$ ). No bipolar manic-depressive patients and 14 (14.6%) of schizophrenic patients were lost to follow up. In marked contrast 14 (87.5%) of patients with personality disorder, 18 (69%) of neurotic subjects and eight (66.6%) of the category 'other' were lost to follow-up. Attendance for those with affective psychosis was intermediate between these extremes with 38% being lost.

Being married was predictive of dropping out with 36 (56%) of those lost being married, compared to 46 (37%) of those who were still attending ( $\chi^2=5.75$ ; d.f.=1,  $P<0.02$ ). As the married/unmarried ratios in the groups of non psychotic and psychotic patients were comparable, diagnosis did not account for the predictive value of marriage.

Those employed at the time of the NA were significantly more likely to drop out of treatment ( $\chi^2=7.1$ ; d.f.=2;  $P<0.001$ ), but employment was positively correlated with non psychotic diagnosis.

Sex was not predictive of eventual dropping out. Age, however, was a factor with most of the difference being accounted for by an excess in the 26–35 age group. Patients who were not receiving any medication were also more likely to drop out. ( $\chi^2=23.2$ ; d.f.=1;  $P<0.001$ ).

Future attendance was predicted by a history of at least one previous admission ( $\chi^2=18$ ; d.f.=1,  $P<0.001$ ), but this correlated positively with psychotic illness.

One hundred and seven (56%) patients had been seen by a psychiatric trainee prior to the identified NA, while 82 (43%) had been seen by a senior psychiatrist. The rank of psychiatrist last seen was not predictive of eventual drop-out.

Attendance and non-attendance patterns (percentage of out-patient appointments attended per diagnostic group) for the six-year period, showed patients with personality disorder to be the worst attenders, with only 44% of appointments attended. The percentage of appointments attended for the other diagnostic groups were 83% for bipolar manic-depression, 71% for schizophrenia, 68% for depression, and 64% for neuroses.

### Comment

Overall one-third of the patients who had missed an appointment in the initial six months had been lost from the mental health services three years later.

This study had limitations imposed by the retrospective design and the reliance upon case-note data. We attempted to address the question: "who is the drop-out?". The strongest predictive factor for

future dropping-out was the diagnostic category. Patients with bipolar manic-depressive psychosis proved to be the best attenders, all of them still being in treatment at follow-up, while patients with personality disorders were the worst attenders. The relative composition of the attrition group according to diagnostic category was consistent with logical expectation. The nature of functional psychotic illness such as manic-depression and schizophrenia is such that reliance upon out-patient services is desirable for a long period of monitoring treatment. This contrasts with the categories of personality and neurotic disorders, for whom poor attendance and eventual dropping out with disruption of care was a marked feature.

The reason for poor attendance in these two categories might lie in the nature and treatment requirements of the disorders. A proportion of such patients might benefit from referral to more specialised services (e.g. psychotherapy or psychology). They might view brief out-patient sessions as a poor alternative to such services, and drop out. This tendency would be stronger where local availability of such services was limited and referral patterns were poorly coordinated.

Their poor attendance might be a consequence of less strenuous efforts by medical staff to preserve their relationship with the service. Support for this view is found in the study by Lewis & Appleby (1988) describing the attitudes of psychiatrists towards individuals with a diagnosis of personality disorder. Poor co-operation between services and professionals can further militate against continued attendance. It cannot be assumed that individuals lost to follow-up necessarily require further psychiatric help. Spontaneous improvement in referrals to out-patient clinics has been well documented (Endicott & Endicott, 1964; Gottschalk *et al.*, 1973). Apart from the patient's perception of reaching a satisfactory level of functioning, others may have sought help elsewhere on their own initiative.

Direct comparison with similar studies is difficult owing to the relative paucity of research in this country.

Regarding the predictive value of marriage, we felt that marriage could offer social stability and a confiding relationship such as to diminish dependency on the service. We found it reassuring that the status of the psychiatrist was not a significant variable in the out-patient department career of the subjects. It was interesting to observe that employment militated against regular attendance. On the one hand, the employed might be expected to have more to lose from poor compliance with psychiatric services. Another explanation could be that the employed were less ill, and this is supported by the positive correlation between employment and the diagnostic groups of neurosis and personality disorder. Also

unemployed individuals have more flexible time schedules for keeping appointments.

By concentrating on established attenders to the service, we understood the fear of clinicians to be well grounded, i.e. "is the known individual who has missed an appointment likely to re-contact the service?". Put another way, who among the non-attenders has been seen unwittingly for the last time? Is this cause for relief or concern.?

In general terms our study demonstrated that patients lost to follow-up are less ill, more likely to be employed and more likely to have the support of a marital relationship, and as such this is not a cause for concern. However in economic terms, failure to attend the clinic is wasteful in terms of staff time and may result in unnecessary home visits.

The role of out-patient services has gradually changed over the years from being an adjunct to in-patient treatment (Kessel & Hassall, 1965) to having adopted a more independent role and being engaged in the diagnosis and treatment of a wide range of psychiatric disorders (Johnson, 1973). It is important to establish which patients fail to make use of the service so that the out-patient resources are fully utilised, and so that alternative provision can be made for those patients who do not make full use of the existing services.

Further prospective studies will be required to establish more information about patients who are

lost to follow-up, than we have been able to report in this retrospective study.

The results of this study are relevant to the optimum utilisation of resources as different services for different client populations evolve.

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*Psychiatric Bulletin* (1990), **14**, 149–150

## Rejection of psychiatric treatment

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The growing realisation that health care resources are limited has led to increasing concern about the wastage caused by the failure of patients to keep their psychiatric appointments. Generally, non-attendance following psychiatric referral is particularly high (e.g. Baekland & Lundwall, 1975), although in the north-east of Scotland the rate is roughly similar to those reported by other specialties (Alexander & Hillis, 1989). However, little effort has been made to elicit the views of non-attenders them-

selves or to consider what aspects of the referral system may contribute to this failure to attend.

The aims of this study were to: identify features which distinguish those patients who failed to keep their appointments following referral from general practitioners; and establish the views of non-attenders.

The computerised records of the Grampian Adult Psychiatric services were used to identify all 129 patients referred by their general practitioners during