

A prospective study of psychiatric outpatient non-attenders

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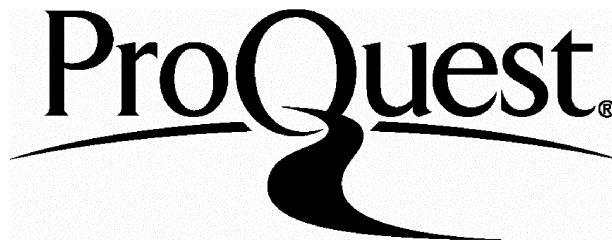
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Abstract

Background

Psychiatric clinics have high non-attendance rates and failure to attend may be a sign of deteriorating mental health, but there have been no prospective studies of psychiatric outpatient non-attendance in the United Kingdom. Good communication between professionals following outpatient appointments is essential for well coordinated management of community patients but has not been researched for follow-up patients.

Aims

- 1.To investigate why psychiatric outpatients miss appointments and the consequences of non-attendance.
- 2.To examine the quality of communication between GP's and psychiatrists following outpatient appointments.

Method

A prospective cohort study of randomly selected attenders and non-attenders at general adult psychiatric outpatient clinics in a geographically defined area of inner London. Subjects were interviewed at recruitment and severity of mental disorder and degree of social adjustment were measured. General practitioners were interviewed to assess their opinion on the quality of communication received from the psychiatrist following outpatient appointments. The

quality of general practitioners' referral letters and psychiatrists' clinic letters were compared. Subjects' engagement with the clinic and any psychiatric admissions were noted six and twelve months later.

Results

Of the 365 patients included in the study, 30 were untraceable and 224 consented to participate (a response rate of 66% for those traceable and 61% overall). The most common reasons given for non-attendance were having forgotten (27%) and being too psychiatrically unwell to attend (14%). Follow-up patients were more psychiatrically unwell than new patients. For follow-up patients, non-attenders had lower social functioning and more severe mental disorder than those who attended and at twelve months, those who missed their appointment were more likely to have been admitted than those who attended (42 [33%] versus 27 [20%], $\chi^2=5.5$, df 1, $p=0.018$). There was no difference in the quality of referral letters of attenders and non-attenders. Psychiatrists were less likely to write to GPs about follow-up patients than new patients and they were least likely to write when a follow-up patient did not attend.

Conclusions

Those who miss psychiatric follow-up outpatient appointments are more unwell and more poorly socially functioning than those who attend. They have a greater chance of subsequent admission yet psychiatrists communicate poorly with the GP about them.

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Chapter 1

Introduction

1 Introduction to the study

1.1 Overview of the introduction

- The introduction begins with a history of the evolution of psychiatric outpatient services in the United Kingdom.
- The difficulties in defining outpatient non-attendance are described.
- The extent of the problem of outpatient non-attendance is then reviewed.
- The implications of outpatient non-attendance, both economic and clinical are considered.
- Difficulties in interpreting the results from previous studies which have investigated factors associated with missing appointments are explored.
- Justification for carrying out this study of psychiatric outpatients is given.

1.2 History of the outpatient department

The development of psychiatric outpatient services in the United Kingdom can only really be understood by taking into account the historical and social context that influenced the evolution of psychiatric services in general.

The origins of psychiatric services date back to 1247 when a monastic priory was founded in the City of London on the site where Liverpool Street station now stands. This priory provided shelter for the sick and infirm and from 1330 onwards was referred to as a hospital, The Bethlem Hospital (the name being derived from Bethlehem). In 1403, King Henry IV ordered a Royal Commission to investigate allegations of scandals, malpractice and embezzlement of funds at the Bethlem Hospital. The report of the Royal Commission provides the earliest evidence that the Bethlem Hospital was treating men suffering from insanity as well as physical illnesses (Allderidge, 1995).

In 1676, the City of London commissioned a new building for The Bethlem Hospital to be built at Moorfields. This was the first hospital for the insane to be opened in the United Kingdom. This building became something of a tourist attraction and the patients considered most appropriate for admission were described in Stow's Survey of London (1720) as:

“those that are raving and furious and capable of Cure; or, if not, yet are likely to do mischief to themselves or others; and are Poor and cannot be otherwise provided for” (Allderidge, 1995).

The History of Bethlem (Andrews *et al*, 1997) gives a comprehensive account of the 750 year history of the hospital and a description of what was probably the earliest form of any psychiatric outpatient service in the world. This service was the innovation of Edward Tyson, a physician at the Bethlem in the early 1700's who recognised the benefits of apothecary prescriptions to prevent relapse. Under his instructions, the introduction of outpatient dispensing of “physick” was established:

“patients who have been Cured of their Lunacies....in Bethlem being poore and not able to procure themselves a little necessary Physick at the Spring and the fall of the years for want thereof many....have relapsed.....and become Patients again” (Bethlem Hospital Committee records, 1718).

The Governors of the hospital made arrangements for such patients to obtain “Physick” at hospital expense on application to the Hospital Committee (Andrews *et al*, 1997, p.275-276).

Concern for the well being of those suffering from mental illness gradually increased and was particularly embraced in the social and

political policy of the Victorians. County asylums were the recommendation of a House of Commons select committee, which had been set up in 1807 to “enquire into the state of lunatics”. Legislation in support of the establishment of asylums followed, including Wynn’s Act of 1808 “for the better care and maintenance of lunatics, being paupers or criminals” and the Shaftesbury Acts of 1845 “for the regulation of the care and treatment of lunatics” (Hunter and MacAlpine, 1974, p.13).

Most asylums were built on the outskirts of major cities, in order to provide a rural retreat for patients. They were therefore isolated from the local community and psychiatrists working within them were isolated from their colleagues in other medical specialties. The Lunacy Act of 1890 set the parameters for admission, providing a legal system where a patient had to be certified as insane in order to be admitted to the asylum. Under the Act, asylums became “a last resort for the insane rather than a means to their recovery” (Andrews *et al*, 1997, p.653). No psychiatric opinion was sought prior to admission. The parish doctor declared patients insane and they were then placed on a compulsory reception order by a local magistrate under the Lunacy Act of 1890 and taken to the asylum (Hunter and MacAlpine, 1974, p.17). As Henry Rollin describes in his autobiography:

“Medical officers in mental hospitals had no control over the selection of the patients they were called upon to treat, nor was there any opportunity to follow them up once they had been discharged into the community” (from *Festine Lente*, Rollin, 1990).

There was no legislative provision for patients to be treated voluntarily in the asylum, but the situation was different for registered hospitals such as The Bethlem where admissions could take place free from certification. The Bethlem stopped admitting parish patients in 1857 and, from the late 19th century, prided itself on being one of the pioneers of uncertified cases. By 1900, only 3% of patients were certified compared to 97% of the asylum population (Andrews *et al*, 1997, p.651). Admission policy at The Bethlem during this period specified that no patient could be admitted if they had been unwell within the previous 12 months and the length of stay should not exceed 12 months.

These differences in admission criteria between registered hospitals and asylums contributed to an exponential rise in the asylum population. Colney Hatch Asylum, the largest in Europe, was originally built to accommodate 1,250 patients but was enlarged within ten years to take 2,000 and in 1937 (when it was renamed Friern Hospital) there were 2,700 patients. The rising population was due to a number of factors including the admission of many severely disabled patients who

could never be discharged and the expanding Middlesex population. There were also a large number of poorly understood and untreatable conditions presenting with psychiatric symptoms such as metabolic disorders, lead poisoning, syphilis and intracranial tumours. Once admitted to the asylum, medical officers' duties included classifying patients as "curable" or "incurable" according to the duration of their illness and the presence of complications such as epilepsy and paralysis (Hunter and MacAlpine, 1974, p.16).

In response to the pressure on beds, the Mental Treatment Act of 1930 extended the voluntary admission procedure to asylums. It was hoped that this would encourage the admission of cases at an early and curable stage of illness. By 1938, voluntary patients made up 35% of all admissions to asylums. At The Bethlem the figure was 75% (Andrews *et al*, 1997, p.651).

In 1917, John Porter-Phillips, Physician Superintendent of The Bethlem from 1914 to 1944, suggested the need to develop an outpatient service to encourage early detection of psychiatric illnesses. This was seen as progressive policy, in keeping with the growing interest in psychoanalysis and psychological treatments for those returning from the First World War and it was hoped that it would allow:

“ early diagnosis of abnormal nervous and mental retardation leading to a complete eradication of the causative factor in mental illness” (Bethlem Annual Report, 1917).

The outpatient department opened in 1918 in Lambeth Road as “The Hospital for Nervous Diseases”. It was so named in order to encourage attendance, since any overt association with The Bethlem was acknowledged to be stigmatising for patients. St. Thomas' Hospital had treated psychiatric patients in its medical clinics since 1890, but The Bethlem's outpatient department was the first to be established at a London psychiatric hospital. It was considered successful and was widely acclaimed. However, due to financial problems it was closed in 1927 “having failed to attract suitable cases” (Governors Report, Bethlem Hospital, 1927). Most patients who attended had, in fact, been previously treated and were not easily cured.

John Porter-Phillips considered this a retrograde step and was subsequently vindicated by the 1930 Mental Treatment Act which encouraged psychiatric hospitals across the country to establish their own outpatient departments “for the examination of applicants as to their fitness for reception as voluntary patients into asylums” (Hunter and MacAlpine, 1974, p.155). In 1925 there were 25 psychiatric outpatient departments in the United Kingdom and by 1935 this figure had increased to 162 (Andrews *et al*, 1997, pp. 555-557).

The development of outpatient services for Friern Hospital was soon established. A weekly outpatient clinic staffed by doctors from the Maudsley Hospital “who had diagnostic experience with early cases of mental trouble” was held at St. Mary, Islington Hospital which later became the Whittington Hospital (Hunter and MacAlpine, 1974, p.155). In 1948, the establishment of the National Health Service led to the medical officers at Friern Hospital being upgraded to consultant status and they subsequently manned the outpatient clinic at the Whittington Hospital on an equal footing with their medical colleagues.

The establishment of the National Health Service, the introduction of phenothiazine drugs in the 1950's and the social and political climate around this time were all factors which influenced the gradual closure of the large Victorian institutions. This led to the increasing awareness that to keep patients in hospital when they had recovered from the acute stage of their illness was an infringement of their human rights. The 1957 Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (Department of Health and Social Security, 1957) recommended that “no patient should be retained as a hospital inpatient when he has reached the stage at which he could go home”.

The 1959 Mental Health Act was the first mental health legislation to clarify the reasons why an individual might need to be admitted to hospital and treated against their will, and the distinction between

voluntary and involuntary treatment became clearer. The work of Goffman (1961) and Wing and Brown (1970) on institutionalisation of psychiatric patients fuelled a political and social movement to close down the Victorian asylums. In 1961, Enoch Powell gave his renowned “water tower” speech in support of the dissolution of the asylums, and in 1962, the Hospital Plan for England and Wales (Ministry of Health, 1962) predicted the closure of half of all mental health beds by 1975.

There followed a dramatic change in the placing of psychiatric services within district general hospitals and a period of rapid development of psychiatric outpatient clinics. District general hospitals began to include psychiatry as a medical specialty and recognised the need to deliver mental health services to the local community. The model adopted for the organisation of psychiatric services was the same as for other hospital disciplines, namely inpatient and outpatient facilities based within the district general hospital. Outpatient clinics therefore became an integral part of psychiatric service provision.

This process is described in John Crammer’s book, *Asylum History: Buckinghamshire County Pauper Lunatic Asylum - St. John’s* (1990). He details how, in 1936, an outpatient department was set up at the Royal Buckinghamshire Hospital. One clinic per week was held, staffed by one psychiatrist. Eight medical beds were made available on the medical ward for the treatment of patients with psychiatric

disorders. By 1943, almost 300 outpatients had been seen, only six had any history of past contact with psychiatric services, only 38 were subsequently admitted to the asylum and nine to the Royal Buckinghamshire Hospital. The service was expanded to two sessions per week, staffed by two senior and two junior psychiatrists.

Alongside these developments, there was a shift towards the provision of other community based services for people with mental illnesses (such as supported housing, day services and community based mental health nurses and social workers). This was colloquially referred to as “community care” and was supported by government legislation: “community care with special reference to mentally ill and mentally handicapped people “ (House of Commons Social Services Committee, 1985). The development of community facilities for those individuals who had previously lived in psychiatric hospitals and the inadequacies of service provision have been the subject of a great deal of debate over the last three decades. Outpatient clinics are still widely used in the United Kingdom for assessing and treating people with mental health problems in the community. The department of Health’s National Service Framework for Mental Health (1999) specifically states:

“any service user who contacts their primary health care team with a common mental health problem should have their mental health needs identified and assessed and be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it.”

For many patients, this means a referral to the psychiatric outpatient clinic. It is interesting that no reference is made to outpatient clinics in the National Service Framework, perhaps because they are so much a part of the structure of psychiatric services that their effectiveness is not questioned.

1.3 Definition of outpatient non-attendance

The simplest definition of outpatient non-attendance is when a patient fails to keep a scheduled appointment. However, this definition is not always easily applied when examining the literature on appointment keeping. Baekland and Lundwall (1975) carried out a comprehensive review of the literature on dropping out of treatment in six specialty areas including psychiatry. A common criticism of many of the studies they reviewed was the lack of description of the term “drop-out”. This term could mean a patient who fails to attend their first appointment, a patient who fails to return to the clinic for a follow-up appointment, a patient who refuses to return to the clinic or a patient who is expelled from the clinic. They stressed that it was important to make the

distinction between a patient who had missed a single appointment and a patient who had completely dropped out of treatment. They made the point that it was the number of visits to the clinic (and subsequent exposure to the clinical intervention) that was important, rather than the time since the patient had first been seen. They suggested that definitions that used a temporal measure of dropping out of treatment could therefore be misleading, since patients would have been seen different numbers of times within the same time period. They concluded that in any investigation of dropping out of treatment, the investigators should be sure to clearly define their own meaning of the term “drop-out”.

1.4 The size of the problem of outpatient non-attendance

A number of authors have investigated exactly how many outpatient appointments are missed by examining non-attendance rates at different clinics. Jones (1987) carried out a comprehensive survey of all referrals to general hospital outpatient clinics in Wales over a six week period in 1985. A questionnaire collecting information about each referral was completed by clinic staff and a response rate of 92% was achieved. A total of 240,000 appointments were scheduled and the overall non-attendance rate was 17%. Around one quarter (23%) of these non-attendances were first appointments following referrals from general practitioners.

More recently, Simmons *et al* (1997) carried out an audit of all 367 new patients referred to a general medical and gastrointestinal clinic in Leeds over a six month period. They found that an average 2.9 appointments were made per patient and 38% of patients missed at least one of these appointments during the six months. First appointments were missed in 17% of cases and 59% of these patients went on to miss a second appointment and were discharged from the clinic (around 10% of all patients). The overall non-attendance rate was 21%.

Deyo and Inui (1980) carried out a review of the literature on missed appointments at general medical clinics in America and found rates of non-attendance varied from 15 to 30%. The 1995 the National Audit Office report on outpatient services in England and Wales (HMSO, 1995) estimated that around 40 million outpatient consultations were booked per year in England and Wales and 12% of outpatients failed to attend their appointments during 1993-1994.

In psychiatry, outpatient non-attendance is of particular concern since it may be a sign of deterioration in the patient's mental health leading to difficulties in accessing services. The rates of outpatient non-attendance at psychiatric clinics have consistently been found to be greater than most other hospital specialties. For example, in Belfast, McGlade *et al* (1988) carried out a retrospective study of all 269 referrals made from a single general practice to hospital services over

a three month period. They found a non-attendance rate of 15% overall and 20% for patients referred to outpatient clinics. The highest rates of outpatient non-attendance were at psychiatric (40%) and ear, nose and throat (ENT, 41%) clinics.

Other studies have confirmed the finding that psychiatric clinics have high non-attendance rates. Carpenter *et al* (1981), working in America studied 1100 new referrals to a psychiatric clinic and found a non-attendance rate of 31% at initial appointments. Morgan (1989) carried out a prospective study of new referrals from general practitioners to psychiatric outpatient clinics in Kent over a six month period and found a non-attendance rate of 34%. Baekland and Lundwall (1975) also confirmed the high non-attendance rates in general psychiatric clinics. They reported that 20%-57% of patients failed to return after their first appointment and 31%-56% attended no more than four times.

1.5 The implications of outpatient non-attendance

1.5.1 Financial implications

The high rates of non-attendance in all hospital specialties are of major concern to service providers since they represent such an enormous waste of resources. In 1995 the National Audit Office (HMSO, 1995) estimated that the total cost of outpatient services in England and Wales was around £2.4 billion per year and the cost of each missed

appointment was approximately £50. Assuming a non-attendance rate of 12%, the estimated cost of missed appointments was therefore around £240 million per year. Since the rates of non-attendance are higher in psychiatry than most other specialties, the economic implications are also greater.

1.5.2 Clinical implications

As well as the financial cost of outpatient non-attendance, there may be clinical implications to consider. There have been no prospective studies of the outcome for medical patients who drop out of treatment, but Caldwell *et al* (1970) studied a group of 42 patients who had stopped attending a hypertension clinic and who subsequently received treatment in the emergency department for hypertensive crises. This study is considered in detail in the literature review (Sections 2.5.1; 2.5.5 and 2.5.11).

In psychiatry, a patient's failure to attend an outpatient appointment may be the result of relapse of the patient's mental health problem. This may lead to subsequent risk of harm to the patient or to others, either through self-neglect, self-harm or unpredictable aggression. The issue of public safety with regard to people suffering from mental illnesses has been highlighted in recent years by tragic incidents such as the unprovoked attack on Jonathan Zito by Christopher Clunis (*The report of the inquiry into the care and treatment of Christopher Clunis*, Ritchie *et al*, 1994).

Some authors have suggested that a patient's non-attendance does not signify relapse, but rather recovery from their symptoms such that they feel no need to seek specialist advice after all. Endicott and Endicott (1963) suggested that patients on a waiting list for psychotherapy experienced improvement in their symptoms without receiving any specific treatment. However, their data did not support their conclusions since only 16 (40%) of the 40 patients included in the study were rated as "improved" after six months on the waiting list. This study is considered in more detail in the literature review (Section 2.5.15).

Some authors have suggested that certain medical clinics, such as dermatology and ENT are more prone to non-attendance due to the self-limiting nature of symptoms (McGlade *et al*, 1988). However, Lloyd *et al* (1993) carried out a prospective study of 1,492 patients booked into new patient assessment appointments at ENT and gastroenterology clinics at a London teaching hospital and found no difference between attenders and non-attenders in their ratings of symptom severity. They concluded that there was no association between non-attendance and resolution of symptoms.

The concern that non-attendance at psychiatric outpatient appointments is of clinical significance, particularly for patients with a diagnosis of a serious mental illness, is supported by evidence from a

number of studies. For example, Renton *et al* (1963) carried out a follow-up study of 155 patients with a diagnosis of schizophrenia who had had an admission to a psychiatric unit in Edinburgh lasting at least two weeks between 1959 and 1961. They were able to interview 132 of these patients at home 12 months later to gather information about their contact with health services following discharge. Three had had no contact at all with any health professional (including their general practitioner) during the 12 months and 21 (16%) had had no contact with the outpatient clinic. Of these 21 patients, 10 (48%) were classified as either poorly socially adjusted and/or to have had a further admission within the 12 month period compared to 26 of the 111 (23%) patients who received outpatient treatment.

Since the authors grouped readmission and poor social adjustment together, the exact number of patients who required readmission is unclear. They also failed to specify how many of those who did not receive outpatient treatment had actually been offered an appointment, stating only that “many of these 21 patients had been requested to attend the clinic but failed to do so.” Despite these criticisms, the results of this study suggested that outpatient contact influenced the chance of readmission for patients with schizophrenia.

In America, Green (1988) carried out a small case note study of a group of 25 outpatients who had a history of recurrent admissions to the clinic's inpatient unit. He noted that for 19 (76%) of them, there

was some reference in their notes to non-compliance with after care plans, usually meaning that they had missed outpatient appointments. He found that this group of patients were more likely to have a diagnosis of a serious mental illness (such as schizophrenia, schizoaffective disorder or bipolar affective disorder) than the outpatient population as a whole. He also found that 92% of his group of frequently hospitalised patients also had some reference in their case file to non-compliance with medication. This study had a number of limitations including the small sample size and the lack of definition of the term “non-compliance with aftercare” but he concluded that further study of “outpatient commitment to treatment” was required. This topic is reviewed in Section 2.15.3.1.

To date, three prospective studies have been carried out specifically examining outcome for patients who miss psychiatric outpatient appointments. The results from two of them appear to confirm that psychiatric outpatient non-attendance is of clinical significance (Koch and Gillis, 1991; Pang *et al*, 1996). Both studies found a higher rate of admission amongst outpatient non-attenders as compared to patients who kept their appointments.

Koch and Gillis’s study was carried out in 1991 in South Africa. They investigated a cohort of 164 patients who had been discharged from the acute psychiatric inpatient unit and followed them up one year after their first scheduled outpatient appointment. It was found that patients

who failed to attend this appointment were over three times more likely to have a further admission during the 12 month period than patients who kept their appointment.

Pang *et al* (1996), working in Hong Kong, followed up 258 patients six months after missing an outpatient appointment. They found that 129 (50%) attended no further appointments at the clinic. Comparing this group of “drop-outs” with the remaining 129 who subsequently reattended, they found that 23 (18%) drop-outs were admitted to the psychiatric inpatient unit within the six month period compared to five (4%) of those who reattended.

The results of these studies suggest that outpatient attendance, in some as yet unidentified way, may be acting to reduce the likelihood of readmission. Alternatively, patients who keep appointments may be less vulnerable to relapse, perhaps because they are less unwell than those who fail to attend.

Conversely, the third prospective study of psychiatric outpatient non-attendance, which was carried out in a military veterans’ clinic in America (Sparr *et al*, 1993) did not show any association between non-attendance and adverse outcome. Over a three month period, the clinic had 1,620 appointments scheduled of which 9% were missed, representing 130 individual patients. Six months later psychiatrists were asked to fill in a questionnaire which included a question about

any “adverse outcomes” for non-attenders during the intervening six month period. None were reported but no definition of “adverse outcome” was given in the paper. The authors reported that over 70% of patients who missed their appointment spontaneously contacted the clinic to reschedule and they concluded that there was no need for the clinic to actively re-engage non-attenders.

Since none of these three studies were carried out in the United Kingdom, the findings may not be easily extrapolated to outpatient populations in this country. Also, the subject selection in each study differed, making the results difficult to compare. All three studies are reviewed in more detail in the literature review (Sections 2.2.1, 2.2.2 and 2.2.3).

1.6 Why do patients miss appointments?

An important reason why patients might fail to attend appointments is that they are dissatisfied with their treatment and therefore “vote with their feet”. There is a concern that dropping out of outpatient treatment may be “an expression of serious dissatisfaction with care” (Deyo & Inui, 1980). In America it has been shown that patients who rate their out-patient service poorly, are likely to desert their physicians (Rubin *et al*, 1993). To date there have been no studies of whether patients who are dissatisfied with the treatment of their mental health problems are likely to desert their psychiatrists.

Various factors such as demographic characteristics, communication between the referrer and the patient and the appropriateness of the referral have been investigated for any association with outpatient non-attendance. The relevant studies are considered in detail in the literature review (Chapter 2). The subject of outpatient non-attendance in general has received a considerable amount of interest from researchers, but the findings are often inconsistent. The specific area of non-attendance at psychiatric outpatient clinics has been examined much less extensively and, again, inconclusive findings can be partially explained by the degree of heterogeneity of the studies. Outpatient clinics vary greatly from one setting to another in terms of the populations served and the style of individual services. Different countries have different health care systems, some state run, some private and various combinations of both. This creates difficulties in the comparison and interpretation of study data.

1.7 Justification for this study

The last 30 to 40 years have seen a shift in locus of mental health service delivery, with many services for patients suffering from serious mental illnesses now being provided in the community rather than from the hospital base. Despite these developments, outpatient clinics remain in widespread use for the assessment and treatment of patients

presenting with mental health problems. In reviewing the background literature for this study it was interesting to note the dearth of available data reporting exactly how many hospitals across the United Kingdom provide a psychiatric outpatient service. This seems to indicate that the outpatient model is considered so much a part of psychiatric service provision that such data is unnecessary and the assumption is therefore that most hospitals offer psychiatric outpatient clinics.

No study has specifically examined the outcome for patients who miss appointments at the psychiatric outpatient department in the United Kingdom. Since the results of studies carried out in other countries have shown a higher chance of admission for patients who miss their appointments compared to patients who attend, it appears that this area is worthy of further investigation. There have also been no studies, which have investigated whether patients who miss psychiatric outpatient appointments are dissatisfied with their treatment. As noted in Section 1.6, a number of factors have been found to be associated with outpatient non-attendance, yet the results from studies are inconsistent.

This revealed a need to design a study to investigate the factors associated with outpatient non-attendance and to specifically investigate the outcome for patients who missed appointments. The study focuses on a neglected, yet fundamental, area of psychiatric service provision. The results of this study provide the first data in the United Kingdom on outcome for psychiatric outpatient non-attenders.

1.8 Summary of the introduction

- The outpatient model of care for psychiatric patients in the community remains in widespread use across the United Kingdom.
- Around 12% of all hospital outpatient appointments are missed and the non-attendance rate at psychiatric clinics is higher than most other specialties, with around one in every three appointments being missed.
- The reasons for non-attendance have been widely investigated but the results from studies are inconsistent.
- There is evidence to suggest that outpatient non-attendance is of clinical, as well as economic significance in psychiatry, but there have been no prospective studies of the consequences of psychiatric outpatient non-attendance carried out in the United Kingdom to date.

Chapter 2

Literature Review

2 Literature review

2.1 Overview of literature review

- Description and critical appraisal of Baekland and Lundwall's (1975) comprehensive review of publications on the subject of outpatient non-attendance between 1955 and 1975.
- Description and critical appraisal of Deyo and Inui's (1980) review of the literature on missed appointments at general medical clinics in America.
- The evidence for the clinical implications of psychiatric outpatient non-attendance is explored through a critique of the three prospective studies of psychiatric outpatient non-attendance.
- The factors associated with outpatient non-attendance are examined by considering the relevant literature according to: factors associated with the patient; factors associated with the referral process; and factors associated with the outpatient department.
- A review of the reasons that patients themselves give for missing appointments.
- A review of the literature regarding patient satisfaction with treatment.
- A review of incentives introduced to encourage outpatient attendance and alternatives to the outpatient model.

2.2 Dropping out of treatment; a critical review (Baekland and Lundwall, 1975)

2.2.1 Summary of article

Baekland and Lundwall (1975) carried out a comprehensive review of the literature published between 1955 and 1975 on dropping out of treatment in six specialty areas. These were: hospital treatment of general psychiatric and tubercular patients; outpatient psychotherapy services; medical outpatient clinics; alcohol services; heroin addiction services; and patients in double blind drug trials. As well as the high rates of non-attendance at general psychiatric clinics mentioned in the introduction, they reported that 32% to 79% of voluntary psychiatric inpatients discharge themselves from hospital within the first few months of treatment. They noted that between one third and one half of those patients receiving psychotherapy as outpatients drop out of treatment (although no time scale was reported) and between 50% and 75% of those being treated as outpatients for alcohol or heroin addiction drop out of treatment before the fourth session. They reported that general medical clinics can also have considerable drop-out rates with rates of 20% to 50%.

They criticised many of the papers they reviewed for not clearly addressing the factors (such as demographic and other characteristics) which might have influenced attendance. For example, they commented that patients who had previously dropped out of treatment were likely to drop out again (Baekland *et al*, 1970; Meyer *et al*, 1967)

but that many of the authors they reviewed had not enquired about this.

They noted that certain clinics (e.g. psychotherapy) were likely to select patients who were well motivated to attend and might be unrepresentative of other outpatient populations. They criticised the lack of description of non-responders. They also criticised studies for not acknowledging that the assignment of different patients to different staff might have influenced attendance (e.g. medical students were likely to be allocated less complicated cases who might be more likely to attend).

They questioned the assumption in many papers that drop-out would necessarily lead to deterioration and a poor outcome. They suggested that up to 50% of patients who miss an initial assessment appointment end up in treatment elsewhere and that this is particularly true of the substance abuse and addiction specialties where repeated attempts at engaging patients in treatment have to be made. Without reporting any supporting evidence, they stated that “in psychotherapy there is often an initial improvement in ratings of anxiety and depression after the first session, but that more complex interpersonal shifts do not occur within the first year of treatment.” They referred to the study by Endicott and Endicott (1963) which reported that patients on a waiting list for psychotherapy experienced improvement in their symptoms without any specific treatment. However, as detailed in Sections 1.4.2 and 2.5.15, the data from this study did not support the authors’

conclusions. Referring to the study by Renton *et al* (1963), Baekland and Lundwall (1975) conceded that contact with psychiatric outpatient clinics appeared to reduce the likelihood of readmission for patients suffering from severe mental illnesses such as schizophrenia.

In summarising their review, Baekland and Lundwall divided the factors associated with non-attendance into three main groups:

- demographic and personality factors of those referred;
- attitudes towards the patient of those making the referral;
- “environmental” factors such as the family’s attitude towards the patient’s treatment and any current life events.

They reported how many of the studies they reviewed had included each of the following factors and how many had found them to be relevant to non-attendance, giving a proportion for each factor:

- age
- sex
- socioeconomic status
- social isolation
- social stability
- severity of symptoms
- diagnosis
- therapist’s attitude to the patient
- family’s attitude to treatment
- patient’s expectations of treatment

The exact proportions of relevant studies where an association was found are reported later in this literature review under the appropriate subheadings.

2.2.2 Critical appraisal

In 1975, Baekland and Lundwall undertook to review all the literature from the preceding 20 years on dropping out of treatment. Their search was comprehensive, including a total of 350 papers. However, they did not focus on any particular medical or psychiatric specialty and the reason for their choice of the six specialties is not given.

Baekland and Lundwall's review was somewhat confusing with regard to psychiatric outpatient clinics. They were not specifically included as one of the six specialty areas, yet in the opening paragraph the authors gave figures for dropping out of treatment from general psychiatric clinics. These figures were, in fact, based on studies of both general psychiatric outpatient clinics and outpatient psychotherapy services. This may reflect the overlap between outpatient psychotherapy and general psychiatric outpatient services at the time of the review.

They did not specify any particular clinical question within the area of dropping out of treatment and this probably limited the degree to which they could generalise in their conclusions. They did not define any specific criteria for inclusion of a study in their review, but do state that

“we ignored papers that did not support their conclusions with legitimate statistical analyses and tests of significance.” They did not appraise the validity of the included studies in any statistical manner, but made a number of general comments about the shortcomings of studies on dropping out of treatment.

There is no way to assess the precision of their results other than to sift through the papers they reviewed and check that their conclusions are robust. However, it seems rather unfair to apply strict “evidence based medicine” criteria to this review since it was carried out 25 years ago. The size of the work undertaken and its presentation as a text which comprehensively assessed all the relevant literature of the previous 20 years accounts for its well respected and often quoted status. It was the first review paper to examine the area of dropping out of treatment and, in fact there has been only one further review article on this subject since 1975 which is considered next.

2.3 Drop-out and broken appointments: a literature review and agenda for future research (Deyo and Inui, 1980)

2.3.1 Summary of article

Deyo and Inui (1980) reviewed the American literature on missed appointments with particular reference to general medical clinics, as they felt that the factors involved in dropping out of treatment were “most relevant to patients with chronic diseases for whom long-term ambulatory care is often necessary.” They reviewed 86 papers, including Baekland and Lundwall’s (1975) review, eleven studies of psychiatric clinics, eleven of paediatric clinics, two of dental clinics, one of a drug trial and one of an alcohol clinic. They therefore reviewed a total of 60 studies of general medical clinics.

Like Baekland and Lundwall (1975), they highlighted the difficulty in use of the term “drop-out” due to the variability and arbitrary nature of different authors’ definitions. They stated that in general medical clinics, the rate of non-attendance ranged from 15 to 30%. They went on to divide the factors influencing attendance into:

- Features of the patient (demographic and sociobehavioural)
- Features of the medical provider
- Features of the disease or reason for referral
- Features of the patient-provider interaction
- Features of the treatment
- Features of the clinic (access and waiting time)

They concluded that younger patients of lower socioeconomic status and with lower educational achievement were more likely to miss appointments. They quoted findings from Baekland and Lundwall's (1975) review, that male therapists were more likely to lose their patients than female therapists and that therapists who appeared bored or disliked their patient were likely to have a high drop-out rate. They reported on no studies where the patient-provider interaction had been examined in non-psychiatric settings. They found that lack of continuity of care was found to be associated with missing appointments in a number of studies that examined it. They did not feel that there was conclusive evidence for any association between the method of payment for health care services and non-attendance and stated that:

“The patient's beliefs about his/her illness and treatment were important as correlates of compliance with medical recommendations in general, including appointment keeping”.

They noted that patients with chronic illnesses tended to keep their appointments. Patients who were prescribed medication were also more likely to continue to attend than those where no medication was given. This may relate to their other finding that:

“Where providers judged a visit to be fulfilling a supervisory role rather than a direct therapeutic function, failed appointment rates were higher.”

However, medication side effects, cost and duration of prescriptions were negatively correlated with appointment keeping. Distance from the clinic and poor weather were not found to be associated with non-attendance, but important associations were found between length of waiting time for an initial appointment or in the clinic itself and non-attendance.

The authors went on to discuss interventions to reduce clinic non-attendance rates. They reported that a number of studies reviewed had shown that telephone or mailed appointment reminders could reduce non-attendance rates at medical clinics by as much as 20%.

They discussed the difficulties inherent in trying to build predictive models to identify potential outpatient non-attenders, since so many interactive factors were involved. They suggested that “more data are needed regarding the potential savings from avoided morbidity as a result of improved clinic attendance.”

2.3.2 Critical appraisal

Deyo and Innuï (1980) did not specify the main aim of the literature review, but in their introduction they inferred that they were carrying out a review of the literature on dropping out of treatment at medical clinics. As stated above, they reviewed 60 such papers and a further 26 from other specialties including psychiatry and paediatrics. They gave no statement of their inclusion criteria for the studies in their

review and do not appear to have carried out any analyses of data for comparison between studies. They made no mention of the calibre of papers included by way of sample size or robustness of findings. It is unclear whether they included all relevant literature (at least with regard to medical clinics) and if not, how they carried out their literature search. Their discussion of patient-provider factors was derived from the psychiatric literature on the subject, but all other factors summarised above were taken from studies of medical patients.

These criticisms of their review mean that their findings cannot be considered robust. In particular, their conclusions about telephone and mailed reminders are overly optimistic and are discussed in detail in Section 2.15.5. Since they reviewed only American literature, their findings are not easily extrapolated to other, non-fee paying health service models such as that of the United Kingdom. Having said this, Deyo and Inui's (1980) paper is the only published overview of non-attendance at medical clinic appointments.

It is important to include the literature on non-attendance at medical and other non-psychiatric clinics in this thesis since there is a degree of overlap in the factors that have been found to be associated with non-attendance at both medical and psychiatric clinics. Certain demographic characteristics (age, gender, socioeconomic status, employment) have been repeatedly investigated for any association with non-attendance in various specialty clinics, yet the findings from many studies are inconsistent. Factors such as waiting times and

family support for the referral or treatment appear relevant to all patients. A full review of all the factors that have been examined at both psychiatric and non-psychiatric clinics is given in Sections 2.5 to 2.9.

2.4 Three prospective studies of psychiatric outpatient non-attendance

2.4.1 Non-attendance of psychiatric outpatients following discharge from hospital in South Africa

2.4.1.1 Summary of article

This study was carried out by Koch and Gillis (1991) in Cape Town. They investigated all 164 patients who had been discharged from an acute psychiatric inpatient unit over a period of four months. They interviewed them at home two months after discharge and again at one year "in order to determine the reasons for non-attendance and their subsequent clinic attendance". At the one year interviews all patients were asked about their attendance at clinic appointments since discharge. The attitudes of patients to attending the clinic were noted and they were also asked whether their family knew about the outpatient appointment. The authors stated that "sociodemographic data, diagnosis and the number of previous admissions were noted on all patients".

Although 64 patients failed to attend their first follow-up appointment (39%), thirteen had been readmitted prior to the appointment. Those admitted were excluded from the rest of the study, leaving a cohort of 51 non-attenders and 100 attenders. Seventy-one of the total cohort (43%) had a diagnosis of schizophrenia.

At one year, one patient who had attended their first follow-up appointment (1%) and 14 non-attenders (27%) could not be traced. The remaining 136 patients were all interviewed, giving an 83% response rate overall. No statistically significant differences in demographic factors or diagnostic profiles were found between attenders and non-attenders.

Factors which were found to be associated with missing outpatient appointments were: "active resistance to attending"; being on "leave of absence" from the ward rather than formally discharged; lack of family knowledge about the appointment; and loss of the appointment card. Attendance was associated with being in receipt of a disability grant.

At one year, 88% of those who had kept their first appointment were still attending outpatient appointments regularly whereas 84% of those who had missed their first appointment had completely dropped out of contact with the outpatient clinic. More importantly, there was more than a three-fold increase in the likelihood of readmission amongst the non-attender group (68% readmitted) compared to the attenders (20% readmitted).

2.4.1.2 Critical appraisal

The aim of the study and the selection of subjects were clearly described. However, the authors did not state their null or primary

hypothesis and no power calculation was given. There was no detailed explanation of how data were collected. The fact that patients' diagnoses were reported in the paper suggested that certain data were collected from the case notes but this was not stated. No diagnostic schedule was referred to. It is unclear who carried out the home interviews with patients and their families and whether the same interviewers were used on both occasions. There was no mention of whether any corroboration of patients' answers took place, particularly with regard to their attendance at appointments since discharge. This could have been checked using case note data. Since specific factors associated with non-attendance were described in the results, it is likely that some sort of questionnaire or proforma was used in data collection but this was not specifically stated. Also, there was no statistical analysis of the differences in numbers of attenders and non-attenders who dropped out of contact with the clinic and the differences between the two groups in admissions at one year.

Despite these criticisms, the results of this study indicate that once a patient misses a single appointment, they are likely to disengage from outpatient care altogether. Furthermore, non-attendance is associated with a higher chance of readmission as compared to patients who keep their appointments.

Koch and Gillis specifically studied patients whose severity of psychiatric illness had meant that they had required admission to hospital on at least one occasion. Thus their data appear to confirm

that outpatient attendance is important in reducing the chance of hospital admission for patients with serious mental illnesses.

2.4.2 Non-attendance of psychiatric outpatients at a military veterans' clinic in America

2.4.2.1 Summary of article

The second prospective study of psychiatric outpatient non-attendance was carried out in America in 1991 (Sparr *et al*, 1993). Over a three month period all outpatients who missed an appointment scheduled at the Portland Veterans' Administration Mental Health Clinic in Oregon were investigated. The authors do not describe in detail from where their referrals originated, but report that around half their clients had chronic psychiatric disorders which began or were exacerbated when they were in military service and 86% of their clients were male. They reported data from a random sample of 20% of their total clinic population, giving a diagnostic profile as follows: 32% had a diagnosis of schizophrenia or schizoaffective disorder; 15% had post traumatic stress disorder (PTSD); 10% had major depression; and 10% had bipolar affective disorder.

In this study, all patients who missed an appointment during the three month study period were included. Six months later the psychiatrists with whom the patients were booked were asked to complete a questionnaire about the type of appointment (medication review,

supportive psychotherapy, or insight orientated psychotherapy), the primary diagnosis, any adverse outcome and whether the patient had made further contact with the clinic. The reasons for missing appointments were gathered directly from patients who recontacted the clinic.

During the study period there were 1,620 scheduled appointments and the overall non-attendance rate was very low (9%), representing 130 individual patients. Only 3% of appointments were for new patient assessments at which there was a non-attendance rate of 20%. Sixty percent of the missed appointments were for medication reviews and 7% were for insight orientated psychotherapy. It was found that patients with a diagnosis of PTSD and/or substance abuse were more likely to miss their appointments than patients in other diagnostic categories.

The authors reported that over 70% of non-attending patients spontaneously rescheduled their appointments within the six month follow-up period, three quarters doing so within two weeks of the missed appointment. The psychiatrists reported no adverse outcomes for any patients included in the study. Of the 25 (19%) non-attenders who did not reschedule or were not reappointed by the psychiatrist, 24 were men and seven were new patients. Nine had a diagnosis of schizophrenia (36%), four (16%) had PTSD and six (24%) had a previous history of disengagement from treatment due to substance misuse. Four (16%) patients had moved without leaving forwarding

addresses, including one patient who had been under the care of the clinic for many years. Two patients were found to have been wrongly assigned to the mental health clinic and their appointments should have been cancelled by the clinic.

The authors concluded that their data did not indicate that the clinic should make particular efforts to re-engage patients who miss appointments since the majority rescheduled a further one themselves. They did not conclude that drop-outs suffered adverse clinical or social outcomes but did concede that an investigation into the hospitalisation rates of outpatient drop-outs would provide more definitive data for their conclusions.

2.4.2.2 Critical appraisal

The selection of subjects for this study and the main aims were well described. However, once again, the authors did not state their null or primary hypothesis and no power calculation was given. The method included a description of the breakdown of the diagnostic profile of a small sample of the clinic's clients and the types of appointments offered but there was no detail given about how this 20% sample were selected and how these classifications of appointment type were defined. There was also no reference to the use of any diagnostic schedule in this sample or for the subjects included in the study. The authors described how the psychiatrists completed a questionnaire six months after the subject's missed appointment but did not mention

whether the psychiatrists had access to the subjects' case notes to help them. Whether they did or not, this method would be associated with a high level of recall bias. Also, nowhere in the paper is there any definition of the term "adverse outcome".

Given that this clinic treated service veterans and therefore saw mostly male patients and many patients had a diagnosis of post traumatic stress disorder, the findings are not easily extrapolated to other psychiatric outpatient services. However, the fact that around 45% of the population were reported to have a diagnosis of a severe mental illness (schizophrenia, schizoaffective disorder or bipolar affective disorder) suggests that the population had considerable mental health needs. No information is given about whether inpatient facilities, other hospitals or the police were contacted to try to trace the outcome of the 25 patients who did not reschedule their missed appointments. One presumes such efforts were not made and therefore the clinic's policy on discharging patients who had not been seen in six months appears potentially dangerous. One could argue that attempts ought to have been made to re-engage patients with severe mental illnesses who accounted for more than one third of those lost to follow-up.

The high proportion of patients who spontaneously rescheduled their appointment is a surprising and encouraging finding and may have more to do with the fact that the clinic dealt with ex-servicemen (and women) who are, perhaps more conscientious about such things than the usual non-military trained psychiatric outpatient population! A

diagnostic breakdown of this group would have been helpful in establishing whether they were patients with less severe illnesses who might have been more able to arrange a further appointment than patients whose organisational skills were more severely impaired by their illness. The study was compromised by the lack of detail on the collection of diagnostic data and its conclusions were severely limited by the lack of definition of the term "adverse outcome".

2.4.3 Non-attendance of psychiatric outpatients in Hong Kong

2.4.3.1 Summary of article

The third prospective study of psychiatric outpatient non-attendance was carried out in Hong Kong by Pang *et al* (1996). All 258 patients who missed a follow-up appointment at the hospital psychiatric clinic during a two month period were included. The following data were collected from the case notes at baseline: demographic details; past psychiatric history including any history of dropping out of treatment or missing appointments; diagnosis; and whether they had received a telephone reminder of their appointment.

Case notes were re-examined six months later to determine whether the patient had reattended the clinic and, if so, whether there had been any adverse event such as hospital admission or death during the six months. Patients who did not reattend (or their relatives) were contacted by telephone and asked about: current symptoms; whether

they had received treatment elsewhere; whether they had been admitted to a psychiatric unit; and the reason for their dropping out of treatment.

The authors found that exactly half the participants (129) reattended the clinic during the six months, amongst whom there were five admissions and no deaths. Of the 129 who did not reattend the clinic (the defaulters), 56 subjects and 28 relatives of other subjects agreed to the telephone interview, giving an overall response rate of 65%. It was reported that 23 (18%) defaulters had been admitted to the inpatient unit during the six month period and five had died (three from suicide, one from a physical illness and one where the cause of death was unknown). These differences between patients who reattended the clinic and defaulters were statistically significant. The defaulters were also more likely to be married, to be employed, to have a history of previous defaulting, and to have been receiving treatment at the clinic for less than one year as compared to those who reattended. The authors stated that reattenders were more likely to have received a telephone reminder prior to the initial missed appointment as compared to the defaulters. The reasons that defaulters gave for dropping out of treatment are given in Section 2.11.

The diagnoses of reattenders and defaulters were similar with no statistically significant differences between them. Around a third were suffering from schizophrenia or delusional disorder, one third were diagnosed as suffering from a neurotic disorder, 15% had an affective

disorder and the rest consisted of various other diagnoses (organic disorder 7%, drug induced psychosis 4%, mental retardation 4% and personality disorder 2%). Almost one half of the 23 defaulters who were admitted had a diagnosis of schizophrenia or delusional disorder and one quarter had an affective disorder. No patients suffering from neurotic disorders were admitted. The diagnoses of the five reattenders who were admitted were not given in the paper. The authors concluded that active re-engagement of psychiatric outpatient defaulters was required.

2.4.3.2 Critical appraisal

This study was generally well designed although no study hypothesis or power calculations were reported. The simple outcome measures (admission and death) were available on all reattenders and 65% of defaulters and were probably recorded accurately in the case notes. However, the defaulters and their relatives may not have been so precise in remembering the exact dates of any admissions occurring prior to inclusion in the study rather than in the six month follow-up period. The authors could have checked the accuracy of admission data through the records held at the inpatient units involved. It is unlikely that a relative would inaccurately report a patient's death, so this data is probably accurate. On balance, the results appear robust. Indeed, if the outcome for the remaining 35% of defaulters had been available, it is likely that the admission rate may have been even higher. Therefore, assuming minimal inaccuracy in the defaulters'

outcome data, the results clearly showed a higher admission rate amongst patients who dropped out of contact with the clinic as compared to those who reattended.

The reason for this higher readmission rate is not clear, but since the diagnoses of reattenders and defaulters were similar, diagnosis per se did not appear to be associated with an adverse outcome. The authors did not make any assessment of symptom severity at baseline or follow-up so no comparison between the reattenders and defaulters can be made. However, the higher admission rate amongst defaulters suggests greater symptom severity in this group. The study therefore showed that outpatient attendance is associated with lower symptom severity, but the nature of the relationship is unclear.

2.4.4 Summary of three prospective studies of psychiatric outpatient non-attendance

- Two of the three studies found a higher admission rate amongst patients who missed follow-up appointments at the psychiatric clinic as compared to patients who attended.
- The American study did not examine admission rates and used an undefined measure called “adverse outcome” which was subject to considerable recall bias. The possible outcomes for non-attenders (including hospital admission) were inadequately investigated but 70% of their population spontaneously contacted the clinic to reschedule their appointment.
- The results of all three studies are not easily extrapolated to other settings in the United Kingdom since service structure and reasons and thresholds for admission vary between countries.
- The South African and Hong Kong studies appear to contain more robust findings than the American study, which may have been dealing with a specialised population, quite dissimilar to most general adult psychiatric clinics.

2.5 Factors associated with outpatient non-attendance: factors related to the patient

2.5.1 Age

Baekland and Lundwall (1975) reported that younger age was found to be associated with dropping out of treatment in 16 out of 51 (31%) studies they reviewed that considered it. Only one of these studies was carried out in a medical clinic (Caldwell *et al*, 1970), the rest related to psychiatric services (elopement from psychiatric hospital, general psychiatric clinics and drug services). Thirty-five out of 51 (69%) studies found no relationship between age and continuing in treatment.

2.5.1.1 Non-psychiatric patients

Deyo and Inui (1980) reported in their review of American literature on missed appointments at medical clinics that younger age was associated with a higher chance of non-attendance.

Frankel *et al* (1989) carried out a study investigating non-attenders at first appointments at outpatient clinics in Wales in six specialties, not including psychiatry. These were: general surgery; gynaecology; ear, nose and throat; orthopaedics; general medicine; and dermatology. Postal questionnaires were sent out to 277 non-attenders and 135 attenders and response rates of 58% and 84% respectively were achieved. They found that non-attenders were more likely to be

younger than attenders. This finding held true when all patients, including non-responders were considered.

Frankel *et al's* (1989) study used a case-control design and investigated all non-attenders over a three month period. However, their control group was not selected randomly and it is not clear whether the controls were also attending first appointments or whether they were follow-up patients. They were drawn from the patients who attended the same clinic under the same consultant on the same day as the cases. A control was the next attender following every second non-attender. This, in part addressed Baekland and Lundwall's criticism of the non-random assignment of patients to staff described in Section 2.2.2. Frankel *et al* (1989) used self-report questionnaires to collect their data, although the details of the questions they asked are not clearly described. As well as the age difference between attenders and non-attenders, other relevant findings from their study data are reported later under the appropriate headings.

Lloyd *et al* (1993) found in their prospective study of 998 new referrals to ENT clinics that younger patients were less likely to attend.

Carpenter *et al* (1981) carried out a comparison of attenders and non-attenders at 1106 initial appointments at a psychiatric clinic in America and found that those aged 18 to 24 were more likely to miss their appointments than older patients.

Caldwell *et al* (1970) studied patients at a hypertension clinic in America and defined dropping out of treatment as non-attendance for at least three months after the last scheduled appointment or discontinuation of medication for at least 30 days. The study was carried out in two parts, the first being a retrospective case note survey which showed that over a one year period, 76 new patients started treatment at the clinic, 50% of whom had dropped out eleven months later. At five years this figure had risen to 74%. The authors went on to study a group of 42 patients who presented to the emergency department in hypertensive crisis and who had previously dropped out of outpatient treatment. They do not describe how or when they ascertained the patients' "drop-out" status. They compared this group with a non-randomly selected group of 24 patients who were attending the clinic and who had responded to a letter asking them to take part in the study. The drop-out patients were interviewed by the physician in the emergency department and, later, by a social worker. Various demographic and medical data were collected. The control group was interviewed similarly by the same social worker at an arranged appointment. Patients in the "drop-out" group were younger than those who were attending the clinic. Drop-out patients also had shorter histories of diagnosed hypertension as compared to those attending the clinic (35% drop-outs had histories of less than five years compared to 4% of clinic attenders). The authors concluded that younger patients are poorer attenders and they are also likely to have a shorter history of known hypertension than older patients. They suggested that, since hypertension is "a chronic disease requiring life-

long supervision”, older patients have “ learnt through bitter experience that regular attendance in long term antihypertensive treatment is advisable.”

The main criticisms of this study are: the lack of stated hypotheses; the absence of any statistically based sample size calculation; the small sample size; and the selection of the control group. A random sample of attenders would have been a more robust comparison group. Other findings from this study are reported in Sections 2.5.5 and 2.5.11.

2.5.1.2 Psychiatric patients

In keeping with the evidence for an association between younger age and non-attendance, Myers (1975) showed a positive correlation between increasing age and regular attendance at an outpatient group. He studied a group of patients referred from general psychiatric outpatient clinics to a weekly outpatient group described as offering a “supportive, non-analytical and non-directive” approach. He sent a questionnaire to 60 patients, all of whom had attended at least four sessions and achieved a 58% response rate. The questionnaire asked patients to rate on a 5 point scale their own estimate of improvement in the areas of symptoms, relationships, life problems and insight.

He found that there was a positive correlation between the number of sessions attended and increasing age but that patients aged 37 to 47 years were most likely to persist in attendance as compared to

younger or older patients. He also found a correlation between increasing age and symptomatic and interpersonal relationship improvement. However, he reported no data on the patients' diagnoses, socioeconomic class, social situations or any other possible confounders. He also did not describe whether the questionnaires were anonymous. If they were not this could have introduced bias into the self reporting of symptomatic improvement since the questionnaires were sent out by a consultant psychiatrist from the hospital where the group was held. There were also no baseline data with which to compare the reported symptomatic improvements.

Other, smaller studies have failed to show the same relationship between younger patients and non-attendance at both psychiatric clinics (Hillis and Alexander, 1990; Koch and Gillis, 1991; Pang *et al*, 1996) and psychiatric day centres (Bender and Pilling 1985).

However, one common finding in studies of psychiatric outpatient populations is that there appears to be a bias towards the referral of younger patients to the outpatient clinic relative to the total prevalence of psychiatric disorder in the general population (Johnson, 1973a; Kaesar and Cooper, 1971; Morgan, 1989; Goldberg and Huxley, 1991). If it is the case that younger patients are less likely to keep appointments than older patients, then this age referral bias could be contributing to a considerable waste of psychiatric outpatient resources.

2.5.2 Summary of Section 2.5.1: age

- Younger patients are poor attenders at non-psychiatric clinics.
- There is conflicting evidence about whether age is associated with non-attendance at appointments at psychiatric clinics
- Younger age has been found to be associated with a greater chance of referral to the psychiatric outpatient department.

2.5.3 Gender

There appears to be no definite agreement on whether men or women are more likely to default on appointments. Baekland and Lundwall (1975) reported that 13 out of the 29 (45%) studies they reviewed that took gender into account found women were poorer attenders than men. However this conclusion has not been repeated in more recent studies of both non-psychiatric clinics (Deyo and Inui, 1980; Lloyd *et al* 1993) and psychiatric outpatient populations. For example, Hillis and Alexander (1990) compared attenders and non-attenders at their first appointment at the psychiatric clinic and found no gender difference between them. Carpenter *et al* (1981) also found no gender difference between initial attenders and non-attenders at a psychiatric clinic in America. Lister and Scott's retrospective case note study of new referrals to the psychiatric clinic (1988) failed to show any association between gender and non-attendance. Bender and Pilling (1985) found no association between gender and under attendance at a psychiatric day centre. Pang *et al* (1996) found no gender difference between

patients who missed a follow-up appointment at a psychiatric clinic in Hong Kong and subsequently reattended as compared to those who never came back.

There does, however appear to be good evidence that men are more commonly referred to see a psychiatrist than women (Goldberg and Huxley, 1991). Brown *et al* (1988) carried out a case note study of 185 patients newly referred to psychiatric services over a three year period in South London. Patients were referred from one of two general practices, both of which had psychiatric liaison clinics held on the premises. The numbers of referrals to each of the three available treatment settings (primary care liaison clinic, hospital outpatient clinic or psychiatric emergency clinic) were examined and differences in demographic factors, past and present psychiatric illnesses and the outcome of the consultation were compared. It was found that men were more commonly referred to the hospital treatment settings whereas women were more likely to be seen in the primary care clinics.

The authors noted that this difference was despite the finding from previous research that twice as many women as men present to their general practitioner with psychiatric problems (Kaesar and Cooper, 1971; Johnson, 1973a). They also noted that this bias towards referring men to hospital services could not be explained by a higher prevalence of psychotic disorder in men. Around a third of the men in their study who were seen in the primary care psychiatric clinics had a

history of psychotic illness compared to 10 to 15% who were treated at the hospital. Around 10% of the women seen in each of the three settings had a history of psychotic illness. They also found that a large proportion of women referred to the primary care clinics had a past history of anxiety or phobic disorders. They concluded that patients seen by psychiatrists in the primary care setting have significant levels of psychotic disorder and chronic illnesses and were not the “worried well”.

One criticism of this study is that the authors based their conclusions on the case note data available about subjects' past psychiatric histories and not on any assessment of their current psychiatric presentation. Sixteen percent of men who were referred to the psychiatric emergency clinic were admitted to the inpatient unit compared to 4% of men and 4% of women in the other two treatment settings. This suggests that the severity of symptoms was greater for this group compared to the others. Data on the reason for referral and/or a diagnostic breakdown of their population at the time of the current referral would have been a more informative measure of their severity of illness than past psychiatric history.

2.5.4 Summary of Section 2.5.3: gender

- There is no consensus in the literature about whether men or women are more likely to keep outpatient appointments.
- Men are more commonly referred to the psychiatric outpatient department than women.
- Women appear to be more commonly referred to general-practice liaison clinics (where they exist) as compared to men.

2.5.5 Socioeconomic status

In Baekland and Lundwall's review (1975), 35 out of 57 (61%) studies that examined socioeconomic status found an association between lower socioeconomic status and dropping out of treatment. However, of these, one third were studies of psychotherapy clinics and one third were studies of alcohol and other substance abuse clinics. Only 5 (9%) were of general psychiatric clinics (two of which emphasised psychoanalytically orientated psychotherapy as their main treatment) and one was a study of a hypertension clinic (Caldwell *et al*, 1970).

2.5.5.1 Non-psychiatric patients

Deyo and Inui (1980) reported that lower socioeconomic class was found to be associated with missing appointments at medical clinics in America in the majority of studies they reviewed. They gave no possible explanation for the association. However, one of the studies

included was carried out by Caldwell *et al* (1970) who found that lower socioeconomic status (as defined by education, type of work and income) was associated with dropping out of treatment from a hypertension clinic. They suggested that “patients of lower social class are faced with daily economic needs which conflict with their health needs. Patients in higher social classes are financially able to value their health more and accept the idea of long term preventative medical care.”

2.5.5.2 Psychiatric patients

Results from more recent studies of general psychiatric clinics have been inconsistent with regard to any association between lower socioeconomic status and non-attendance at appointments. For example, Burgoyne *et al* (1983) used telephone prompting to try to increase psychiatric outpatient attendance rates at a clinic in America and found that patients of lower socioeconomic status were less likely to attend. However, they concluded that this was because they were also less likely to have a telephone. This study is reviewed in more detail in Section 2.15.5. Bender and Pilling (1985) found that living in a hostel was associated with under attendance at a psychiatric day centre. This could be considered an indirect measure of lower socioeconomic class. However, it could also indicate a group of patients in non-permanent accommodation who are less familiar with local services.

Conversely, Carpenter *et al* (1981) carried out a study of 1106 patients newly referred to a psychiatric clinic and found no difference in socioeconomic class between attenders and non-attenders. Koch and Gillis (1991) found no difference in socioeconomic class between patients who attended and patients who missed their first follow-up appointment after discharge from an acute psychiatric ward.

2.5.5.3 Psychotherapy patients

The possible reasons for the association between lower socioeconomic status and dropping out of psychotherapy were explored in detail in Baekland and Lundwall's (1975) review. They suggested that many psychotherapists were "middle class" and therefore had a different background and experience of life to their patients, "many of whom are from lower socioeconomic backgrounds". This, they explained, led to disparity between the therapist's and patient's expectations of treatment. They also reported that "the lower social class patient is less likely to conform to social and expert opinion". Baekland and Lundwall offered no explanation for the association between lower socioeconomic status and dropping out of treatment from other types of clinics included in their review.

2.5.6 Summary of Section 2.5.5: socioeconomic status

- Lower socioeconomic status appears to be associated with non-attendance at non-psychiatric clinics in America but there is no evidence to support any association in UK populations.
- There is no consensus on whether socioeconomic class has any association with the likelihood of attending outpatient appointments at the psychiatric clinic.
- There is considerable evidence that patients of lower socioeconomic status are more likely to drop out of psychotherapy than patients of higher socioeconomic status. This may mean that psychiatric clinics that have an emphasis on psychotherapeutic treatments may find a higher level of non-attendance amongst patients of lower socioeconomic status.

2.5.7 Employment

Baekland and Lundwall (1975) reported that “social stability”, whether defined by occupational, residential or marital status, was found to be associated with dropping out of treatment in 20 out of 41 (44%) studies that examined it. No association was found in the remaining 21 (56%) studies. However, 19 of the 20 studies they included examined populations with substance abuse problems which may not be comparable to general adult psychiatric populations. Baekland and Lundwall stated that where an association was found, the poorer the

social stability, the greater the chance of dropping out. However, one of their own studies on which they based this statement appeared to find the opposite result: Baekland *et al* (1973) found that there was a higher correlation between i) age and income and ii) education and income, for patients who dropped out of treatment at an alcohol clinic as compared to patients who stayed in treatment. The authors interpreted this to mean that occupational stability was associated with dropping out of treatment. More recent studies of outpatient populations have also been inconsistent in their findings of any association between employment status and non-attendance at appointments.

2.5.7.1 Non-psychiatric patients

In non-psychiatric settings, Frankel *et al* (1989) reported that non-attendance at outpatient clinics in six hospital specialties was greater for those who were employed but the authors failed to show any evidence to support this statement. Deyo and Inui (1980) did not find any association between occupational status and non-attendance at medical clinics.

A number of studies of medical (non-psychiatric) clinics have found that difficulty in getting time off work is an identified reason for missing appointments. Ten percent of non-attenders at a dermatology clinic (Verbov, 1992) and 3% at an ophthalmology clinic (Potamatis, 1994) stated they missed their appointment due to work commitments. Frankel *et al* (1989) found that difficulty in getting time off work was

given as the reason for missing an appointment by 12% of non-attenders in his study of six different medical clinics. By contrast, three studies of non-attenders at psychiatric clinics did not find that any patients gave “difficulty in getting time off work” as the reason for missing their appointment (Sparr *et al* 1993; Carpenter *et al*, 1981; Pang *et al*, 1996). This may reflect the high unemployment rate among psychiatric populations (Smyth *et al*, 1990).

The need for greater flexibility in clinic hours was identified by Kaufmann *et al* (1993) in their survey of user satisfaction with psychiatric community drop-in centres, but has not been specifically examined in studies of reasons for non-attendance at outpatient clinics.

2.5.7.2 Psychiatric patients

Smyth *et al* (1990) studied psychiatric patients already engaged with the service (follow-up patients) by way of a retrospective case note study and found that those who were employed were more likely to drop out of treatment over a three year period compared to those who were unemployed. Seventy percent of their sample were unemployed and employment was associated with non-psychotic diagnoses.

Pang *et al* (1996) found that employment was associated with dropping out of outpatient treatment at a psychiatric clinic in Hong Kong. The authors do not report the proportion of patients who were in

employment. This study has been described in Section 2.4.3, but to summarise, patients who missed a follow-up appointment were included in the study. Six months later, those who had completely dropped out of treatment were more likely to have been admitted to the inpatient unit as compared to those who reattended. These findings do not suggest that employed patients are more mentally well (as indicated by their ability to hold down a job) than those who continue to attend for outpatient treatment. In contrast, Bender and Pilling's (1985) study of non-attenders at a psychiatric day centre showed a positive correlation between stability of employment (as defined by at least one year's continuous employment in the preceding ten years) and regular attendance.

2.5.8 Summary of Section 2.5.7: employment

- There is no consistency in the literature regarding any association between employment status and outpatient non-attendance.
- Difficulty in getting time off work to attend appointments may be relevant, particularly for non-psychiatric populations.

2.5.9 Marital status

The amount of social support a patient has appears to be related to non-attendance at the psychiatric clinic, yet the results of studies which have examined marital status are inconclusive.

2.5.9.1 Non-psychiatric patients

For specialties other than psychiatry, Frankel *et al* (1989) showed that single people were more likely than married people to miss their first appointment at outpatient clinics in Wales. Deyo and Inui (1980) stated that most studies they reviewed found no association between marital status and missing appointments at medical clinics in America.

2.5.9.2 Psychiatric patients

Smyth *et al*'s (1990) retrospective case note study of follow-up patients at psychiatric clinics found that being married was predictive of dropping out of treatment. The Hong Kong study (Pang *et al*, 1996) of patients at a follow-up psychiatric clinic also showed that patients who completely dropped out of treatment were more likely to be married than those who reattended. In an earlier audit of follow-up patients at the psychiatric clinic (Pang *et al*, 1995) they also found that patients who missed appointments were more likely to be married than the outpatient population as a whole. They postulated that this was because "marriage provides social stability and confiding relationships, thereby reducing the need for psychiatric services". However, it has been suggested that the protective or stabilising effect of marriage is only applicable to men and that the reverse is the case for women, where marriage is associated with higher rates of depression than being single (Bebbington *et al*, 1991). It may be that married men feel less need to attend psychiatric clinics than married women and marriage therefore shows up as a factor associated with non-

attendance simply because men presenting with psychiatric problems are more commonly referred to the hospital outpatient setting than women (Kaesar and Cooper, 1971; Brown *et al*, 1988). In other words, gender and marriage are confounders with regard to attendance.

Bender and Pilling (1985) found no association between marital status and under attendance at a psychiatric day centre. Carpenter *et al* (1981) did not find any difference in marital status between attenders and non-attenders referred for the first time to a psychiatric clinic in America.

Altman *et al*, (1972) studied 6,764 patients admitted to acute psychiatric inpatient units in Missouri. Routinely collected demographic, diagnostic and mental state data for a group of 151 “elopers” (patients who absconded from the inpatient units) were compared with the rest of the group. These data were collected on checklist forms from staff, patients and relatives during admission and entered into an electronic “the electronic data processor”. The authors used a “linear discriminant analysis function” to identify variables that were highly correlated with elopement. They did not describe this statistical procedure in any detail. They found that elopement was associated with being single (never married) and having a diagnosis of a personality disorder. Being widowed, divorced or separated was negatively correlated with eloping.

They did not describe over what period of time their data were gathered or whether the staff who gathered the data and entered them into “the electronic data processor” had been trained in data collection. Since the data were gathered across five state hospitals, it is possible that a large number of staff would have been involved. Inter-rater reliability was not measured and may have been a source of error, but the large sample size would have limited this.

2.5.10 Summary of Section 2.5.9: marital status

- The literature is unable to show any clear relationship between marital status and the likelihood of outpatient attendance in both psychiatric and non-psychiatric settings.

2.5.11 Family attitude to treatment

Baekland and Lundwall (1975) reported that eight out of ten studies they reviewed which took the family’s attitude to the patient’s treatment into account found an association between a positive attitude and the patient staying in treatment. All ten studies were of child psychiatric clinics.

2.5.11.1 Non-psychiatric patients

Caldwell *et al* (1970) compared patients at a hypertension clinic who were absent from treatment for more than three months (the drop-out

group) with those who attended continuously for five years. The drop-out group were less likely to have a family history of hypertension than those who stayed in treatment. Fourteen percent of drop-outs stated that they had discontinued treatment due to “lack of family support”, although this term is not explained in the paper.

2.5.11.2 Psychiatric patients

Koch and Gillis (1991) found that for patients who had been recently discharged from the inpatient ward, subsequent attendance at a follow-up appointment was more likely if the patient’s family were made aware of the appointment at the time of discharge.

For first referrals to a London child psychiatry clinic, Cottrell *et al* (1988) found that attendance was less likely if the child’s parents were against the referral. They investigated 100 children referred over a three month period and used operationalised interviews with team members to gather information on a number of factors which might affect attendance including the parents’ attitudes to the referral and any domestic social problems. They traced all 100 cases three years later and found that 53% had dropped out of treatment and 16% had not attended any appointments at all. The only predictor of non-attendance in the “never attended” group was if the child’s parents were against the referral. Parental separation was associated with cases where dropping out after the initial assessment occurred.

2.5.12 Summary of Section 2.5.11: family support

- Family support has been shown to be an important factor in encouraging attendance at outpatient appointments in psychiatric and medical clinics.

2.5.13 Diagnosis

It appears that non-attendance rates at substance abuse clinics are higher than general adult or non-psychiatric clinics. Baekland *et al* (1973) found that, six months after commencing treatment, 73% of patients at an alcohol outpatient clinic had stopped attending. In their review, Baekland and Lundwall (1975) report rates of drop-out from methadone maintenance programmes varying from 7% to 64% by six months.

Although psychiatric clinics have higher non-attendance rates than most medical or surgical clinics, certain medical clinics (such as ENT, ophthalmology and dermatology) have higher rates of non-attendance than other non-psychiatric specialties (McGlade *et al*, 1988). There have been no studies of any association between specific medical diagnoses and appointment keeping, but Deyo and Inui (1980) reported that patients with chronic medical conditions tended to be better at attending clinic appointments than patients newly diagnosed.

Personality style and having a diagnosis of personality disorder have been found to be strongly associated with high attrition rates. There may, of course, be an overlap between certain personality traits or personality disorder and substance abuse and such patients may also miss appointments at non-psychiatric clinics. Baekland and Lundwall (1975) reported that nine out of 11 (82%) studies in their review which examined passive-aggressive personality traits and 14 out of 19 (79%) which examined sociopathic traits found them to be associated with dropping out of treatment. Included in these are two studies, one English (Muller, 1962) and one American (Altman *et al*, 1972), both of which found that patients who discharged themselves against medical advice from inpatient psychiatric care had a higher prevalence of sociopathic personality disorder than those who stayed. Altman *et al* (1972) is described in detail in Section 2.5.9.

Muller (1962) studied the case notes of 98 patients who had “unauthorised absence” from a large psychiatric hospital in a nine month period. He stated that he interviewed the patients on their return, but did not specify how many patients did so. It is therefore unclear whether the 98 patients constitute all absconders or a subgroup who returned to hospital. He presented data on the diagnostic categories of absconders and the total hospital population, but did not describe how these data were collected. Bearing this in mind, he found that 11% of absconders had a diagnosis of “psychopathic personality” compared to 1% of the total hospital population.

Other authors have confirmed the association between having personality problems and non-attendance. For example, Lister and Scott (1988) carried out a retrospective case note study of 113 patients who had failed to attend their first appointment after referral to a psychiatric outpatient clinic and compared them with a similar number of patients who had attended. Few details of their method are given, but they report that non-attenders often had “personality, social, marital and multiple problems”.

Similarly, Bender and Pilling (1985) found that a diagnosis of personality disorder was strongly associated with dropping out of treatment at a psychiatric day centre. They reported that no patients who remained in treatment had been given a diagnosis of personality disorder compared to 47% of under-attenders. However, they do not describe how or when their data on diagnosis were gathered or which types of personality disorder were diagnosed.

Smyth *et al* (1990) carried out a retrospective case note study of all 189 patients already engaged with a psychiatric clinic in Birmingham who failed to attend an appointment during an identified six month period. They collected demographic information (age, sex, marital status, employment status) and made a diagnosis from the case notes. They also examined the patients’ attendances for three years prior to and three years subsequent to the six month period. Associations between employment, marriage and drop out are reported in Sections 2.5.7 and 2.5.9. They found that the strongest predictor of attendance

was diagnosis. Those with a diagnosis of personality disorder were most likely to become lost to follow up within three years of the missed appointment and to attend the least number of appointments over the six year period compared to other diagnostic categories. Those with a diagnosis of neurosis were only slightly better at attending and were almost as likely to drop out of treatment. No breakdown of the types of personality disorders diagnosed was given.

In the same study it was found that although 51% of the non-attenders had a diagnosis of schizophrenia and 21% had a diagnosis of bipolar affective disorder, patients with these diagnoses were the least likely to become lost to follow-up over the three year period compared to those with a diagnosis of personality disorder or neurosis. No patient with a diagnosis of bipolar affective disorder was lost to follow-up. Patients with bipolar affective disorder or schizophrenia also attended a much higher percentage of appointments over the total six years than patients with a diagnosis of personality disorder.

Table 2.1 gives a breakdown of diagnostic categories from two studies of patients newly referred to psychiatric clinics (Johnson, 1973a; Morgan, 1989). Johnson (1973a) carried out a case note survey of all 456 patients newly referred to one of three psychiatric outpatient clinics in Manchester over a four month period. Diagnoses were made from the information in the case notes. Morgan (1989) studied 106 new referrals to a psychiatric clinic in Kent in detail using: interviews with the patients, their relatives and their general practitioners;

questionnaires completed by the psychiatrist for each patient which included a provisional diagnosis and a rating of symptom severity; and case note data. Similar proportions of patients in each diagnostic category were found in both studies, although Morgan (1989) did not breakdown the “psychoses” category into schizophrenia or other major psychotic illness. In Morgan’s study, only 3% of patients were rated by the psychiatrists who assessed them as having severe symptoms and over one quarter were rated as having “minimal or no psychiatric impairment at all”.

Taking these results together with Smyth *et al*'s (1990) findings it appears that a large number of patients referred to psychiatric outpatient clinics do not remain in treatment over time, but that those who do are more likely to have a diagnosis of a serious mental illness such as schizophrenia, bipolar affective disorder or other psychotic illness. Morgan’s (1989) finding that around one quarter of newly referred patients have minimal symptoms suggests that this group either stop attending or are discharged from treatment quite soon after referral. For patients with more significant symptoms, diagnosis of personality disorder appears to be a strong predictor of attendance behaviour. Smyth *et al* (1990) postulated that the poor attendance of those with a diagnosis of personality disorder could reflect the inadequacies of the outpatient clinic as a treatment setting for this group of patients who might benefit from referral to a more specialised psychotherapy service. It might also reflect less strenuous efforts on the part of staff to engage with such clients who have been shown to

generate “pejorative, judgmental and rejecting attitudes” in those treating them (Lewis and Appleby, 1988).

Table 2.1 Diagnoses of patients newly referred to psychiatric clinics

Diagnosis	Johnson (1973) n=456	Morgan (1989) n=106
Depression	34%	47%
Neurosis	11%	
Personality disorder	30%	19%
Psychosis	4% schizophrenia	17%
Other psychiatric	8%	13%
Organic disorder	5%	Not recorded
No psychiatric problem	8%	3%

2.5.14 Summary of Section 2.5.13: diagnosis

- Clinics treating patients for substance misuse have higher non-attendance rates than medical or psychiatric clinics.
- Certain non-psychiatric clinics (e.g. ENT, dermatology) have higher rates of non-attendance than other non-psychiatric specialties.
- Personality disorder has been repeatedly shown to be associated with poor appointment keeping and dropping out of treatment.
- The type of personality disorder is rarely described, but early studies found that sociopathic traits were associated with self-discharge from inpatient psychiatric units.
- Amongst patients newly referred to psychiatric clinics, almost one half have a diagnosis of depression or anxiety and 20-30% have a personality disorder.
- A maximum of 20% of newly referred patients have a psychotic illness, but those with more serious mental illnesses are more likely to remain engaged with the psychiatric clinic over time.

2.5.15 Severity of symptoms

The degree of severity of a patient's symptoms and, more specifically the limiting effect of symptoms on a patient's activities may have an association with the likelihood of keeping an outpatient appointment in both psychiatric and non-psychiatric settings. Baekland and Lundwall (1975) reported that 22 out of 35 (63%) studies they reviewed that

considered symptom severity found it to be related to dropping out of treatment.

However, it is not clear whether the degree of severity of symptoms makes it more or less likely that a patient will keep their appointment, since the results of studies examining the relationship are inconsistent. For example, of the studies included in Baekland and Lundwall's (1975) review, Hiler (1959) found that patients with a primary diagnosis of depression who were severely depressed were likely to drop out of psychotherapy treatment. He suggested that this could be a result of their depressive symptoms such as pessimism, low energy and feelings of hostility. However, Frank *et al* (1957) found that less anxious and/or depressed patients tended to drop out of psychotherapy. Baekland *et al* (1973) found that patients who dropped out of an outpatient treatment program for alcohol dependence within four weeks had higher levels of anxiety and depression than those who dropped out later or those who stayed in treatment.

2.5.15.1 Non-psychiatric patients

More recently, there have been two large studies examining severity of symptoms and its relationship to outpatient attendance in non-psychiatric clinics. Frankel *et al* (1989) studied patients newly referred to outpatient clinics in six different hospital specialties (not including psychiatry) over a three month period. All 277 non-attenders and 135 controls completed a self-report questionnaire. A critique of the

method used in the study is described in Section 2.5.1. The seriousness of the presenting complaint was ranked on a three point scale by the researchers according to: the provisional diagnosis (as given in the patient's own words); the degree to which the patient's activity was limited by their condition; the level of pain reported; and the duration of symptoms. No differences between attenders and non-attenders were found in the seriousness of the presenting complaint.

The second large study was a prospective study of 1492 new referrals to ENT and gastroenterology clinics at a London teaching hospital (Lloyd *et al*, 1993). Self-report questionnaires were used to gather information from patients about the nature of their presenting problem, its duration, the degree to which it affected their daily activities and the severity of and anxiety caused by the problem over the preceding week. Questionnaires were sent to half the patients in the first instance in order to check whether the receipt of a questionnaire might affect attendance behaviour. They were then given to all attenders at the clinics and sent to non-attenders. They achieved a 70% response rate for the initial postal questionnaires, a 67% response rate for those given to attenders and 43% for those sent out to non-attenders. The non-attendance rate was 23%. No difference in attendance was found between patients sent an initial questionnaire and those who were not. No statistically significant relationship was found between non-attendance and the nature of the patients' presenting problem, the severity, duration, effect of the problem on usual daily activities or associated anxiety at the time of referral. The authors concluded that

their findings did not support previous suggestions that non-attendance might be related to resolution of symptoms.

Deyo and Inui (1980) reported that patients who were less aware of the significance of their symptoms and the need for ongoing monitoring of their condition were less likely to attend their appointments. This finding was substantiated by Caldwell *et al* (1970) who studied patients who had dropped out of treatment at a hypertension clinic. They found that 36% of drop-outs who were later treated for hypertensive crises, stated that they been poorly informed about the prognosis of malignant hypertension and did not understand the need for ongoing monitoring.

2.5.15.2 Psychiatric patients

In contrast, Grunebaum *et al* (1996) carried out a retrospective case note study of 90 attenders and 90 non-attenders booked into a primary care clinic in New York for initial psychiatric assessment during 1994. The non-attendance rate for psychiatric consultation was 38% and subjects were selected consecutively rather than randomly. An assessment of the degree of distress the patient's symptoms were causing was made using a scale of 0 to 3 from comments in the notes. An assessment of their resistance to referral was made using a similar scale from 0 to 2, the results of which are discussed later in Section 2.42c. The authors used logistic regression to identify predictors of non-attendance. They found that patients who were less distressed by their symptoms were more likely to miss their appointment (66% non-

attendance) than patients whose symptoms were more distressing (25% non-attendance). The main criticism of this study is the fact that the reviewers of the case files were not blind to whether the patient attended their appointment and this could have introduced bias into the grading of severity of distress and resistance to referral.

Endicott and Endicott (1963) reported that patients on a waiting list for psychotherapy experienced improvement in symptoms without receiving any particular treatment. Unfortunately, the authors did not report how many patients declined treatment after the six month wait and whether any who did so had been assessed as having "improved". In fact, their results did not support their conclusions since only 16 (40%) of the 40 subjects were rated as "improved" after six months, five (13%) had been admitted to an inpatient unit and the remaining 19 (48%) were rated as "unimproved". They found that patients who improved had lower levels of anxiety and hostility and higher self-esteem at initial interview than those who remained "unimproved". After six months, they did not rate any patients as having "worse" symptoms, despite the fact that five patients had been admitted to hospital. Their initial assessment included a one hour interview and a further two hour psychological assessment. Patients were re-interviewed six months later. They therefore had clearly received considerable attention to the recording of their life stories and symptoms and cannot really be considered as having had no treatment.

2.5.16 Summary of Section 2.15: severity of symptoms

- The severity of symptoms experienced by patients at both psychiatric and non-psychiatric clinics is associated with the likelihood of dropping out of treatment but the nature of the relationship is unclear.
- Evidence from two large studies does not support any relationship between resolution of medical symptoms and non-attendance at initial medical outpatient appointments.
- Contradictory results from studies of patients at psychiatric clinics mean that no conclusions about symptom severity and attendance can be made.

2.5.17 Past psychiatric history

A patient's previous experience of mental health services has been found to influence their likelihood of attending outpatient appointments at the psychiatric clinic if re-referred. Carpenter *et al* (1981) studied 1106 new referrals to a psychiatric clinic and gathered basic demographic data at the time the patient telephoned to arrange their appointment. As well as age, gender, socioeconomic status and marital status (the results of which are described in Sections 2.5.1, 2.5.3, 2.5.5 and 2.5.9) they asked about the source of referral, any past psychiatric treatment and the nature of the presenting problem. They went on to contact non-attenders by telephone to ask them why

they had missed their appointment. They found that attenders were more likely than non-attenders to have a history of previous contact with psychiatric services, a finding confirmed in the United Kingdom by Hillis and Alexander (1990). This could be because the patient knows what to expect from the referral and this might be particularly important in psychiatry where there may be misconceptions and fears about referral to a psychiatrist.

Carpenter *et al's* (1981) study population may have been rather unusual in that all the patients included were motivated enough to contact the clinic to arrange the appointment. There is no attempt at diagnostic breakdown but they do give data on the patient's description of their chief complaint: 16% "family/marital problem"; 62% "personal problem"; 11% "vague problem"; 12% "externally located problem". These data suggest a low level of serious mental illness in this population.

Although a history of previous psychiatric outpatient contact seems to encourage attendance after subsequent re-referral, patients who have been admitted to a psychiatric unit are less likely to attend outpatient appointments than patients who have never been admitted (Smyth *et al* 1990). This could be due to a negative experience as an inpatient and subsequent fear of readmission.

Pang *et al* (1996) found that patients who dropped out of treatment were more likely to have a history of contact with psychiatric services

of less than one year as compared to those who remained engaged in treatment. Those who dropped out of treatment were also more likely to have a previous history of defaulting from treatment. Their earlier audit of non-attenders at follow-up appointments (Pang *et al*, 1995) showed that shorter length of contact with the clinic and a history of previous admission were more common amongst patients who missed an appointment than the total outpatient population.

2.5.18 Summary of Section 2.5.17: past psychiatric history

- A history of previous contact with the psychiatric clinic increases the chance of subsequent appointment keeping.
- Previous admission to a psychiatric inpatient unit is associated with subsequent non-attendance at the outpatient clinic.
- The association between previous outpatient contact and appointment keeping in specialties other than psychiatry has not been studied.

2.6 Summary of Section 2.5: factors related to the patient

- Younger age and lower socioeconomic status appear to be associated with non-attendance at non-psychiatric clinics, but evidence of their relevance for patients at psychiatric clinics is inconclusive.
- There is no consistent evidence as to whether gender, employment or marital status have any association with outpatient attendance in both psychiatric and non-psychiatric populations.
- Psychiatric and certain medical specialty clinics have the highest non-attendance rates, along with those treating substance misuse.
- Diagnosis of personality disorder is associated with non-attendance at psychiatric clinics and personality factors may be relevant in other settings (e.g. medical clinics and substance misuse clinics)
- Family support for referral and treatment has been shown to encourage outpatient attendance in psychiatric and non-psychiatric clinics.
- Symptom resolution does not appear to be associated with missing appointments at non-psychiatric clinics. Patients with chronic medical conditions are more likely to attend than patients recently diagnosed.
- In psychiatric populations, previous outpatient treatment encourages subsequent outpatient attendance if re-referred, but a past history of admission to a psychiatric inpatient unit is associated with subsequent outpatient non-attendance.

2.7 Factors associated with outpatient non-attendance: factors related to the referral process

2.7.1 Communication with the patient

Communication between referrer, patient and specialist appears to influence whether or not a patient attends their appointment. Most of the research in this area relates to psychotherapy and psychiatric services.

Baekland and Lundwall (1975) reported on a study of communication with patients who presented to the emergency room with symptoms indicative of alcohol dependence (Milmoie *et al*, 1967). Such patients were routinely referred to a psychiatrist by the physician who assessed them. Nine physicians discussed their experiences of interacting with alcoholic patients in a tape recorded interview. The tapes were analysed independently for tone and content. It was found that where there was “anger in the voice of the physician” patients were less likely to attend any subsequent appointment with a psychiatrist.

Baekland and Lundwall (1975) reported that all 35 studies that examined the relationship between therapists’ attitudes and dropping out of psychotherapy found an association. They summarised their findings by describing some of the characteristics of therapists that had been found to be associated with patients leaving therapy. These included: being male; disliking the patient; being bored by the patient;

being permissive; being detached; lack of concern for the patient; and being likely to cancel appointments.

In child psychiatry, Cottrell *et al* (1988) found that consultation with the referrer as part of the management of the case decreased the chance of dropping out of treatment. One of the few studies to consider communication and its relationship with outpatient attendance was carried out by Lloyd *et al* (1993). As described earlier, they conducted a prospective study of new referrals to ENT and gastroenterology clinics and gathered information about the referral process using a self-report questionnaire, which asked patients to rank the following item “discussed health problem with your doctor” on a five point scale. They found that non-attendance was more likely among patients who had been unable or only partly able to discuss their presenting problem with their general practitioner prior to referral. Unfortunately they did not describe the term “partly able” in any detail.

Appropriate discussion between referrer and patient at the point of referral may be especially important in psychiatry, since issues of stigma are particularly relevant and may influence whether or not the patient attends.

Bursztajn & Barsky (1985) used a case report to illustrate psychological and social factors, which can prevent the offer of a psychiatric referral being taken up by patients with psychosomatic symptoms. They stated that

“the physician must first foster an open and trusting relationship with the patient, allowing the patient to voice his concerns openly and honestly and discuss them in detail. “

They described how referral to a psychiatrist can be a socially stigmatising event, since the patient feels that:

“visiting a psychiatrist denotes the label of mental illness which is viewed at best as weak and at worst as immoral, deprived or worthless”.

Similarly, they reported that it can threaten the patient's self-esteem, since

“psychological problems and emotional difficulties betray weakness, failing or character defect “ and that “the patient may feel rejected or dismissed by the referring physician.”

They suggested that empathic discussion of these issues with the patient and, if appropriate, with family members can reduce the patient's anxieties and resistance to the referral.

2.7.2 Summary of Section 2.7.1: communication with the patient

- Appropriate discussion between the referrer and patient at the time of referral influences subsequent outpatient attendance.
- Discussion about the referral is especially important in psychiatry, where issues of stigma may reduce the chance of attendance.
- Hostility from the referrer towards the patient makes subsequent attendance unlikely. Patients who perceive their psychotherapist to have a negative attitude towards them tend to drop out of treatment.

2.7.3 Understanding the reason for referral

Frankel *et al* (1989) found that non-attendance in six hospital specialty clinics (not including psychiatry) was associated with a poor understanding of the reason for referral. This has also been shown to be the case in studies of psychiatric clinics (Carpenter *et al*, 1981; Hillis and Alexander, 1990).

In contrast, Lloyd *et al* (1993) asked patients to rank whether their general practitioner had explained the reason for referral to them.

They found no association between the degree of explanation and non-attendance at ENT and dermatology clinics.

Skuse (1975) carried out a study during his time as a medical student in Manchester. He interviewed patients newly referred to the

psychiatric outpatient clinic and reported that many of these patients seemed to have only limited understanding of the psychiatrist's training and role. Almost one third had not been told that they were going to see a psychiatrist by their referring general practitioner, but euphemisms such as "nerve specialist" and "someone who has more time to talk to you than me" were used. Half the patients did not realise that psychiatrists are medically qualified. One quarter had no idea why they had been referred and described themselves as "not ill in any way". Almost half the patients were unhappy about the referral. Twenty-two percent believed they were likely to be hypnotised. Skuse reported that:

"there was a widespread belief that they would lie on a couch and be taken back to relive unpleasant experiences from their childhood or be given injections or ECT against their will".

Skuse (1975) felt that attendance rates could be improved if general practitioners were to explain to their patients more clearly the reasons for referral to the psychiatrist and what treatment to expect. He carried out semi-structured interviews at 60 patients' homes after referral and prior to their appointment, representing an 86% response rate. He asked them how the referral had been initiated, their attitudes towards mental illness and their feelings about seeing a psychiatrist. He explained the nature of a psychiatric referral to them and reassured them regarding any concerns. For his control group he used a similar number of patients who had been referred during the four weeks prior

to those he interviewed and the two groups were matched for sociodemographic characteristics. He found a non-attendance rate at the first appointment of 13% in the interviewed group compared to 30% in the control group.

Of course, it is possible that the visit itself rather than the content of the interview and Skuse's reassurances might have made patients feel less able to miss their appointment, given that he was a medical student at the hospital where the clinic was held. The lack of anonymity may have made it difficult for patients to reply honestly to his questions, although his results do seem to show that he was able to gain frank and honest opinions.

Baekland and Lundwall (1975) reported on a similar study (Hoehn-Saric *et al*, 1964) which showed that an initial explanatory interview which included the reasons for treatment and the roles of therapist and patient, increased subsequent attendance for psychotherapy.

"Orientation" prior to psychotherapy or psychiatric referral is discussed in more detail in Section 2.15.5.

Johnson (1973b) carried out a further study of patients newly referred to a psychiatrist in Manchester, following on from his original case note survey (Johnson, 1973a). He interviewed a group of 105 attenders prior to their first appointment with the psychiatrist. They were asked about their understanding of the reason for referral, who had instigated the referral and their expectations of treatment. Only 66% admitted

that they might have a psychological or emotional problem. Eleven percent thought they had a physical problem and 23% did not see themselves as ill and did not see the psychiatrist as fulfilling a medical role. In one third of cases the patient expected a complete medical cure for their symptoms and in 17% of cases the patient did not expect that the psychiatrist would be able to help in any way. These results are of considerable interest given that Johnson only interviewed those who attended and one wonders why this last group kept their appointment if they really did not expect to gain anything from the psychiatric assessment. His results are difficult to interpret as he omitted to give a response rate for the interviews. Given that he sent 220 questionnaires to general practitioners, presumably he interviewed less than 50% of the patient sample. He does not report the non-attendance rate anywhere in the paper.

2.7.4 Summary of Section 2.7.3: understanding the reason for referral

- There is some evidence to suggest that as many as one third of patients have no idea why they have been sent to see a psychiatrist.
- Patients who do not understand why they have been referred to the outpatient clinic (whether for medical or psychiatric assessment) are unlikely to attend.
- Initial explanation about psychiatric treatment can allay patients' fears and misgivings, and has been shown to increase the chance of subsequent attendance.

2.7.5 Resistance to referral

Grunebaum *et al* (1996) found that patients who expressed resistance to referral to a psychiatrist were less likely to attend appointments and that the degree of resistance was a good predictor of the likelihood of attendance. In their study, all the patients who expressed "significant" resistance to referral to a psychiatrist, (i.e. they indicated an intention not to attend) failed to attend.

Koch and Gillis (1991) also showed a clear association between the expression of resistance to appointment keeping and subsequent non-attendance. In their study of patients discharged from the psychiatric inpatient unit, "active" resistance to attending follow-up appointments

was expressed by 65% of patients who subsequently failed to attend compared to only 4% of subsequent attenders.

In India, Bender and Koshy (1991) investigated the factors associated with continuing attendance at a city based psychiatric clinic following initial assessment. They asked the psychiatrists to complete questionnaires, which collected demographic details, diagnosis, prognosis, previous contact with psychiatric services, and the patient and relatives' willingness to receive psychiatric treatment. Attendance compliance was defined as attendance at the first follow-up appointment. Questionnaires were completed in 80% of cases.

Unfortunately they do not describe how they assessed "willingness" and admit that the nine psychiatrists completing questionnaires varied in their assessments of this factor, with two doctors regarding all their patients as willing. Bearing this in mind, they found that patients who attended the initial assessment willingly were more likely to attend the next appointment than those who were assessed as unwilling.

Attendance rates at initial appointments could therefore be improved by general practitioners or other referrers ensuring that their patients have a clear understanding of the reason for referral and that they agree to attend the appointment. These findings seem to show that for patients who do not agree to attend or show "resistance" to the referral and for whom the general practitioner feels that psychiatric assessment is definitely required, it might be more appropriate to arrange an alternative assessment setting (such as in the general

practitioner's surgery) or to request a domiciliary visit from the psychiatrist or community mental health team. For patients who are resistant to the referral and where psychiatric assessment is not essential, the general practitioner might save considerable outpatient resource by reassessing the situation at a later date rather than forcing the issue by going ahead with the outpatient referral. The same is presumably true of non-psychiatric referrals, although this issue has not been specifically investigated.

2.7.6 Summary of section 2.7.5: resistance to referral

- Patients who express resistance to referral to a psychiatrist are unlikely to attend their appointment.
- Settings other than the outpatient clinic may be more appropriate for the assessment of resistant patients who definitely require a psychiatric opinion.

2.7.7 Who instigates the referral?

"Self" referral occurs when the general practitioner makes the referral at the suggestion of, or secondary to pressure from the patient or their family. The rate of self referral is surprisingly high. Johnson (1973a) found that one third of the new referrals who attended their first psychiatric appointment fitted into this category. Kaesar and Cooper (1971) found in their study of general practitioner referrals to the Maudsley Hospital in London, that in up to one quarter of cases the

referral had been initiated by the patient or a relative with the general practitioner playing an essentially passive role. This was more common for male than female patients. In his study of new referrals to a psychiatric clinic in Manchester, Skuse (1975) found similar rates. Morgan (1989) found that as many as 38% of referrals to a psychiatrist had been instigated by the patient or their relatives. However, in America, Carpenter *et al* (1981) found that new patients were more likely to attend their first appointment with a psychiatrist if they had been referred at the suggestion of a local physician rather than referring themselves. In concurrence with this finding, Lloyd *et al* (1993) did not find that patients who had requested referral to an ENT specialist or gastroenterologist themselves were any more likely to attend their appointment than patients who were referred at the instigation of their doctor.

These findings are rather surprising. It seems that patients and their families quite commonly prompt the general practitioner to make a referral to a hospital specialist, including a psychiatrist but this does not make subsequent attendance at the appointment any more likely. Perhaps this is due to the referral being at the instigation of the relatives more than the patient, and the relatives do not then have any power to influence whether or not the patient actually attends, but the studies reported do not make this clear.

2.7.8 Summary of Section 2.7.7: who instigates the referral?

- Between one quarter and one third of referrals to medical and psychiatric clinics are instigated by the patient or their relative/s rather than the general practitioner (“self” referral).
- Self referral does not make subsequent attendance more likely.

2.7.9 “Inappropriate” referrals

In Morgan’s study (1989) of new referrals to a psychiatric outpatient department in Kent, psychiatrists considered that up to 26% of referrals had been inappropriate. He gathered detailed information about the factors influencing the referral by carrying out in depth interviews with 106 of 120 (88%) patients who attended their first appointment over a six month period. He asked them about their problems and the events and discussions with their general practitioner prior to referral. He corroborated this information by interviewing a close relative or friend separately. He also interviewed the general practitioners about the circumstances around referral and gathered clinical data from the psychiatrists using a standardised form which included: diagnosis; severity of symptoms; treatment plan; and appropriateness of referral.

The diagnostic breakdown of the group has already been described in Section 2.5.13 and shows that few patients (17%) had a major psychotic illness and almost half had depression or a general anxiety

state. Psychiatrists rated one in seven patients as having “major” symptoms and 26% minimal or no psychiatric symptoms. These patients were considered by the psychiatrists to have been inappropriately referred. In contrast, the majority of patients reported persistent and troublesome symptoms affecting their functioning and quality of life. One third of patients described social or relationship problems yet no patients had been referred for counselling or psychotherapy by the general practitioner (which may relate to the availability of such services at the time of the study).

Morgan found that the mean interval between the patient’s initial consultation with the general practitioner and referral to the psychiatrist was between three and five months. He concluded that the decision to refer to the psychiatrist was often the final event in a series of lengthy interactions in which the patient, the general practitioner and the patient’s family attempted to accommodate and adjust to the patient’s problems. He suggested that the decision to make a referral to a psychiatrist is not particularly related to the severity of the patient’s psychiatric symptoms but can be due to a breakdown in the general practitioner-patient relationship. This, he felt, appears more likely to occur when the patient presents with psychosomatic symptoms, leading to a lengthy interaction between patient and general practitioner with multiple presentations to the general practitioner’s surgery.

Morgan's study is unable to shed light on factors which influence non-attendance at the psychiatric clinic as the 34% of patients referred during the study period who did not keep their appointment were not interviewed. The results of the study do, however, help to highlight the major difference between patient and doctors' perceptions of significant symptoms. However, there is also evidence that psychiatric disorders are under diagnosed by general practitioners. Between one quarter and one third of patients presenting to general practitioners have psychological symptoms lasting at least two weeks but only 2% are referred to mental health services (Goldberg & Huxley, 1991). The majority of patients who have diagnosable psychiatric disorders consult their general practitioners for physical symptoms and more than half of such patients are cases of somatisation (Goldberg, 1994). This helps to explain the difficulties for general practitioners in identifying which patients have a mental disorder when so many patients have "hidden" pathology. There is evidence to suggest that general practitioners are more likely to detect depression in patients who are more psychologically minded than those who are more "normalising" and dismissive of their symptoms (Kessler *et al*, 1999).

According to Morgan's (1989) evidence outlined above, around one quarter of the patients who are referred to mental health services are not considered appropriate for psychiatric treatment once they have been assessed by a psychiatrist. Since many such patients reported social or relationship difficulties one might assume that this problem could be alleviated by encouraging general practitioners to refer

patients for counselling with other agencies or by employing their own counsellor at the surgery. However, there is some evidence that general practices which employ counsellors also have higher rates of referral to psychiatric services (King, 2000). The reason for this is unclear but one possible explanation is that general practitioners who employ counsellors are more interested in mental health problems in general.

Given the hidden morbidity of mental illness in general practice, it seems appropriate for psychiatrists or other mental health professionals (such as community mental health nurses) to be involved in the assessment of patients presenting with recurrent somatic complaints and/or emotional distress. General practice-psychiatric liaison services are a useful model for providing expert support and advice to the general practitioner, thus reducing the need for more formal psychiatric referral. They are discussed in Section 2.15.7.

Rawnsley and Loudon (1962) carried out a thorough investigation of referrals from general practitioners to local mental health services in a single Welsh valley between 1951 and 1959. They collected information from hospital records and a private local census and carried out structured interviews with the general practitioners. They concluded that differences in referral rates between practitioners could not be accounted for by social and demographic differences between the populations studied, nor by selective recruitment of patients to the lists of certain practices. Referral rates were not related to clinical

severity or diagnosis of the individuals concerned. In their reporting of the interviews, they gave examples of the practitioner's decision to refer being influenced by factors such as lack of social support and pressure from the patient and their family. The general practitioners were not interviewed about each individual case but asked about these influences in general. Therefore the results of their interviews cannot be seen as definitive but, nearly thirty years later they were, to some degree substantiated by Morgan's work (1989).

2.7.10 Summary of Section 2.7.9: “inappropriate” referrals

- Around one quarter of patients referred to the psychiatric clinic have minimal psychological symptoms.
- Social, marital and family difficulties may encourage the patient to present to the general practitioner, leading to referral to the psychiatrist.
- Counsellors employed at general practices can provide appropriate intervention to patients with emotional distress who do not require specialist psychiatric treatment.
- Practices that employ counsellors tend to have higher rates of referral to the psychiatric outpatient clinic than practices without counsellors.
- Psychiatric assessment may help to identify patients who are presenting to their general practitioner with somatic complaints but who, in fact, require psychiatric treatment.
- General practice-psychiatry liaison clinics staffed by psychiatrists or community psychiatric nurses are an alternative to outpatient referral, facilitating discussion and assessment of referrals within the primary care setting.

2.7.11 Which patients are referred back to the general practitioner

Kaesar and Cooper (1971) studied 183 patients newly referred to the psychiatric outpatient clinics and the emergency clinic at the Maudsley Hospital in London. They carried out face to face interviews with the general practitioners at the point of referral and sent a follow-up postal questionnaire to them three months later. Patients were interviewed at home three months after referral. They enquired about the reasons and expectations of referral and the outcome in terms of whether the patient was engaged in any treatment three months later. They achieved a 96% response rate for the initial general practitioner interviews and 91% for the postal questionnaires. They interviewed 75% of the patients and gained relevant data from other sources on a further 13%.

The most common reason given for referral to the outpatient clinic was that the patient had failed to respond to the general practitioner's treatment, whereas 80% of those referred to the emergency clinic presented with a serious behavioural or social problem or for assessment of suicidal risk. They found that in over 70% of cases, the general practitioner wanted the hospital to take over clinical responsibility of the patient. After the initial assessment only seven patients (4%) were referred back to the general practitioner. Three months later, 43% were still under the care of the psychiatric services, the majority as outpatients. Twenty percent of patients had an admission during the three month period.

These data do not support the hypothesis that the majority of referrals from general practitioners are inappropriate. However, over three-quarters of the sample received only outpatient treatment whether they had presented as an emergency referral or not and by the third follow-up appointment half had been discharged back to the care of the general practitioner. It would seem therefore that since the majority of patients were under specialist care for only a short duration, the prevalence of serious mental illness in this population was low. The authors made no attempt to classify the population in terms of diagnosis but at their three month interviews data were collected on the patients' severity of symptoms. Unfortunately it is not clear whether this was taken from the general practitioner or patient interviews or both, there is no mention of any standardised tool being used and no such assessment was made at the initial appointment for comparison.

Bearing this in mind, the results showed that 92% of patients who were still under the care of the hospital had mild, moderate or severe symptom ratings compared to 73% of those who had been discharged and 68% of those who had dropped out of treatment but the excess appeared to be amongst patients with mild symptoms: 70% of those still attending had only mild symptoms compared to 52% of those discharged and around 20% in both groups had moderate or severe symptoms. No statistical analyses of these data were reported and no data were collected to explain the clinician's rationale for discharging

patients with significant symptoms. These results suggest that factors other than symptom severity were involved in influencing the psychiatrist's decision to refer a patient back to the general practitioner.

Johnson's (1973b) further analysis of new referrals from general practitioners to psychiatrists in Manchester investigated general practitioners' and patients' views on the referral and treatment received from the psychiatrist. The results of the patient interviews are described in Section 2.7.3. Two hundred and twenty postal questionnaires were sent to a total of 98 general practitioners on receipt of an outpatient referral and prior to the patient's first appointment. The general practitioners were asked their reason for referral including whether they required a diagnostic opinion and any special investigations. They were also asked whether they required advice only or whether they wanted the patient's continuing treatment to be carried out by the hospital.

Johnson achieved a 93% response rate from the general practitioners. He found that 11% of patients had not been seen at all by their general practitioner regarding their psychiatric problem prior to referral and a further 32% had only been seen once. In 43% of cases, the main reason for referral was that "further psychological investigation" was required, meaning a detailed history. He found that in around half the cases, the general practitioner wanted "advice only" i.e. to continue the management of their patient provided they had been assessed and this

was agreed by the psychiatrist. In contrast to Kaesar and Cooper's (1971) figure of 70%, Johnson found that the general practitioner wanted the psychiatrist to take over the patient's management in only 30% of cases. Older general practitioners were more likely to want to continue to manage their patients than younger doctors.

From his earlier outpatient survey (1973a), Johnson showed that in over 90% of cases, the continuing management of new referrals was taken up by psychiatric services and only 14% of patients were referred back to the general practitioner. This was despite the fact that 42% of patients had no intervention or treatment from the psychiatrist other than medication. The psychiatrists in Johnson's study were all consultants so the reluctance to refer back was not due to inexperience. The breakdown of diagnostic categories in Johnson's (1973a) original study population has been described in Section 2.5.13 and shows that the majority of new patients do not have psychotic illnesses, with 75% having diagnoses of depression, personality disorder or neurosis. These results suggest that the psychiatrist's decision not to refer a patient back to the general practitioner is influenced by factors other than the diagnosis of a severe mental illness.

Taking into account the findings from both of Johnson's studies, it appears that the consultative role of the psychiatric outpatient clinic (where the psychiatrist assesses the patient and refers them back to the general practitioner with advice for their further management) is

under utilised. His first study showed that psychiatrists referred only 14% of patients back to the general practitioner after initial assessment, yet in his second study it appeared that the general practitioners only wanted psychiatric services to take over the ongoing management of the patient in 30% of cases.

Forty-three percent of the general practitioners in Johnson's second study were requesting the psychiatrists to take a full and detailed history from the patient. This initial assessment usually takes approximately one hour (much longer than general practitioners have available to see patients) and is acknowledged as being one of the most important skills in psychiatric training. It is also considered therapeutic in itself, providing the time and space for the patient to give an account of their current problem within the context of their life history. It is therefore entirely appropriate that general practitioners should be able to request this form of assessment when they refer a patient to the psychiatrist. However, the diagnostic breakdown data for new patients in Johnson's first study shows the low prevalence of serious mental illnesses (such as schizophrenia, schizoaffective disorder and bipolar affective disorder).

The pressure on mental health services, particularly in the inner city (MilMIS, 1995) means that there is an increasing need for services to focus on patients with serious mental illnesses. This, in turn has reduced the amount of time psychiatrists are able to devote to the ongoing management of patients with mild or moderate depression

and neurotic disorders. Given that 42% of the patients in Johnson's first study were given no specific treatment from the clinic other than medication, it appears that many patients who are offered ongoing management from the psychiatric outpatient clinic are not seriously mentally ill and could be easily managed by the general practitioner, thus freeing up clinic time for other patients and more new assessments.

Johnson's results are in contrast to Kaesar and Cooper (1971) who reported that:

"in the main, the general practitioner wanted the hospital to take over clinical responsibility, the demand for consultative advice being very small".

This may reflect a difference in the style of working of the two populations of general practitioners in the two studies which were carried out in different cities (Manchester and London respectively). Since Johnson noted that older general practitioners were less likely to want the hospital to take over the management of their patient, it could reflect a younger group of general practitioners in the London sample. Whatever the reason for the difference in the general practitioners' reported wishes, it seems that once a patient has been referred to see a psychiatrist a number of subtle factors are at play preventing the psychiatrist from referring the patient back to the general practitioner

with advice for their ongoing management. These issues have been touched on in the studies by Rawnsley and Loudon (1962) and Morgan (1989) and include such things as pressure from the patient or their family and any difficulties that have arisen in the relationship between the patient and their general practitioner.

Repeating studies such as Johnson's which give an overview of psychiatric outpatient services would be useful in examining whether treatment plans formulated after initial psychiatric outpatient referral have changed since 1973. It may be that the increasing focus on patients with severe and enduring mental illnesses may have led to outpatient work becoming more consultative.

2.7.12 Summary of Section 2.7.11: which patients are referred back to the general practitioner

- The psychiatrist's decision to refer a patient back to their general practitioner does not appear to be related to the severity of their diagnosis or psychiatric symptoms.
- Other factors have not been specifically researched but may include: differences in the psychiatrists' and general practitioners' expectations of referral; the patient's desire for specialist treatment; the patient's social and family factors; a poor relationship between the patient and general practitioner.

2.7.13 Quality of communication between psychiatrists and general practitioners

There have been two principal studies which have specifically investigated communication between psychiatrists and general practitioners, both of which examined the quality of referral letters from general practitioners to psychiatrists and psychiatric reports sent to general practitioners (Williams and Wallace 1974, Pullen and Yellowlees 1985). The latter study repeated the former's method to investigate whether communication had improved in the intervening 10 years.

Williams and Wallace (1974) asked a random sample of psychiatrists which items of information they considered important in psychiatric referral letters from general practitioners. They asked the general practice unit at the Welsh National Medical School which items they considered important in psychiatric reports and from these two sources they compiled checklists of twelve key items for both types of letter. They sent questionnaires to all 145 general practitioners and all 33 psychiatrists working in the Cardiff area, asking them to rank these key items in order of importance. Response rates of 56% and 88% respectively were achieved.

Psychiatrists considered the following five items were most important in referral letters (in descending order): current medication; typewritten or easily legible letter; past psychiatric history; current symptoms; and duration of current problem. General practitioners felt the following five

items were most important in psychiatrists' letters: psychiatrist's diagnosis; suicidal risk; prognosis; follow-up arrangements; and treatment.

They went on to study 100 consecutive psychiatric referrals and scored the referral letters and psychiatric reports for the presence of these items. The referral letters correlated well with the items the psychiatrists considered important but the psychiatrists' letters did not correlate well with the items the general practitioners had identified as important. This difference was mostly explained by the psychiatrists rarely including any comment about suicide risk. When this item was removed from the analysis, the letters corresponded quite well with the general practitioners' requirements.

The psychiatrists often included an account of the patient's personal history which was ranked as the tenth most important item by the general practitioners. This is presumably due to the fact that the psychiatrists' letters form a summary of the case for the file and are used for correspondence with colleagues and therefore contain more detail than the general practitioner needs.

Pullen and Yellowlees (1985) carried out a very similar study in Edinburgh, sending out questionnaires to 80 psychiatrists and 80 (a one in six sample) general practitioners. The selection of practitioners is not described in the paper. They achieved 95% and 88% response rates respectively and asked both groups to identify the five most

important items they would like to see in a referral letter (psychiatrists) or psychiatric report (general practitioners).

The key items that psychiatrists identified as important were: current medication; family history; current symptoms; reason for referral; past psychiatric history. General practitioners considered the following items to be most important: psychiatrist's diagnosis; treatment; follow-up arrangements; prognosis; concise explanation of the problem. In contrast to the Cardiff general practitioners, the Edinburgh general practitioners did not list suicidal risk as a key item. This may be explained by the fact that Williams and Wallace's questionnaires contained a checklist of items which the practitioners were asked to rank in order of importance, whereas Pullen and Yellowlees left the selection of important items to the discretion of the practitioners, simply requesting a list of five in any order.

Pullen and Yellowlees (1985) went on to study 120 new referrals to psychiatric clinics in Edinburgh: 60 consecutive referrals in 1973 and 60 consecutive referrals in 1983. Referral letters and the corresponding psychiatric reports were assessed for the presence or absence of the key items previously identified. The researchers also noted the degree of legibility of referral letters and found illegibility to be very uncommon. There was no statistically significant difference in the number of key items contained in referral letters from 1973 as compared to 1983, with an average 3 to 4 items present. The psychiatrists' reports contained a similar number of key items and

again there was no difference over the 10 year period. The authors also found that junior doctors wrote much longer letters than consultants in both 1973 and 1983 and felt that more training around this issue was required.

In conclusion, both studies found that the content of general practitioners' referral letters correlated well with the information that psychiatrists consider appropriate in referral letters. The psychiatrists' reports generally contained information that the general practitioners considered important, but this information was often contained within lengthy reports which the general practitioner might well not have the time to read in detail.

Lister and Scott (1988) reported that non-attenders tended to have referral letters of poorer quality, although they did not specifically describe how letter quality was assessed. However, this finding may suggest that non-attenders' general practitioners were less interested or less confident in assessing these particular patients' psychiatric problems than those who wrote better quality referral letters. If this were the case then it may be that they were less able to explain to the patient the reason for referral and to reassure them about seeing a psychiatrist. Given that good explanation about the reason for referral has been shown to reduce non-attendance rates (Skuse, 1975), this might account for the higher non-attendance rates in these patients. Alternatively, it may be that the non-attenders were a more difficult group whose problems were not easily assessed, and who the general

practitioners felt uninterested in or exasperated by. Their non-attendance might be more related to their diagnosis than any lack of explanation of the reason for referral.

McGlade *et al* (1988) carried out a retrospective case note study of all 269 patients referred to hospital (including referrals to outpatient clinics, accident and emergency and for direct admission) from one general practice in Belfast over a 14 week period. Referrals to all hospital specialties were included. They examined all referral letters in the general practice's files and noted whether the patient had been referred for admission, to casualty or to an outpatient clinic. They used any written communication from the hospital to ascertain the outcome of the referral. They found that in 24% of cases, no correspondence from the hospital was ever received by the general practice about the outcome of the referral. In this study, only five patients were referred for psychiatric assessment. The authors did not give any breakdown of non-communication from the hospital by specialty or treatment setting.

**2.7.14 Summary of Section 2.7.13: quality of communication
between psychiatrists and general practitioners**

- General practitioners' referral letters to psychiatrists generally contain relevant information.
- Psychiatrists letters to general practitioners are often overinclusive.
- There is some evidence that in as many as one quarter of cases of referral to any hospital specialty, no written communication from the hospital about the outcome of referral is received by the referrer.

2.8 Summary of Section 2.7: factors related to the referral process

- Appropriate discussion about the reason for referral to a hospital specialist is essential for patients referred to non-psychiatric and psychiatric clinics since patients who do not understand the reason for referral are unlikely to attend.
- Reassurance about what to expect from treatment is particularly important for patients referred to a psychiatrist since stigma surrounding psychiatric referral may reduce the chance of subsequent outpatient attendance.
- Patients who express resistance to referral are unlikely to attend.
- Up to 25% of patients referred to psychiatrists have no psychiatric illness, but distress due to social, marital and family problems may prompt referral.
- Psychiatric assessment is appropriate in order to identify patients who have psychiatric disorders requiring treatment.
- Psychiatrists appear reluctant to refer patients back to their general practitioners, but a more consultative role could be developed for patients with less severe mental illnesses given the pressure on psychiatric services.
- On the whole, general practitioners' referral letters contain appropriate information but psychiatrists' letters to general practitioners tend to be overinclusive.

2.9 Factors associated with outpatient non-attendance: factors related to the outpatient department

2.9.1 Waiting time

New referrals who do not attend their first appointment in the outpatient clinic have been repeatedly shown to have waited a longer time from referral to being seen by the specialist than those who do attend. This is true for patients referred to psychiatric clinics (Burgoyne *et al*, 1983; Carpenter *et al*, 1981; Lister and Scott, 1988; Grunebaum *et al*, 1996; Chen, 1991) as well as other specialties (Lloyd *et al*, 1993; McGlade *et al*, 1988; Deyo and Inui, 1980).

In McGlade *et al*'s (1988) study of new referrals to hospital, patients who defaulted had waited twice as long for their appointment as those who attended the outpatient clinic. It is also noteworthy that an extended period of time between first and second appointments has been shown to be associated with a higher rate of non-attendance at the second appointment (Bender and Koshy 1991).

When patients are referred to the outpatient clinic from the accident and emergency department, the patient is more likely to attend the appointment if they are given the date and time before they leave the department rather than being left to make their own appointment (Craig *et al*, 1974; Chen, 1991). Chen (1991) recommends that community

mental health centres provide “flexible and accommodating intake procedures to facilitate the referral process” but does not describe any particular model for this. Crawford *et al* (1996) described a community mental health team based model known as the “Urgent Assessment Service” which operated in Camden and Islington Community Health Services Trust in London between 1995 and 2000. The results of the study indicated that the service was able to offer assessment within 72 hours of referral. Despite the fact that 44% of those referred were suffering from psychotic disorders such as schizophrenia and bipolar affective disorder, only 3% required hospital admission at the time of assessment and 75% were referred back to the care of their general practitioner. The authors concluded that the service “filled a gap between outpatient and emergency services and facilitated the process of urgent mental health assessments.”

2.9.2 Clerical error

Studies of outpatient non-attendance in specialties other than psychiatry have found that in as many as a third of cases the reason for non-attendance can be categorised as a clerical error on the part of the hospital. Verbov’s (1992) study of non-attenders at his dermatology clinic showed that in 33% of cases the appointment was missed due to some sort of problem with the timing of or communication about the appointment.

Potamitis (1994) found that in 27% of his study population the reason for non-attendance was “clerical error” such as the patient not receiving the appointment, the hospital transport not arriving or the patient having already cancelled the appointment. He felt that since so many patients forgot their appointment (18%), reminders from the hospital and addressing the clerical errors could reduce non-attendance by around 40%. Postal and telephone reminders are discussed later in Section 2.15.5.

McGlade *et al* (1988) found in their study of new referrals to hospital that in 6% of cases, no referral letter had ever been received by the hospital and therefore no appointment had been sent to the patient.

Frankel *et al* (1989) found that non-attenders were more likely to have been given very short notice of their appointment than attenders and were therefore less able to make arrangements to keep their appointment. In 9% of cases, the patients they studied stated that the reason they did not attend was due to the hospital altering their appointment. Frankel *et al* (1989) concluded that non-attendance may be more a function of administrative problems on the part of the hospital rather than being due to patient factors.

Studies which have examined the reasons that patients give for missing appointments at the psychiatric clinic are described in Section 2.11. The results from these studies show that clerical error appears to be less of a problem at psychiatric clinics than at medical clinics (see

Table 2.2). This may be due to psychiatric clinics having a slower rate of patient throughput than certain busy medical clinics.

2.10 Summary of Section 2.9: factors related to the outpatient department

- Shorter waiting times for hospital appointments are associated with a higher chance of attendance. This applies to both psychiatric and non-psychiatric referrals.
- Clerical error accounts for up to one third of missed appointments at non-psychiatric clinics but is less of a problem at psychiatric clinics.

2.11 Patients' reasons for missing appointments

Baekland and Lundwall (1975) remarked that very few studies have involved directly asking patients their reasons for missing outpatient appointments. Those that have done so show that patients give a range of different reasons, but there appear to be some consistent differences between those attending appointments at medical clinics and those attending psychiatric clinics.

2.11.1 Patients at non-psychiatric clinics

Verbov (1992) carried out a survey of 100 patients who had missed their previous appointment at his dermatology outpatient clinic. It is not

clear whether these patients were new referrals, follow-ups or a mixture of both. He states that following a non-attendance he would examine the patient's notes and, depending on the referral letter contents and probable diagnosis, decide whether to offer them a further appointment. Fifteen percent of his sample were offered a further appointment in this way, 72% rebooked the appointment themselves or were re-referred by their general practitioner (9%). The non-attendance rate at his clinic was around 20%. He directly asked a sample of 100 patients why they had missed their previous appointment. He does not describe how this sample was chosen. The reasons patients gave are shown in Table 2.2. The most common reasons given were being physically unwell (28%) and having a work (10%) or other (10%) commitment.

The patients in Verbov's study may well have felt unable to give honest reasons for their non-attendance since the consultant himself was asking them why they had missed their appointment. This may be reflected by the many practical reasons given and lack of answers suggesting any resistance to the referral. However, by definition, they had all subsequently attended in order to be included in the study, so this may have been less of a problem in his sample.

Potamatis (1994) investigated reasons for non-attendance among patients at his ophthalmology clinic. Over a 13 month period, all patients who missed an appointment were sent questionnaires containing a list of reasons for non-attendance. They were asked to

tick the appropriate answer or add their own if it was not on the list.

The questionnaires were anonymous to encourage frank replies. The non-attendance rate during the study period was 10% (18% for new patients and 7% for follow-ups) and a 43% response rate was achieved. Patients who replied were older than non-responders. The reasons given are shown in Table 2.2. Again, physical illness was cited (22%), 18% forgot and clerical error accounted for 23%.

Frankel *et al* (1989)'s study of medical outpatients who had missed their appointment included a question on the reason for non-attendance. The breakdown of the most common reasons given is shown in Table 2.2. In 28% of cases, patients said they were away on holiday which may relate to the time of year when the study was carried out. Other reasons included feeling better (12%), work commitments (12%), physical illness (9%) and clerical error (9%).

Caldwell *et al* (1970) interviewed 42 patients who had stopped attending a hypertension clinic and subsequently attended the emergency department due to hypertensive crises. Patients were asked why they had discontinued treatment. The results are not shown in Table 2.2 since patients were able to give more than one answer: 39% felt better; 36% stated that they had been poorly informed about the prognosis of malignant hypertension and did not understand the need for ongoing monitoring; 33% could not afford the medication; 24% had been discharged from the clinic; 14% gave lack of family support as the reason; and 10% were unhappy with their treatment.

Deyo and Inui (1980) reported in their review of the literature on missed appointments at medical clinics, that the most common reasons patients gave for missing appointments were that they had either forgotten about the appointment or that they did not know about it.

2.11.2 Patients at psychiatric clinics

One of the few studies which has specifically investigated the reasons that patients give for non-attendance at psychiatric outpatient appointments was carried out by Sparr *et al* (1993). They asked 101 patients who rescheduled missed appointments at a service veteran's psychiatric clinic why they had not attended previously. Three-quarters gave a reason for missing their appointment and the breakdown is shown in Table 2.2. One quarter had forgotten about the appointment and one fifth could not remember the reason.

Carpenter *et al* (1981) contacted 103 (30%) of their group of non-attenders at first psychiatric appointments by telephone and used a proforma to categorise the reasons they gave for missing their appointment. This may have led to some bias in data collection and an open question, categorised afterwards might have been a better method. Each patient appears to have given only one reason. The authors do not say whether they attempted to contact all 347 non-attenders, thus achieving a 30% response rate or whether they

intended to only contact one third and if so, how they selected this group. The breakdown of the reasons patients gave is shown in Table 2.2. One quarter missed their appointment because they sought help at another clinic and 28% said they had not kept the appointment as they were feeling better.

Pang *et al* (1995) carried out telephone interviews with 56 patients who had stopped attending follow-up appointments at a psychiatric clinic in Hong Kong. This constituted a 43% response rate of all 129 patients who dropped out of treatment. The patients' answers to the question "why have you stopped attending?" are given in Table 2.2. Again, 20% could not remember the reason for missing their appointment, 40% said they felt better and 10% had gone to another clinic.

From Table 2.2 it can be seen that the reasons given for missing appointments at non-psychiatric clinics tend to be quite practical such as having a physical illness unrelated to the presenting complaint, being away on holiday, being unable to take time off work and various forms of clerical error. In contrast, patients who miss appointments at the psychiatric clinic are more likely to say that they felt better, that they forgot about the appointment, that they sought help elsewhere or that they cannot remember why they did not attend.

Table 2.2 Comparison of reasons that patients give for missing appointments at non-psychiatric and psychiatric* clinics

Reason for missing appointment	Verbov (1992) n=100	Potamitis (1994) n=224	Frankel <i>et al</i> (1989) n=162	Sparr <i>et al</i> * (1993) n=101	Pang <i>et al</i> * (1996) n=56	Carpenter <i>et al</i> * (1981) n=103
Physical illness unrelated to presenting complaint	28%	22%	9%	6%		
Feeling better	6%	8%	12%		40%	28%
Away on holiday	5%		28%			
Forgot	9%	18%		25%		
Unable to take time off work	10%	3%	12%			
Time to appointment too long						12%
Appointment not received	6%	15%				
Appointment altered by clinic			9%	5%		
Appointment cancelled		8%				
Patient lost appointment card	3%					
Patient mistook appointment time/date	5%			9%		
Other commitment	10%	4%		6%	5%	6%
Family reason	8%	1%		1%		
Transport problem	2%	7%		4%		2%
Can't remember reason	4%			22%	20%	
Overslept				7%		
Too worried about appointment		3%				3%
Went to another clinic					10%	25%
Admitted to inpatient unit				1%		14%
Went to casualty						2%
Stigma of psychiatric treatment					5%	
Moved away					7%	
Unhappy with treatment					13%	

Hillis and Alexander (1990) sent questionnaires to all 129 new referrals who had not attended their first appointment at a Scottish psychiatric clinic during 1986 and achieved a 40% response rate. They reported examples of the different reasons that patients gave for missing their appointment but unfortunately they did not report any breakdown of the numbers of patients in each category. Examples of the reasons given are similar to Pang *et al's* (1996) findings: "feeling better", "fear of admission", "poor image of psychiatry", "stigma of psychiatric referral" and "having to take time off work".

Hillis and Alexander compared their sample of non-attenders with a randomly selected control group of 100 newly referred patients who had attended. They collected data from the case notes of this control group and compared them with the non-attenders. They found that patients were more likely to attend if they had received a personal letter about their appointment rather than an appointment card and if their appointment had been at a health centre rather than at the hospital. Both of these factors may have alleviated some of the feelings of stigma and apprehension about referral to a psychiatrist, thus encouraging attendance.

Koch and Gillis (1991) stated that they asked newly discharged patients the reasons for missing their follow-up appointments at the psychiatric clinic but give only one sentence describing the outcome of their enquiry: "a minority of patients described practical difficulties in attending". They report that non-attenders in their study were less

likely to know the date of the appointment they missed than attenders despite the fact that all the patients were told when their appointment was and they were all given an appointment card before they left hospital. The authors felt that this construed "a lack of co-operation with treatment" but this may not be the case. Factors such as disorganisation, disorientation after an acute admission and oversedation from medication might be more relevant.

Bender and Pilling (1985) investigated attendance at a psychiatric day centre in London. They carried out thorough psychometric testing on 40 of 60 patients offered a place at the centre during a five month period. Of those not tested, ten failed to attend at all, and the rest were unable to complete the tests for various reasons. They defined "under attendance" as 30% attendance or below for the three months after starting at the day centre. Fifteen clients were "underattenders" and 25 "stayers". Underattenders had less stable employment, were more likely to be living in a hostel and were more likely to have a diagnosis of personality disorder than the stayers. In order to examine differences between them the authors asked day centre staff as well as clients to complete the Semantic Differential measure (Osgood *et al*, 1957) which assesses concepts and attitudes towards various parameters including: self; closest other person; average person of the same age; most mentally ill people; and most physically handicapped people.

There were marked differences in the semantic differential measures between clients and staff and these differences were more pronounced between underattenders and stayers. For example, all clients, but particularly underattenders, did not see themselves as “like the mentally ill” whereas the staff saw the day centre client as “virtually identical to the mentally ill”. The authors concluded that underattendance was associated with patients not identifying with the label of mental illness. Verbal IQ was found to be lower amongst underattenders than stayers. The authors felt that this could mean that less verbal clients might have experienced difficulties in adapting to the predominantly verbal culture of the day centre.

Although Bender and Pilling's work was carried out in a day centre and no random selection of clients took place, it does appear to raise interesting questions around staff and patient attitudes towards each other. How far these findings can be extrapolated to the outpatient setting is difficult to say. However, their results suggest that attendance is associated with the patient being able to acknowledge their mental health problem to some degree and being able to engage in the treatment on offer. Both of these are relevant to the outpatient setting since patients attend of their own free will.

2.12 Summary of Section 2.11: patients' reasons for missing appointments

- Surprisingly few studies have specifically asked patients why they missed their appointment but those that have done so have reported a variety of reasons.
- Patients booked into medical clinics tend to give practical reasons for not attending, such as physical illness and difficulty in getting time off work.
- Patients booked into the psychiatric clinic tend to say that they felt better, that they forgot or cannot remember why they did not attend.
- Fear of stigma about psychiatric referral has also been reported.

2.13 Non-attendance and dissatisfaction with treatment

Another important reason why patients might miss their appointments but feel unable to say so, even when asked, is that they are unhappy with the treatment they are receiving and therefore stop attending.

Deyo and Innui (1980) reported that "patient satisfaction with the visit, therapist or clinic does correlate with lower appointment failure rates."

This statement was based on their review of the American literature on dropping out of treatment. In the United States and other countries where private health schemes are used, a patient's satisfaction with their practitioner may be a powerful component in their decision to

continue in treatment. Non-attendance may simply be a sign that a patient is "voting with their feet".

Rubin *et al* (1993) carried out a large, multicentre study of patients' satisfaction with their clinicians. The study was carried out in Chicago, Boston and Los Angeles and included 367 clinicians working in various types of practice (52% single handed and/or single specialty, 32% health maintenance organisations and 16% multispecialty group). The clinicians were: general medical practitioners (53%); family practitioners (26%); cardiologists (11%); endocrinologists (7%); and nurse practitioners (4%). During a nine day period, the clinicians were asked to give each adult patient who visited their clinic a brief, self-report questionnaire to complete after their appointment. All patients were asked to rate (on a five point Likert scale) their opinion of the visit overall. A randomly chosen half of respondents were also asked to rate various aspects of their treatment including: their practitioner's skills and manner; the waiting time for the appointment and at the clinic; the convenience of the clinic's location. The response rate was 75% for health maintenance organisations and 65% for the two other forms of practice.

A total of 17,671 individual patients completed questionnaires. Responses were analysed linearly (on a scale of 1 to 100) and dichotomously (excellent or not) and both analyses gave similar results. Fifty-five percent of patients rated their overall visit as excellent. Patients of single-handed practitioners were more likely to

rate their visit as excellent than other types of practice organisation. They rated most aspects of their care higher than other practices, particularly appointment waiting times and telephone access. The authors then rated individual physicians according to the number of patients who rated them as excellent. An average 57 patients rated each physician. Six months later, patients were asked to complete a follow-up questionnaire. Physicians with ratings in the lowest 20% were nearly four times as likely to have been left by their patients at the six month follow-up than physicians in the highest 20%. Despite the lack of description of follow-up data collection, the size of the study suggests that this last result is robust.

In countries such as the United Kingdom, the state health system is available to everyone and competition for patients is less evident than in private health care systems. This could lead to complacency on the part of service providers. In the United Kingdom there has been a government led move in recent years to pay more attention to patients' opinions about the care they would like to receive. This has been encouraged by publication of documents such as the Patients' Charter (Department of Health, 1997). However, there has been very little research into patient satisfaction in the United Kingdom, and most has been carried out in mental health settings.

2.13.1 Dissatisfaction with medical care

One of the few studies to examine patient satisfaction with medical outpatient services was carried out by Bishop *et al* (1991) in Leicester. They conducted a survey of 90, self selected, attending patients' views on various aspects of medical outpatient clinics. They do not describe the setting, how the survey was publicised, how patients became involved, the content of questionnaires or the time period of the study. They found that patients wanted nursing staff to wear uniforms, doctors to wear white coats and all staff to have name badges. Patients expected to be seen for 20 to 30 minutes at initial appointments and for 5 to 10 minutes at subsequent appointments. They made no specific measure of patient satisfaction with services, but found that over 80% of patients were able to recall their diagnosis and the results of investigations and over 90% felt they understood their treatment. This survey was severely flawed by the self selection of subjects. Clearly patients who did not attend were not included and patients who did not understand their treatment or were unhappy with it may have been less likely to take part.

2.13.2 Dissatisfaction with mental health care

McIntyre *et al* (1989) carried out an important and unusual investigation of the views of patients admitted to one of seven wards at a psychiatric hospital. All 117 patients who had been inpatients at the Maudsley Psychiatric Hospital in London for at least one week were interviewed. A response rate of 85% was achieved. Forty-two percent

of patients had a diagnosis of schizophrenia, 13% mania, 21% depression, 8% substance dependence, 7% personality disorder, and 8% had an organic disorder. Twenty-four patients were detained under the Mental Health Act. Only seven patients were considered too unwell to interview. Patients were asked to rank on a four point scale the helpfulness of ten items: talking to the doctor; talking to the nurse; talking to patients; ward groups; occupational therapy; medication; the ward round; being in hospital; visitors; and being able to come and go freely from the ward. A global assessment of functioning was recorded for each subject although the authors do not state how this assessment was made.

It was found that the items patients rated most highly were being free to come and go from the ward, having visitors and talking to staff. The ward group was rated as least helpful. Patients who scored higher on global assessment (and were considered less ill) rated talking to staff and occupational therapy higher than patients who were more unwell. There were no differences in the results when patients admitted for the first time were compared with those readmitted or between patients who were detained under the Mental Health Act and voluntary patients. The authors concluded that talking to patients in the acute inpatient setting should not be forgotten.

A survey carried out in America used interviews and focus groups to assess consumer satisfaction with consumer managed community mental health drop-in centres. No details of the assessments were

given in the paper, but the authors reported that clients were highly satisfied in general with the centres, but problems with inflexible opening times were identified (Kaufmann *et al*, 1993). Qualitative data gathering techniques such as focus groups are an alternative to the more formal, quantitative rating scales. However, it could be argued that service users might feel even less able to speak openly about their views on the quality of a service in a group, particularly if the group is run by the researcher evaluating a service (as was the case in this study) than when asked to complete an anonymous questionnaire.

One of the few studies to examine psychiatric out-patients' satisfaction with treatment was carried out in Edinburgh by Jones and Lodge (1991). They surveyed a one in three sample of all psychiatric outpatient attenders over a two week period and used structured interviews to ascertain their opinions about the out-patient service. They were particularly interested in finding out what the client group felt about the facilities in the department as well as their views about the consultation. The interviews were conducted by five researchers over a two week period and were in two parts, one before and one after the consultation. The first part asked about: waiting time from referral to initial appointment; access to the department; waiting area facilities; and waiting time in the department. The second part investigated the patients' feelings about the consultation itself, their satisfaction with their treatment and with the service overall.

A response rate of 86% (203 patients) was achieved for the first interviews and 58% (166 patients) for the second. The authors erroneously reported a 70% response rate for the second interview. It was found that 75% of new patients had been seen within four weeks (and almost 50% within two weeks). Only 3% of patients were kept waiting more than 30 minutes before seeing their psychiatrist. A number of questions assessed the quality of communication during the consultation and in over 90% of cases, patients were satisfied with it. Over 90% were satisfied with their treatment and service received overall. Dissatisfaction was closely related to waiting more than eight weeks for the appointment. More than half the patients were dissatisfied with the facilities of the department, complaining that it was poorly sign-posted, uncomfortable and lacked privacy.

In criticism of this survey no validated satisfaction rating scales were used, the use of interviews meant that lack of anonymity could have led to the reporting of high levels of satisfaction and no assessment of inter-rater reliability was reported. Given that the survey was of patients who were attending their appointments, the sample may be unrepresentative of the whole outpatient population since those who were unhappy with their treatment might not have attended or might be over-represented in the group who declined to take part.

There are inherent difficulties in investigating patient satisfaction: "patients may not wish to offend interviewers and may rationalise behaviour in retrospect" (Deyo and Inui, 1980). However, Rubin *et al*

(1993) stated that “considerable research supports the reliability and validity of patient ratings of quality of care.” Anonymous, validated, self-report instruments are therefore preferred. There have been no studies in the United Kingdom investigating whether dissatisfaction with treatment is associated with outpatient non-attendance.

2.14 Summary of Section 2.13: non-attendance and dissatisfaction with treatment

- In America it has been shown that patients are likely to leave physicians whom they rate poorly.
- There has been only limited research into patient satisfaction in general but most of that carried out has been in the area of mental health.
- There have been no studies investigating whether patient dissatisfaction is associated with outpatient non-attendance at psychiatric clinics.

2.15 What can be done about outpatient non-attendance?

The implications, both clinical and financial of outpatient non-attendance have been described in Section 1.4. It is therefore no surprise that a number of investigators have attempted various interventions to try to reduce non-attendance rates. Many of these interventions have been within the field of mental health, perhaps because the clinical implications are more apparent than in other

specialties and because patients may lack insight into these implications.

Chen (1991) published an overview of clinical interventions to reduce non-compliance in community psychiatry. He emphasised simple measures such as: reducing the time interval from referral to initial appointment (or discharge from hospital and follow-up appointment); orientation statements or explanatory interviews to reassure patients of what to expect at the psychiatric clinic; and encouraging family support, particularly in relation to the use of medication for patients with chronic mental illnesses.

The different approaches considered by a variety of authors can be divided into four main categories which are discussed in detail below:

- The use of incentives to encourage attendance.
- The use of coercive strategies such as court orders and the linking of disability payments to patient attendance at appointments.
- The use of telephone or mailed reminders about appointments.
- Alternatives to the outpatient clinic for the assessment, treatment and ongoing management of patients referred to hospital specialists.

2.15.1 Incentives

Deyo and Inui (1980) made mention of various incentives to increase appointment keeping at clinics in America, but acknowledged that they had been unable to find any relevant literature examining them. Such incentives included: discount in medical bills for patients who require regular monitoring of their condition; discounts for low numbers of broken appointments; fees for missed appointments; refusal to reschedule further appointments after a certain number have been missed. Clearly these measures are irrelevant in non-fee paying health care systems and the last one could probably be considered negligent.

One study, carried out in America (Carey and Carey, 1990) used token incentives to try to encourage attendance at a day treatment centre for those with a dual diagnosis of mental illness and chemical (substance) abuse. All 53 patients registered at the centre were included. The study was carried out over a twelve week period: four weeks baseline phase; four weeks incentive phase: four weeks post-incentive phase. The incentive was a reward of \$3 value (either restaurant or bowling tokens) if they attended the centre at least 5 hours per day for at least 5 days per week. Those who earned rewards were congratulated and given their tokens at a weekly community meeting. Attendance was measured during each of the three phases and the incentives were shown to have a positive effect on increasing attendance. The study was, however conducted on a relatively small and specialised

population and since baseline attendance was very low, alternative interventions might also have had a positive effect.

2.15.2 Summary of Section 2.15.1: incentives

- Incentives to increase attendance at outpatient appointments have not been researched.
- One study (Carey and Carey, 1990) showed an increase in day centre attendance through the use of incentives such as restaurant tokens.

2.15.3 Coercive strategies

Outpatient commitment and linking disability payments to treatment engagement are strategies which are legally practised in America and not in the United Kingdom.

2.15.3.1 Outpatient commitment

Outpatient commitment is a form of civil commitment where the court orders an individual to comply with a specific psychiatric outpatient treatment programme. This system is available in 35 states in America but its use is controversial. Proponents argue that it reduces the frequency and length of individuals' admissions to hospital and improves their quality of life by reducing their symptoms of mental illness and facilitating rehabilitation.

Others argue that it is an infringement of individuals' civil liberties and their right to refuse treatment and that it damages the therapeutic relationship between the individual and the professionals involved in their care (Torrey & Kaplan, 1995). A survey by the same authors suggested that these issues, as well as the cost of enforcing such a system were the most likely factors leading to the low usage of outpatient commitment in 23 states. However, in states where the uptake of the system is high, such as North Carolina, the average number of admissions per patient assigned to outpatient commitment fell from 3.7 in the three years before it was implemented to 0.7 in the three years afterwards (Torrey & Kaplan, 1995).

The criteria required to use an outpatient commitment order are the same in most states as those used for involuntary hospital admission. The maximum duration of the order varies from three months to an indefinite period of time, but for most states it is defined as either six months or one year.

2.15.3.2 Linking disability payments to appointments

Koch and Gillis (1991) showed that patients who were receiving a disability grant were more likely to attend a follow-up appointment after discharge from the psychiatric unit than patients receiving no such benefit. They felt that this was probably due to the grant's continuance

being dependent on regular review by a psychiatrist, although they describe no further details of how this system works in South Africa.

Ries & Dyck (1997) conducted a postal survey of the “representative payee” practices of community mental health centres in Washington State. This system is run by the Department of Social Security and involves the individual's mental disability payments being handled by a third party who is known as the representative payee. Representative payees are directed to use benefit payments for constructive uses such as housing, food or therapy. This system was set up to address the problem of patients with substance abuse problems or dual diagnoses using their benefit payments to buy alcohol or drugs and to prevent patients spending their money irresponsibly.

The survey collected data on the number of patients registered with the community mental health centre who were subject to the representative payee scheme. The frequency of payments disbursed to patients was also noted. The degree to which the system was linked to the patients' substance misuse, treatment attendance, money management skills and functioning level was indicated on a five point Likert scale. The director of each community mental health centre was asked to indicate on a similar scale to what extent the centre philosophically supported such linkage of payments and patient behaviours.

The authors sent out questionnaires to 80 centres, 41 of which were returned (a 51% response rate) of which 73% were using the representative payee scheme. An average 57 patients were involved in the scheme per centre and one third were reported to have a dual diagnosis. Benefits were usually disbursed weekly. The representative payees were case managers in 62% of cases and administrators in the remainder. Money management skills were most tightly linked to disbursement and attendance was least tightly linked. Philosophical support for the scheme was associated with payments being more tightly linked to patient behaviours and larger centres were found to be more supportive of the scheme than smaller ones.

The authors acknowledged the study's limitations: the lack of random selection of the sample; the use of a self-report instrument; and the lack of verification of linkage between disbursements and patient behaviours. They went on to discuss the ethical implications of linking patient behaviours to benefit payments and highlighted the concerns that some representative payees might "abuse" the patient by managing the account too tightly, using it to force the patient into "healthy" behaviours. For example, by denying them their money if they were going to spend it in ways that were judged by the representative payee to be inappropriate rather than allowing the patient to learn from their own mistakes.

2.15.4 Summary of Section 2.15.3: coercive strategies

- Coercive strategies to encourage patients to maintain contact with mental health services exist in some states in America.
- Outpatient commitment orders have been shown to reduce admission rates.
- Linking attendance to the receipt of disability payments is controversial and there have been no studies of its impact on attendance or admission rates.

2.15.5 Telephone and written appointment reminders

Baekland and Lundwall (1975) commented that telephoning or writing to patients to remind them of appointments had been shown to increase attendance at initial assessments. In 1980, Deyo and Inui published an overview of the literature on dropping out of treatment which particularly emphasised the success of telephone and mailed reminders of appointments in reducing non-attendance rates at a variety of clinics in America. Chen (1991) also recommended letter and telephone appointment prompts in his review of clinical interventions to reduce non-compliance in various community psychiatry treatment settings.

Burgoyne *et al* (1983) carried out a randomised controlled trial of telephone prompting to increase psychiatric outpatient attendance at first appointments in a university based clinic in Los Angeles. The

study was carried out over a three month period and 339 new patients were randomly selected to receive a reminder telephone call two days prior to their scheduled appointment. A control group of 351 new patients were not telephoned. It was not known whether or not patients had a telephone before they were randomised. Three attempts to telephone those in the intervention group were made and a standardised message was used.

No statistically significant difference in attendance rates was found between the intervention group (49% did not attend) and the control group (46% did not attend). However, only 54% of all patients possessed a telephone (equally distributed between the intervention and control groups) and only 40% of patients in the intervention group who had a telephone actually received a telephone reminder prior to their appointment. When those who had been contacted were compared with all other patients in the study (none of whom had been contacted) there was a statistically significant difference between them, such that the reminder system appeared to increase the likelihood of outpatient attendance.

However, when they were compared to those in the intervention group who had a telephone but were not contacted, there was no difference in attendance rates. Attendance appeared to be strongly associated with whether or not the patient had a telephone rather than the intervention. The authors concluded that having a telephone was an

indicator of a higher socioeconomic grouping which determined attendance behaviour (lower groupings being poorer attenders).

Kluger and Karras (1983) carried out a study to investigate whether different interventions could improve attendance at initial appointment at a community mental health centre in America. The three types of intervention used were: an orientation statement describing the working of the clinic and what to expect at the initial appointment which was read out at the time a patient booked an appointment; an orientation statement read out at the time of booking plus a telephone prompt within 24 hours of the appointment; a telephone prompt within 24 hours of the appointment. Subjects were 141 individuals who telephoned (in succession) to make an appointment at the centre. They were randomly assigned to receive one of the three interventions described above or to a control group. Two callers were excluded as they were unwilling to give their telephone numbers. Twenty-five were assigned to the orientation only group, 41 to both interventions, 50 to the telephone prompt only group and 25 to the control group. When the data were analysed on an intention to treat basis, the only group to show a significantly higher attendance rate than the control group were those who received an orientation statement only. Telephone prompting only improved attendance in subjects who could actually be reached by telephone (around 50% of the sample could not be contacted by telephone despite giving a telephone number at entry to the study).

There are a number of difficulties in interpreting the findings of this study. Firstly, the subjects were recruited when they telephoned to arrange the appointment and it is therefore difficult to extrapolate the findings beyond clinics with similar intake procedures to this (which are rare in the United Kingdom). The subjects were clearly motivated enough to arrange the appointment and therefore might have been more easily encouraged to attend than patients whose appointments are sent to them in response to a referral from a general practitioner. Also, because the study was carried out in America, the clinic appeared to treat only patients who were either paying or who had medical insurance and, again this clientele is rather different to the usual psychiatric outpatient population in the United Kingdom.

The results are in keeping with Burgoyne *et al's* (1983), supporting the finding that telephone prompts are not an effective intervention to increase attendance at initial appointments at psychiatric clinics. However, the authors did not report any pre-study calculation of the numbers of subjects needed to examine differences between the groups. The low numbers of subjects in each group suggest that the study was under powered and only a large difference between groups would have shown up. Therefore the results are probably not robust.

Swenson and Pekarik (1988) carried out a similar study of two different written interventions to reduce the non-attendance rate at initial appointments at a community mental health centre in America. They aimed to investigate whether written reminders and written orientation

statements (describing the work of the clinic and what to expect at the initial appointment) could improve attendance and whether these interventions were more effective if sent as close to the appointment date as possible. Of the 150 subjects included in the study, 30 received a letter prompt three days before their appointment, 30 received a letter prompt one day before their appointment, 30 received a letter prompt and orientation statement three days before the appointment, 30 received them one day before the appointment and the remaining 30 (the control group) received only their appointment card with no subsequent prompt or orientation statement. The authors found a statistically significant higher attendance rate amongst subjects who received an orientation statement, irrespective of when it was received, as compared to the control group. Written reminders of the appointment did not appear to lead to improved attendance if unaccompanied by an orientation statement.

There are a number of criticisms to be made about this study. The selection of subjects is not described. As in the previous study by Kluger and Karras (1983), subjects had telephoned to arrange the appointment and may therefore have been more motivated to attend than patients in other settings who are sent appointments on referral from another doctor. Again, the private medical system of the United States may have influenced the results as patients may be more likely to attend if they have to pay or arrange medical insurance. Finally, the authors did not make any prior estimate of the power of their comparisons of expected differences between groups and the numbers

of subjects in each group suggest that the study was too small to be certain of the findings.

The authors concluded that written prompts which included an orientation statement could provide an inexpensive means of improving attendance at initial appointments and were cost effective when measured against the waste of resources involved in missed appointments. These findings support Burgoyne *et al's* (1983) conclusions in suggesting that written prompts are more effective than telephone prompts in encouraging attendance at outpatient appointments. Kluger and Karras (1983) felt that, for patients who telephone to arrange their own appointments, the orientation statement could be read out over the telephone at the point of booking the appointment, thus minimising labour for the clinic staff.

The use of verbal contact between therapist and patient prior to initial assessment was investigated by Larsen *et al* (1983) in San Francisco. They showed a 10% drop in the non-attendance rate of new referrals to a community based mental health centre following the introduction of a system whereby allocated therapists contacted their patients by telephone prior to the initial appointment. Unfortunately, the authors did not describe the content of the verbal communication or the actual number of patients who took part. They referred to patients receiving "psychotherapy" but it was unclear what was meant by this term. A second phase of the study involved 52 patients who all received help from an independent member of staff (i.e. not their therapist) with

completion of referral information forms. Half the group were randomly allocated to also receive a 15 minute pre-therapy orientation interview. It was found that only one patient in the experimental group dropped out of treatment within four weeks compared to seven in the control group.

Larsen *et al's* (1983) study is subject to similar criticisms of the other American studies described above (Swenson and Pekarik, 1988; Kluger and Karras, 1983) and the results are difficult to extrapolate to outpatient populations in the United Kingdom: patients who contact the clinic to arrange their initial appointment may be more motivated to attend; fee paying populations may be more motivated to attend; the results are based on small numbers of patients and the lack of inclusion of any calculation of the power of their comparisons of expected differences between groups suggests that the study was too small to be certain of the findings. Also, this population was not described in terms of diagnosis or reason for referral and was referred to as receiving psychotherapy. It may therefore have consisted of patients with very different problems to those seen at community mental health centres in the United Kingdom.

A number of authors have investigated methods to increase outpatient attendance in the United Kingdom. Rusius (1995) carried out a study to test whether postal reminders were able to reduce the non-attendance rate for new patients at a psychiatric clinic in Sheffield. All 144 new patients over a five month period were included in the trial

and randomly allocated to receive a reminder or not. The non-attendance rate of those who received a reminder was 13% compared to 28% for those who did not and this result was statistically significant at the 5% level.

Although the findings appear encouraging, no data are given on diagnosis and symptom severity, both of which could have acted as important confounding factors. This omission was addressed by the random allocation of patients to the intervention group but there is a lack of description of the randomisation process or how balanced the groups were with regard to these factors at baseline.

Skuse's (1975) finding that a brief explanatory interview was able to increase subsequent attendance at initial psychiatric outpatient appointments in Manchester has been described in Section 2.7.3.

Webster (1992) found that patients newly referred to a mental health day centre in London were more likely to attend if they had received an information sheet explaining what to expect from the initial assessment beforehand. All new referrals over an eight month period were included in the study. A randomly selected group of 39 patients were sent the information sheet with their appointment letter and 35 were not (the control group). Eighty-two percent of those sent the sheet attended their appointment compared to 57% of controls. This difference was statistically significant at the 5% level. Interviews were carried out with a sub-group of 31 patients, comprising all those who

attended their initial assessment over a six month period, to assess their satisfaction with the appointment in terms of the help offered and information received about their particular problem. The timing of interviews in relation to initial assessment was not reported, nor was the identity of the interviewer. The author reported that he was blind to which patients had been sent the information sheet. It was found that patients who were sent the information sheet and attended their appointment were more satisfied with their assessment than patients in the control group who attended.

In criticism of this study, the number of patients included was small and, again the lack of any prior calculation of the expected differences between the intervention and control group suggests that the findings may not be robust. No data regarding e.g. diagnoses and symptom severity were reported to illustrate the balance of cases and controls at baseline. Also, the author's blindness as to which patients had been sent the information sheet might have been compromised during the interviews. The high levels of satisfaction reported in both groups may reflect the lack of anonymity in interviews.

Macheria (1992) carried out a systematic review of randomised evaluations of strategies to improve patients' appointment keeping in different health care settings. Their comprehensive search identified 164 relevant articles, 23 of which were randomised controlled trials which used attendance as the primary outcome measure. Eight of these trials examined appointments for screening purposes (such as

cancer), and the remaining 15 trials examined appointments for medical or “psychosocial” illnesses including psychiatric problems. The studies were all carried out between 1964 and 1990, 68% were conducted in the United States and 20% in the United Kingdom. Pooled odds ratios from statistically homogeneous studies were used to establish whether interventions such as written or telephone reminders were useful in increasing attendance.

A reminder letter sent to the patient a few days before the appointment proved effective in increasing attendance in general medical populations. This also seemed to improve attendance for “psychosocial” populations but no pooling of results was possible due to heterogeneity of results. He found that telephone reminders were effective in increasing attendance at both “psychosocial” appointments and medical appointments. Reminder letters and telephone prompting also increased the attendance of patients for screening tests.

The meta-analysis specifically excluded settings where patients attend appointments for ongoing care and where medication is not administered at the appointment itself. Therefore the findings are not easily extrapolated to the follow-up psychiatric outpatient population. On closer examination, the “psychosocial” group on which the pooled results were reported for telephone prompting consisted of four American studies, two of which were in community mental health populations and which have been described above (Kluger, 1983; Swenson and Pekarik, 1988). The third study included is also critiqued

above (Burgoyne *et al*, 1983) and the fourth was carried out in a specialised outpatient alcohol treatment programme (Nirenberg *et al*, 1980). None of these studies included patients booked for follow-up appointments at the psychiatric clinic. Therefore, the results of this meta-analysis do not provide good evidence to support the use of telephone or mailed reminders to increase attendance at psychiatric appointments, particularly in the United Kingdom, and any positive correlation between the two is only applicable to new patients.

2.15.6 Summary of Section 2.15.5

- Written and telephone reminders of appointments have been shown to increase attendance at non-psychiatric clinics.
- Small studies have shown that “orientation statements”, information sheets and explanatory interviews can increase attendance at initial appointments in mental health settings, but larger studies of general psychiatric outpatients are needed to confirm this.
- Telephone prompts do not appear useful for psychiatric populations.

2.15.7 Alternatives to the outpatient clinic

2.15.7.1 General practice psychiatry liaison

Over the last 20 to 30 years there has been increasing interest in the establishment of psychiatric liaison clinics within the general practitioner's surgery. Strathdee and Williams (1984) showed that 19% of general adult psychiatrists in England and Wales and 50% of those in Scotland had established consultation clinics in primary care settings since the late 1970's. These clinics varied from the "shifted outpatient model" where the psychiatrist sees patients in the local surgery for assessment, crisis intervention and short term management, to longer term liaison and joint management of patients with the primary care team.

Tyrer (1984) carried out an evaluation of five general practice psychiatry liaison clinics which were set up as an alternative to hospital outpatient clinics in Nottingham. The general practitioner clinics served areas that were identified by Nottinghamshire County Council as particularly disadvantaged in terms of poor housing, low income, poor health and family problems. All 185 patients referred to the general practice liaison clinics over a two year period were studied and case notes were used to collect data on diagnosis and past psychiatric history. Self-report questionnaires were given to 100 patients consecutively referred to investigate their opinions about the clinics.

Sixty-one percent of patients were women. Eighty percent of patients referred had had previous contact with psychiatric services and one quarter of patients had previously received inpatient treatment. Despite this only 22 patients (12%) required an admission during the episode under study and most were treated wholly in the primary care setting, sometimes with extra visits or appointments from a community psychiatric nurse. Over half the patients were diagnosed as suffering from neurotic disorders and 15% had functional psychoses. These proportions are similar to Morgan's (1989) diagnostic breakdown of new referrals to psychiatric outpatient clinics.

Seventy-three percent of patients who took part in Tyrer's (1984) study said that they preferred the general practice liaison clinic to the hospital outpatient clinic. The reasons given included: convenience; less formal setting; less stigma; and closer liaison between the general practitioner and psychiatrist with subsequent greater understanding of the problem on the part of the general practitioner.

A further evaluation of these five clinics was carried out a few years later (Darling and Tyrer, 1990) in which all face to face contacts between the team of three psychiatrists and all primary care staff at the clinics were investigated over a twelve month period. The study included a total of 33 general practitioners and their associated staff and during this time there were 351 contacts between the psychiatrists and primary care workers. After each contact the psychiatrist completed a form detailing the content of any discussion and a primary

diagnosis was made if the discussion was about an individual patient. The authors found that typical contacts occurred before and after the psychiatrists' clinics almost anywhere within the building including either the psychiatrists' or general practitioners' consulting rooms, corridors, reception areas, car parks or in the lavatories. The majority (89%) were between the psychiatrist and general practitioner, 58% of which were initiated by the psychiatrist and 74% of patients discussed were already under psychiatric care. Over 79% of contacts lasted for less than five minutes. Around one third of contacts concerned patients with a diagnosis of a psychotic disorder and one third had a neurotic disorder.

Although these two studies were not designed to map the development of these particular clinics, the results suggest that the role of this psychiatric liaison service may have evolved over time. Eighty percent of patients in the first study (Tyrer, 1984) and 74% in the second (Darling and Tyrer, 1990) were known to psychiatric services yet the diagnostic breakdown of the two groups is quite different with twice as many patients in the second study suffering from a psychotic disorder as in the first.

Tyrer's first study (1984) clearly investigated new referrals to the liaison clinics, patients who would otherwise have been referred to the hospital psychiatry outpatient clinic. The later study (Darling and Tyrer, 1990), being focused on contacts, does not describe whether the patients under discussion were new referrals to the liaison clinic or

whether they were already undergoing treatment there. The assumption is that they were probably a combination of both which might explain the differences in the diagnostic breakdown of the two groups. Nevertheless, these results suggest some kind of shift away from hospital based care for patients already known to mental health services. In other words the presence of the psychiatric-liaison services appears to encourage discussion between psychiatrists and general practitioners about mutual patients and, presumably also encourages closer liaison and joint management of patients with serious mental illnesses.

As well as encouraging better communication between the general practitioner and psychiatrist, some patients will agree to see a psychiatrist in the familiar setting of the general practitioner's surgery, finding the psychiatric clinic too intimidating. They might feel apprehensive or afraid of attending a hospital based psychiatric clinic and not attend the appointment. Brown *et al* (1988) showed a much lower non-attendance rate at two primary care psychiatric liaison clinics compared to a local hospital outpatient clinic (19% versus 40%), despite similar proportions of patients with a history of psychotic disorder in both groups. In fact, the proportion of male patients with a history of a psychotic illness was much higher in the primary care group than the hospital group. This may indicate that patients who suffer from schizophrenia and other paranoid illnesses feel more able to attend appointments in the more familiar and less threatening environment of the general practice.

2.15.7.2 Home visits

An obvious alternative to waiting in a clinic for a patient who may not attend is to visit them at their home. The importance of domiciliary visits has been recognised in the discipline of old age psychiatry for over 20 years (Arie and Isaacs, 1978). Home assessments are optimal in old age psychiatry since mobility difficulties, frailty and confusion are more prevalent than in younger patients and access to the clinic can therefore be difficult and unsettling. However, home assessment also has a number of advantages over the outpatient clinic which are relevant to general adult psychiatric services.

For example, assessment in the patient's home provides a unique opportunity to gather useful information about the patient that would not be available from an interview in the outpatient clinic. The level of general tidiness and cleanliness of the home gives an indication of the patient's domiciliary functioning and their ability to perform "activities of daily living" (such as cooking and cleaning). It can also reflect their current mental state. For example, a chaotic home may improve when positive symptoms are less prevalent. An impoverished home, sparsely furnished, may indicate an impoverished mind and/or a low income. An assessment of risk in the home can also be made, such as leaving the gas cooker on or not extinguishing cigarettes adequately and medicine bottles can be examined (Banerjee, 2001)

Home visits can also facilitate links with relatives and carers. The home provides a more informal setting for gathering collateral

information than the clinic and can encourage areas of concern to be discussed openly between the patient and family. The advantages of home visiting have been incorporated into the model of care used by certain "crisis resolution teams". Such teams provide a home based, short-term treatment service to patients in acute mental health crisis, visiting them as often as two or three times per day if needed. The involvement of the family in the discussion about the crisis and management plan is considered an especially important component of this approach (Polak, 1979).

Many community mental health teams use a combination of home visits, appointments at the community mental health centre and CPA meetings to provide a flexible, comprehensive service, tailored to the individual patient's needs and wishes.

Proponents of psychiatric outpatient clinics argue that home visits are time consuming and that far more patients can be seen in a single clinic session than in the community. Clearly, a balance has to be struck between carrying out unessential home visits on patients who are willing and able to attend the outpatient clinic, and wasting clinic time waiting for patients who do not attend. For this reason, the identification of patients who are likely to attend and those who are not is very important. Over time, individual clinicians learn which of their patients tend not to keep appointments and which are reliable. Some patients attend the clinic when well and stop attending when they are relapsing. A home visit at this point would therefore be the obvious

course of action.

As referred to in Section 2.15.7.3, some psychiatrists now review patients who have serious mental illnesses through the CPA system and rely on community keyworkers to provide regular review and monitoring for these patients either in their own homes or at the team base. There is some evidence that patients prefer to be seen at home rather than attending the outpatient clinic (Bennet and Freeman, 1991).

Of course, some patients might not wish to be visited at home and their views need to be respected, although the degree of concern sometimes necessitates a home visit against the patient's wishes.

Since the advantages of home visits are numerous, it could be argued that at least one domiciliary visit should take place in order to maximise the information available for a comprehensive assessment, particularly for patients with serious mental illnesses.

2.15.7.3 The care programme approach

In 1990 the Government published a paper entitled "The Care Programme Approach for people with a mental illness referred to the specialist psychiatric services". This paper called for all local mental health services to implement a policy (the care programme approach or CPA) for the planning and documentation of treatment for patients with serious mental illnesses. The CPA requires comprehensive assessment of mental health and social needs and the allocation of a

named keyworker (usually a community mental health nurse or social worker) to co-ordinate the care plan. The most intensive level of CPA provision is known as the supervision register and is used for close monitoring of patients considered to be at special risk of self-neglect, harm to themselves or others and at risk of loss of contact with services. A recent review of the CPA system has suggested that stringent documented care planning for patients who are only under the care of the outpatient services and not the community mental health team is unnecessary (Department of Health, 1999).

Patients are reviewed regularly by their keyworker and at CPA meetings to which all those involved in their care (including the psychiatrist) are invited. This approach has the advantage of systematically ensuring that regular reviews are held for all patients, whether or not they themselves attend. It also allows closer working between community mental health teams and psychiatrists so that joint discussions can take place and management plans can be agreed between patients and professionals at the same time point, reducing the number of written communications needed and subsequent misunderstandings that can ensue. In particular, it avoids duplication of work so that a mutually agreed "division of labour" takes place rather than the psychiatrist and keyworker working in isolation from each other. Regular feedback of any issues of concern can take place between the community keyworker and psychiatrist in between such meetings as needed. If appropriate, the patient can be reviewed by

the psychiatrist outside of the care planning meetings, either in the clinic setting or in the patient's own home.

The CPA system has been implemented across England, but there are inconsistencies in its application, particularly with regard to the use of the supervision register. These variations are not explained by variations in population need (Bindman *et al*, 1999). A recent survey of all mental health trusts in England found that patients always attended their CPA meetings in 33% of cases, often attended in 56% of cases and sometimes attended in 21% of cases (Schneider *et al*, 1999).

The CPA system cannot provide an alternative for all patients who were previously seen in the psychiatrist's outpatient clinic since not all outpatients require the input of the community mental health team. It does, however, allow patients with the most serious mental illnesses and higher levels of need to be more adequately reviewed and monitored in the community.

2.15.7.4 Assertive outreach

Assertive outreach teams, originally developed in America (Stein and Test, 1980; Lehen *et al*, 1997,1999) and in Australia (Hoult *et al* 1986) are now evolving across the United Kingdom. These teams use a specific model of working and have a remit to try to target their service to patients with serious mental illnesses who have recurrent admissions to psychiatric units and who are "difficult to engage". That

is to say, that they have a tendency to drop-out of contact with psychiatric services after discharge from hospital. Such patients tend to miss appointments at the outpatient clinic and are often not at home when visited in the community. Sometimes their “difficulty in engagement” with services is due to symptoms of their mental illness (such as paranoia or disorganisation) and sometimes it is due to lack of insight or negative experiences of psychiatry, leading to an active avoidance of services. Assertive outreach team workers have small case loads and make multiple attempts to contact and visit patients in their own homes or other, public places (such as parks and cafes).

A full review of the subject of assertive outreach is outside the scope of this literature review, but in summary this approach has been reported to increase patients’ engagement with services and reduce hospital admissions (Marshall *et al* 1996; Marshall & Lockwood, 1998). It is certainly an alternative to the outpatient clinic for a specific group of patients who are at the most severe end of the spectrum of mental illness, but it has not been fully evaluated in the United Kingdom.

2.16 Summary of Section 2.15.7: alternatives to the outpatient clinic

- **Psychiatric liaison sessions held in general practices facilitate communication between psychiatrists and general practitioners and may encourage attendance as they are less formal and less stigmatising than the outpatient clinic.**
- **Home visits provide the opportunity for important information to be gathered about the patient's functioning and they can facilitate links with family and carers.**
- **Care planning meetings provide a forum for regular review of community patients' management plans, even if the patient does not attend, encouraging closer liaison between the psychiatrist and community keyworker for patients with serious mental illnesses.**
- **The assertive outreach model has been successfully employed outside the United Kingdom for patients with serious mental illnesses who are "difficult to engage".**

2.17 Summary of the literature review

In the United Kingdom, 12% of all outpatient appointments are missed. The rate of non-attendance at psychiatric clinics is around 30% and is even higher at clinics for the treatment of substance abuse. The monetary cost of missed appointments is estimated at around £240m per year. There is evidence from outside the United Kingdom that patients who miss appointments at the psychiatric clinic are at greater risk of admission to a psychiatric unit than those who attend. There have been no similar outcome studies for patients at non-psychiatric clinics. The risk of relapse and subsequent admission for patients with mental illness raises issues around the risk that such patients may pose to themselves and others prior to admission.

Table 2.3 shows a summary of factors discussed in the literature review which have been investigated for their possible association with outpatient non-attendance at non-psychiatric and psychiatric clinics. Factors which were most convincingly shown to be associated with non-attendance at both included: younger age; lack of family support for the referral or treatment; poor understanding of the reason for referral; waiting a long time for an appointment; and clerical error. In non-psychiatric populations, ENT and dermatology were found in a number of studies to have higher non-attendance rates than other medical and surgical clinics. In psychiatric populations, diagnosis of substance abuse or personality disorder and a past history of

admission to a psychiatric unit have been shown to be associated with higher rates of outpatient non-attendance.

Table 2.3 Summary of factors associated with missing appointments

Factor	Non-psychiatric clinics	Psychiatric clinics
Younger age	Yes	Inconclusive
Female gender	Inconclusive	Inconclusive
Lower socioeconomic status	Yes in USA	Yes for psychotherapy
Employment	No, but difficulty getting time off work is relevant	No, high unemployment in psychiatric populations
Marital status	Inconclusive	Inconclusive
Family support for treatment	Reduces non-attendance	Reduces non-attendance
Diagnosis	ENT, dermatology	Substance abuse, personality disorder
Symptom severity	Inconclusive	Inconclusive
Past psychiatric history	Not applicable	Previous outpatient contact increases attendance, inpatient contact reduces it
Poor understanding of reason for referral	Yes	Yes
Resistance to referral	Not investigated	Yes
Longer waiting time from referral to appointment	Yes	Yes
Clerical error	Accounts for up to one third of missed appointments	Accounts for less than 10% of missed appointments
Dissatisfaction with treatment	Yes in USA	Not investigated

Appropriate discussion between referrer and patient of the reasons for referral has been shown to reduce patients' anxieties about the process of seeking specialist advice and increase the chance of outpatient attendance at both psychiatric and medical clinics. This may be of particular benefit for patients who are referred to see a psychiatrist due to the stigma associated with mental illness. Patients who express resistance to the referral have been shown repeatedly to be very unlikely to attend.

The results of the studies reviewed suggests that around one quarter of patients referred by general practitioners to see a psychiatrist have no psychiatric symptoms but social, family and marital conflicts prompt referral. On the other hand, up to one third of patients presenting to their general practitioners have psychiatric symptoms but these symptoms can frequently be masked by way of somatisation such that only 2% of patients are actually referred for psychiatric opinion. Once seen by the psychiatrist, many patients receive their ongoing treatment at the outpatient clinic rather than being referred back to the general practitioner. The reasons for this are difficult to discern, but the results of the relevant studies showed that severity of the patient's diagnosis and psychiatric symptoms did not appear to be the main factors involved.

Two studies of communication between referrers and psychiatrists showed that general practitioners' referral letters generally contain the information that the psychiatrist needs whereas psychiatrists' letters to

general practitioners about new patients tend to be overinclusive. One study showed that in 25% of cases, the hospital failed to communicate with the general practitioner at all following referral of patients for various medical assessments.

Studies which directly asked patients their reasons for missing an outpatient appointment showed that patients at non-psychiatric clinics were likely to give excuses such as physical illness or having another commitment, whereas patients at psychiatric clinics were more likely to state that they had forgotten the appointment, that they felt better or that they were concerned about the stigma of seeing a psychiatrist.

Telephone and mailed reminders were found in a number of studies to be useful in increasing attendance at non-psychiatric clinics, whereas written orientation statements or explanations were more useful for patients referred to psychiatric clinics. Telephone reminders were not shown to be of benefit to patients at psychiatric clinics, mainly due to the large proportion of patients who do not have a telephone.

Coercive strategies such as outpatient commitment orders and linking disability payments to attendance at appointments are practiced in the United States. One study showed that the introduction of outpatient commitment was associated with lower rates of admission to psychiatric hospital.

Psychiatric liaison sessions held in general practices encourage communication between professionals and have been shown to have higher attendance rates than psychiatric outpatient clinics. Home visiting is an alternative to the outpatient clinic and provides the opportunity to gain important information about the patient's situation and functioning. Care planning meetings for patients at the more severe end of the mental illness spectrum who are under the care of community mental health teams, promote communication between professionals and avoid duplication of work.

Assertive outreach has been shown in studies outside of the United Kingdom to increase service contact and reduce hospital admissions for patients with serious mental illnesses who are "difficult to engage" in treatment.

Chapter 3

Rationale for the Studies

3 Rationale for the studies

3.1 Implications of the literature review for the design of the studies

The literature review showed that outpatient non-attendance had significant financial implications in terms of wasted resource.

Psychiatric outpatient non-attendance rates were higher than other hospital specialties and, in countries other than the United Kingdom, were associated with adverse clinical consequences.

The literature review showed that a number of factors were involved in determining whether patients kept their appointments at psychiatric and non-psychiatric clinics: diagnosis; family support for the treatment; understanding of the reason for referral; clerical error; and waiting time from referral to being seen in the clinic all appeared to influence outpatient attendance. Results regarding certain demographic factors and symptom severity were inconclusive and needed further investigation. With regard to psychiatric clinics, specific factors which seemed to influence patients' outpatient attendance included: stigma about seeing a psychiatrist; the way in which the referrer explained the need for the patient to see a psychiatrist; and the patient's previous experience of psychiatric services.

Few studies had specifically asked patients the reasons for non-attendance at clinics, and those that had had tended to ask patients

newly referred. In America, dissatisfaction with treatment had been found to be associated with patients leaving their physicians, but this factor had not been investigated with regard to patients at psychiatric clinics. Study 1 was therefore designed to investigate whether patients who defaulted from outpatient clinics were less satisfied with their treatment than those who continued to attend. The literature review had shown that an anonymous self-report questionnaire was a valid way to ascertain patients' opinions of their treatment so this method was employed.

The literature review showed that there had been no prospective studies of the consequences of non-attendance at psychiatric clinics in the United Kingdom. In fact, there had been only limited research carried out into the specific subject of psychiatric outpatient non-attendance in this country. Studies had tended to focus on new referrals to psychiatrists rather than those already engaged with psychiatric services. This is presumably because non-attendance is easily defined in this group and also because more time is allocated for the assessment of new patients than follow-ups so non-attendance results in a considerable waste of clinic time. Many studies had collected data from patients about non-attendance using postal questionnaires that were subject to low response rates. Other criticisms were the retrospective and case note design of many studies, important sources of bias in terms of the interpretation of information collected. Some studies were criticised for their small sample sizes and lack of pre-study estimates of the numbers of

subjects needed to demonstrate any differences between the groups under investigation.

Study 2 was therefore designed to investigate the outcome in terms of outpatient contact and admission to the psychiatric unit for patients who missed appointments at the psychiatric clinic. The study was designed to include data collection on many of the demographic and social factors previously identified as influencing outpatient attendance in order to try to clarify inconsistencies in the findings of previous researchers.

The design of the study took into account some of the limitations of previous research into outpatient non-attendance. Firstly, the study was prospective in design with data on hospital admission rates for non-attenders chosen as the primary outcome. This ensured 100% outcome data would be available. Face to face interviews were used to address the problem of low response rates identified in previous studies that had used postal questionnaires. Most interviews took place in the patients' homes but the venue was flexible to encourage subjects to consent to the interview. General practitioners were interviewed over the telephone in order to maximise response rates without taking up too much of their time.

The interviews with patients included an assessment of psychiatric symptoms and social functioning using previously validated rating scales (Krawiecka *et al*, 1977; Marks, 1986) completed by a single

researcher (HK). This addressed the lack of accurate symptom rating used in many of the previous studies described in the literature review. Subjects were selected by use of a random number generator to minimise selection bias. The same number of attempts were made to interview all non-responders. A pre-study calculation to estimate the number of follow-up patients required to determine any differences between attenders and non-attenders was carried out to ensure that the study would include enough subjects to answer the primary hypothesis (Section 3.3.2).

Evidence from the literature review suggested that the process of referral itself, including the interaction and communication between the patient and referrer (usually the general practitioner), the general practitioner and psychiatrist, and the psychiatrist and general practitioner had been investigated in relation to newly referred patients. One area that had been neglected in previous studies was the quality of communication between the psychiatrist and general practitioner with regard to follow-up patients. The primary hypothesis of Study 2 was that non-attendance was associated with a poor outcome. It was therefore clearly important to include investigation of whether a patient's non-attendance was adequately communicated to the general practitioner, irrespective of whether they had missed a new assessment or follow-up appointment.

3.2 Aims of the studies

3.2.1 Aim of Study 1

- To investigate whether patients who missed follow-up appointments at the psychiatric outpatient department were less satisfied with their treatment than patients who attended.

3.2.2 Aims of Study 2

To investigate the following:

- The reasons for non-attendance at general adult psychiatric outpatient clinics.
- The differences in characteristics of attenders and non-attenders.
- The differences in characteristics of new patients and follow-up patients
- The factors associated with non-attendance.
- The quality of communication between primary and secondary care professionals concerning outpatient attenders and non-attenders.
- General practitioners' opinions regarding the appropriate course of action following outpatient non-attendance.
- The rate of subsequent admission for attenders and non-attenders.

3.3 Hypotheses to be tested

3.3.1 Hypothesis of Study 1

1. Defaulters from outpatient follow-up are less satisfied with their treatment than patients who keep their appointments.

3.3.2 Hypothesis of Study 2

1. Defaulters from outpatient follow-up have a greater likelihood of subsequent admission to inpatient services than patients who keep their appointments.
2. The factors associated with non-attendance differ between patients newly referred to the psychiatric clinic and those with follow-up appointments.
3. Communication between the psychiatrist and general practitioner about defaulters differs between those newly referred and those with follow-up appointments.

Chapter 4

Study 1

4 Study 1: Satisfaction of attenders and non-attenders at psychiatric outpatient clinics

4.1 Method

4.1.1 Setting

The study was carried out from the psychiatric out-patient department of the Royal Free Hospital, London over an eleven week period between October 1995 and January 1996. The catchment area of the Royal Free Hospital is the northern half of the London Borough of Camden which has a population of 170,500, 60% of whom live in north Camden. The MINI (Mental Illness Needs' Index; Glover *et al*, 1998) score for Camden and Islington is 121.7, meaning that the need for mental illness services is 21.7% above the national average, making it an area with one of the highest levels of psychiatric morbidity in the United Kingdom. The MINI score for north Camden is slightly lower at 117.1 (Severe Mental Illness Needs Assessment in Camden and Islington; Camden and Islington Health Authority, 1998).

The psychiatric outpatient department is situated within the main hospital building and around 5,000 general adult psychiatric outpatient appointments are held there per year. The department of psychiatry employs five full-time and two part-time general adult consultant psychiatrists who have responsibility for 70 inpatient beds and two community sectors. Each consultant has a junior doctor under their

supervision and there are two full-time and up to three part-time specialist registrars working within the general adult psychiatry teams. Each sector is served by a multidisciplinary community mental health team and a day hospital. All general adult psychiatry medical staff hold outpatient clinics in the department.

4.1.2 Inclusion criteria

All patients booked into follow-up appointments with a general adult psychiatrist during the study period were included. Patients who were booked into new assessment appointments to see a psychiatrist for the first time were excluded from the study as they had no experience of the outpatient service and were therefore unable to comment on it.

Follow-up patients who attended their appointment during the study period and who agreed to participate were given a questionnaire by the outpatient reception staff to complete whilst waiting to see the psychiatrist. Patients were asked to hand completed questionnaires back to the reception staff before leaving the department. A record was kept of patients who returned questionnaires in order to prevent them from being given another when they next attended. At the start of each week I identified from the clinic lists kept by the outpatient reception staff any patients who had failed to keep their follow-up appointments (non-attenders). Questionnaires were sent to non-attenders along with an explanatory letter requesting that they complete the questionnaire and return it to the department in a pre-

paid envelope. If there was no response within three weeks, a further copy was posted to them. Patients were classified as attenders or non-attenders according to whether they kept the first scheduled appointment during the study period. Patients with more than one appointment during the study period were not asked to complete a further questionnaire.

4.1.3 Data collected from patients

Data were collected using a brief, anonymous, self-report questionnaire to encourage patients to give frank opinions about their treatment. The questionnaire was informed by concepts from earlier studies of patient satisfaction (Ruggeri & Dall'Agnola, 1993) and included specific questions about the quality of communication during the consultation which had been successfully administered in a previous study of psychiatric outpatients' satisfaction (Jones and Lodge, 1991). Self-reporting was used to encourage patients to give frank opinions about their treatment. The questionnaire was designed to be completed in a few minutes whilst patients were waiting to see their psychiatrist. It was therefore designed to be easy to understand and quick to complete and consisted of 20 multiple choice style questions. Patients were asked for information regarding: their demographic details; past psychiatric history; current use of outpatient services; quality of interaction with the doctor; satisfaction with the treatment they receive from their doctor; and satisfaction with the general service they received in the department. Questions assessing

the participants' opinions of the quality of the consultation or their satisfaction with treatment were presented on a four point Likert scale. For example, in answer to the question "Do you feel you understand the things your doctor explains to you?", the possible responses were: Yes, I understand clearly; Yes, I think I understand; No, I am not sure I understand; No, I do not understand. There was also space at the end of the questionnaire for patients to add their own comments about any aspect of their outpatient care.

4.2 Results

During the study period 1,087 follow-up appointments were attended and 416 were not (a non-attendance rate of 28%). This involved 538 individual patients who kept their appointments and 219 who did not. From the attenders, 340 completed questionnaires were received giving a response rate of 63%. Of the 219 postal questionnaires, 118 were returned completed giving a response rate of 54% for non-attenders. Demographic data and details of outpatient variables are shown in Table 4.1 for attenders and non-attenders. There were no statistically significant differences in demographic characteristics between attenders and non-attenders.

Table 4.1 Characteristics of attenders and non-attenders at follow-up appointments

		Attenders	Non- attenders	Total
		n=340 (%)	n=118 (%)	n=458 (%)
Male		166 (49)	61 (52)	227 (50)
Mean age		41	40	40
Ethnic group	White European	271 (81)	86 (73)	357 (79)
	African-Caribbean	25 (8)	14 (12)	39 (9)
	White non-European	16 (5)	6 (5)	22 (5)
	Asian	12 (4)	4 (3)	16 (4)
	Other	10 (3)	8 (7)	18 (4)
Employment	Full-time	56 (17)	21 (18)	77 (17)
	Part-time	26 (7)	5 (4)	31 (7)
	Unemployed	256 (76)	92 (78)	348 (76)
Living situation	Alone	182 (54)	52 (45)	234 (51)
	With partner and/or family	137 (40)	50 (43)	187 (41)
	Supported accommodation	21 (6)	14 (12)	35 (8)

With regard to their outpatient treatment, less than half of all follow-up patients were regularly seen by the consultant but the majority said they would like to see the consultant sometimes. Most patients felt that the frequency and length of consultation was adequate, but 28% wanted longer. No patients wanted to be seen for a shorter length of time.

In terms of the quality of the consultation, over 90% of patients felt that they were always or usually able to ask all the questions they wanted to; that they always or usually received adequate answers; and that they felt they understood the things their doctor explained to them. There were no statistically significant differences between attenders and non-attenders in the characteristics of consultations. These findings are presented in Table 4.2.

Table 4.2 Characteristics of consultations

		Attenders n = 340 (%)	Non-attenders n = 118 (%)	Total n = 458 (%)
Usually seen by consultant		n=333	n=118	n=451
	Yes	133 (40)	50 (42)	183 (41)
	No	156 (47)	54 (46)	210 (47)
	Don't know	44 (13)	14 (12)	58 (13)
Would like to see consultant		n=292	n=92	n=384
	Yes	131 (45)	39 (42)	170 (44)
	Yes, sometimes	97 (33)	40 (44)	137 (36)
	No	64 (22)	13 (14)	77 (20)
Junior Dr. changing 6 monthly		n=243	n=84	n=327
	Very/unhappy	144 (59)	51 (61)	195 (60)
	Don't mind	82 (34)	25 (30)	107 (33)
	Very/happy	17 (7)	8 (9)	25 (8)
Length of consultation		n=335	n=117	n=452
	0-9 minutes	19 (6)	7 (6)	26 (6)
	10-29 minutes	240 (72)	83 (71)	323 (71)
	30-39 minutes	53 (16)	20 (17)	73 (16)
	Over 40 minutes	23 (7)	6 (5)	29 (6)
Consultation long enough?		n=329	n=115	n=444
	Yes	237 (72)	82 (71)	319 (72)
	Prefer longer	89 (27)	33 (29)	122 (28)
	Prefer shorter	0	0	0
Frequency of appointments		n=329	n=114	n=443
	1-4 weekly	157 (48)	59 (52)	216 (49)
	1-3 monthly	113 (34)	39 (34)	152 (34)
	3-6 monthly	43 (13)	13 (11)	56 (12)
	> 6 monthly	16 (5)	3 (3)	19 (4)
Appointments often enough?		n=317	n=109	n=426
	Yes	221 (70)	74 (68)	295 (69)
	Prefer fewer	40 (13)	11 (10)	51 (12)
	Prefer more	56 (18)	24 (22)	80 (19)
Kept waiting over 30 minutes		n=331	n=115	n=446
	Always	4 (1)	3 (3)	7 (2)
	Often/sometimes	83 (25)	22 (19)	105 (24)
	Occasionally	90 (27)	39 (34)	129 (29)
	Never	154 (47)	51 (44)	205 (46)
Admitted in last 2 years		n=335	n=118	n=453
	Yes	144 (43)	52 (44)	196 (43)
Length of contact with OPD		n=339	n=117	n=456
	< 1 month	30 (9)	9 (8)	39 (9)
	1-2 years	146 (43)	60 (51)	206 (45)
	2-5 years	68 (20)	29 (25)	97 (21)
	Over 5 years	95 (28)	19 (16)	114 (25)

Ninety-seven percent of respondents completed the two questions regarding satisfaction with treatment and service. High levels of satisfaction were reported by both attenders and non-attenders with no significant statistical difference between the two groups: 92% (304/329) of attenders were satisfied or very satisfied with their treatment compared to 90% (104/115) of non-attenders ($\chi^2=1.48$, df 1, $p=0.69$); 97% (320/329) of attenders were satisfied or very satisfied with the service they received from the outpatient department compared to 94% (108/115) of non-attenders ($\chi^2=2.42$, df 1, $p=0.49$). These results are presented in Table 4.3.

Table 4.3 Satisfaction of attenders and non-attenders at follow-up appointments

		Attenders n = 340 (%)	Non- attenders n = 118 (%)	Total n = 458 (%)
Treatment satisfaction		n = 329	n = 115	n = 444
	Very satisfied	113 (34)	33 (29)	146 (33)
	Satisfied	191 (58)	71 (62)	262 (59)
	Dissatisfied	19 (6)	8 (7)	27 (6)
	Very dissatisfied	6 (2)	3 (3)	9 (2)
Service satisfaction		n = 333	n = 115	n = 448
	Very satisfied	139 (42)	42 (36)	181 (40)
	Satisfied	181 (54)	66 (56)	247 (55)
	Dissatisfied	9 (3)	6 (5)	15 (3)
	Very dissatisfied	4 (1)	1 (1)	5 (1)

A higher proportion of non-attenders chose to add their own comments at the end of the questionnaire compared to attenders (30/118 [25%] vs 58/340 [17%], $\chi^2 = 3.95$, df 1, $p=0.047$). From these comments, the most frequently raised criticism was that junior medical staff changed every six months leading to a sense of discontinuity in treatment. This issue was also specifically examined in our questionnaire and 59% of attenders and 61% of non-attenders were unhappy with this arrangement. Other patients commented on the drab decor and complained that the department was dirty. Others reinforced their opinions about the issues we had raised in the questionnaire regarding waiting times and not feeling that they were being seen for long enough. A few of the attenders felt that they needed a more psychotherapeutic approach from their doctor. Some made practical suggestions to improve the service such as: having a hot drinks machine; having appointments available outside usual working hours; having a smoking area available; having access to financial guidance; and improving the sign-posting to the department.

4.3 Summary of results of Study 1

- High levels of satisfaction with outpatient service and treatment were reported by both attenders and non-attenders at follow-up appointments.
- 60% of follow-up patients were unhappy with discontinuity in their treatment caused by junior doctors changing posts every 6 months.
- 80% of patients would like to see the consultant at some of their appointments.

Chapter 5

Study 2

5 Study 2: A prospective study of psychiatric outpatient non-attenders

5.1 Method

5.1.1 Setting

Study 2 was also carried out from the psychiatric outpatient department of the Royal Free Hospital in London over a seven month period from September 1996 to April 1997.

5.1.2 Subjects

The study was designed to investigate both new patients and follow-up patients. New assessments make up approximately 10% of the total number of appointments. The sampling frame consisted of all patients living within the catchment area of the Royal Free Hospital who had an appointment with a general adult or liaison psychiatrist during the study period. Patients with appointments at specialist psychiatric clinics (old age psychiatry, psychosexual medicine, forensic psychiatry, eating disorders and psychotherapy) were excluded as it was felt that their attending patterns might differ from those booked into the general adult psychiatric clinics. It was decided that the study should focus on the general adult psychiatric outpatient population so that it would be possible to generalise the results to similar settings where such specialist psychiatric clinics might not be available.

Over the study period there were 253 appointments cancelled by patients and 315 cancelled by the hospital. Appointments cancelled by the hospital were not included in the study since they were routinely rescheduled and these patients were therefore subsequently included in the sampling frame. Patients who cancelled their own appointment were also not included since the majority rescheduled. Some of this group may have been actively disengaging from the outpatient clinic, but since they contacted the clinic to give their apologies it did not seem appropriate to interview them about their reasons for non-attendance.

5.1.3 Numbers and statistical power

Patients were defined as belonging to one of four groups: new patient attenders; new patient non-attenders; follow-up attenders; and follow-up non-attenders. The pre-study power calculation was based on the primary hypothesis that concerned differences in admission rates between follow-up attenders and non-attenders. The calculation was therefore as follows: to detect differences between follow-up attenders and non-attenders, assuming a 20% expected frequency of variables of interest but accepting an error of 9% at most, using 2-tailed tests (with 95% confidence that the calculated value from the sample would lie within the true population 95% confidence limits), a sample size of 75 in each group was needed. That is to say, the study needed to recruit at least 75 follow-up attenders and 75 follow-up non-attenders.

In the time between Study 1 and Study 2, the audit department of the Royal Free Hospital was able to provide outpatient activity data for the financial year 1995 to 1996. This showed that the non-attendance rate at general adult psychiatric clinics had been 34% for new referrals, 37% for follow-up patients and 34% overall. It also showed that new assessments made up around 10% of all appointments and that the total number of appointments for the year was approximately 7,500. The audit data was unable to determine how many individual patients this represented. However, the results of Study 1 showed that around half the follow-up patients were seen in the clinic two monthly and would therefore have been given three appointments in six months.

Using this data it was possible to calculate appropriate sampling fractions of each of the four study groups in order to recruit enough subjects to ensure sufficient statistical power to detect differences between attenders and non-attenders.

The number of new patient appointments expected in six months was 375, 125 of which would be missed. Recruitment of new patient non-attenders was maximised by including them all and a one in three sample of new patient attenders was required to give a similar sized group for comparison.

The sampling fractions for follow-up attenders and follow-up non-attenders were calculated similarly. It was expected that over six months there would be 3,375 follow-up appointments scheduled,

representing 1,125 individual patients. It was estimated that 2,250 appointments (representing 750 individual patients) would be kept and 1,125 (representing 375 individual patients) would not. A one in ten sample of follow-up attenders and a one in five sample of follow-up non-attenders were therefore required to recruit exactly 75 patients in each group. However, these calculations did not take into account any non-compliance in the study. Therefore, recruitment was monitored and the sampling fractions were adjusted after three months to ensure adequate numbers of patients were included. The final sampling fractions are reported in Section 5.1.4.

5.1.4 Random selection of subjects

Over the recruitment period, attendance lists for the preceding day's clinics were collected daily and a 3 digit random number between 0 and 999 was generated by computer for each patient on the list. This random number was then used to select different sampling fractions of the four study groups: new patient non-attenders 1:1; new patient attenders 1:3; follow-up non-attenders 1:5; and follow-up attenders 1:10. As stated in Section 5.1.3, recruitment was monitored and the sampling fractions for follow-up patients were increased after three months to ensure adequate numbers in each group. The sampling fractions were increased to: follow-up non-attenders 1:3; and follow-up attenders 1:7.

The allocation of patients to one of the four study groups was made on their status at their first appointment during the recruitment period. For example, a newly referred patient who missed their initial psychiatric assessment was classified as a new patient non-attender. Their attendance at any further appointments during this period did not alter their group allocation since each subject could only be included once. A note was made of all patients randomly selected to ensure that they were not included twice.

5.1.5 Recruitment

Recruitment is a particular problem when investigating those who by definition have defaulted from their first assessment or treatment plan. The study was therefore designed to attempt to interview, face to face, as many of the selected subjects as possible with the intention of minimising non-response bias. Subjects were sent a letter giving them details of the study in which they were asked to contact the researcher if they did not wish to be included. They were contacted again one week later by telephone or post to arrange an appointment for a home interview. If they were not at home at the time of this interview, a letter was left for them at their home asking them to contact the researcher to arrange an alternative interview time. If there was still no response they were "cold called" once i.e. they were visited without an arranged time. At the end of the study period those who had still not been seen were sent a postal questionnaire that they were asked to complete and return in a pre-paid envelope. This questionnaire

collected the same information as the interview with the exception of a mental state assessment. A few patients were interviewed by telephone, in the outpatient department or on the psychiatric ward rather than at home.

5.1.6 Information collected from case notes

The psychiatric notes for those included in the study were located and their contact details noted. Other information taken from the case notes included copies of referral letters (if they were new referrals to the clinic), recent and relevant past clinic letters, past discharge summaries and the number of missed outpatient appointments out of the last six appointments booked. The likely primary diagnosis of each subject was ascertained from the case notes or referral letter (for new patients) and this was coded using the Tenth Revision of the International Classification of Diseases (WHO, 1991).

5.1.7 Information collected from subjects

Data were gathered by way of a semi-structured interview at which sociodemographic details and past psychiatric contacts for all subjects were noted.

In addition, new referrals were asked about the referral process: who had referred them; whether the referrer had clearly explained the reasons for referral; how many times they had seen their general practitioner about the problem leading to referral; whether the general

practitioner had prescribed any medication for the problem; length of time from referral to receiving the appointment; and whether they had told anybody about the referral. Follow-up patients were asked about their current contact with the clinic, which grade of doctor they saw and their past psychiatric history. Non-attenders were asked the reason(s) for non-attendance.

All subjects other than those who completed postal questionnaires were assessed using the Manchester scale (Krawiecka *et al*, 1977) which measures severity of psychiatric disorder. This is an instrument designed for mental health professionals to rate eight major psychiatric symptoms. Each symptom is scored as either absent (scoring zero) or present from a mild to severe degree (scoring one to four) giving a maximum possible score of 32. It is expected that the interviewer will have prior knowledge of the patient's diagnosis and symptoms when unwell (collected from the case notes) so that the items which are likely to be present can be concentrated on. This makes it a quick and simple scale for those with psychiatric training to use.

Level of social disorganisation was assessed using the work and social adjustment scale (Marks, 1986) which consists of four items: work; home management; social leisure activities (such as going out with friends); and private leisure activities (such as reading). The degree of impairment in each area which the individual attributes to their psychiatric problems is rated on a scale from one to eight. The higher the score, the greater the impairment with a maximum score of 32.

Copies of the Manchester Scale and the Marks' Scale are given in Appendices 8.7.1 and 8.7.2.

5.1.8 Information collected from general practitioners

Each subject's general practitioner was interviewed over the telephone and data on the number of partners in the practice were collected. They were asked about their patient's contact with them in the last year, when the patient was last seen, current medication being prescribed and whether they had received communication from the psychiatrist about the patient's clinic appointment. Their opinion as to whether the communication from the psychiatrists was adequate, inadequate or too lengthy was sought. If their patient had not attended their appointment they were asked whether they felt that a further appointment should be sent. They were then given four options with regard to further action following on from the missed appointment and asked which one they felt to be most appropriate: no further action from psychiatric services; further outpatient appointment only; patient to receive a home visit from member of community mental health; general practitioner to visit patient.

5.1.9 Quality of communication between psychiatrists and general practitioners

A scoring system for the quality of the general practitioners' referral letters and the letters that the psychiatrist wrote to the general practitioner was devised. It was based on the two previous studies

described in the literature review which examined the information that psychiatrists feel to be most useful in referral letters and the information that general practitioners feel to be most relevant from psychiatrists regarding new patients (Williams and Wallace, 1974 ; Pullen and Yellowlees, 1985).

The general practitioners' referral letters were scored out of seven according to whether or not they included the following: reason for referral; medication; past psychiatric history; current symptoms; duration of symptoms; relevant family history; and legibility. All letters were assessed independently by a second researcher and where there was disagreement a consensus score was reached.

The letters that were written by the psychiatrist to the general practitioner after each subject's clinic appointment were scored similarly according to the number of items included. Each item included gained a score of one. Where no letter was written a score of zero was given. An assessment of whether the psychiatrists' letters contained adequate information was also made according to the number of "essential" items included. These items were adapted from the rating scales used in the previous studies by Williams and Wallace (1974) and Pullen and Yellowlees (1985). Non-attenders' letters had a maximum score of two which were awarded if they contained information about: i) non-attendance and ii) follow-up arrangements. Both items had to be included for the letter to be assessed as adequate. For new patient attenders, letters had to score

four to be rated as adequate and had to include the following: i) a summary of the problem; ii) diagnosis; iii) treatment and iv) follow-up arrangements. Follow-up attenders' letters had to score at least three to be rated as adequate and had to include: i) current mental state; ii) medication; and iii) follow-up arrangements. Obviously, some letters contained more detailed information, but these "essential" items were chosen as they were felt to be the most important facts to be communicated to the general practitioner.

5.1.10 Follow-up data collection

Six and twelve months after subjects had been recruited into the study their case files were examined to see if they were still attending the outpatient clinic, whether they had dropped out of treatment or had been discharged from the clinic. Any admission to the psychiatric unit was also noted. These follow-up points were chosen to allow enough time for any changes in the patients' symptoms, social circumstances and subsequent outcomes to become clear and in order to compare the results of this study with those of the other outcome studies of psychiatric outpatient non-attendance.

5.1.11 Impact of the study on subsequent attendance

A number of studies described in the literature review include interventions such as telephone and written appointment reminders as methods used to increase outpatient attendance. It was felt that the fairly tenacious efforts made to interview patients in this study might

alter their subsequent attending behaviours at the outpatient clinic. A control group of follow-up non-attenders were therefore randomly selected from the original sampling frame in order to compare the subsequent clinic attendance of patients included in the study with those who were not. Controls had not been recruited into the study during the randomisation procedure and had therefore not received any information about the study or any interventions that might have encouraged their attendance. Only follow-up patients were included in this part of the study, since many new patients who had not attended the clinic were not offered a further appointment.

A case:control ratio of 1:2 was used which was not based on any pre-study power calculation since the decision to investigate subsequent attendance of patients included and not included in the study was made after recruitment into the study had begun. The ratio chosen allowed maximum data on cases and controls to be gathered within the time and resource constraints of the study.

Data were collected from the case notes of the follow-up non-attender cases and controls detailing whether they attended the next appointment after inclusion (or not) into the study and the number of appointments they attended over the subsequent six months. Any admissions to the inpatient unit were noted and the mode of admission was recorded. This included whether the admission was prearranged, emergency, voluntary or involuntary under the Mental Health Act, (1983) and whether the patient had self presented, been referred by

their general practitioner, brought to the hospital by the police or assessed in the community.

5.1.12 Data analysis

Data collected were entered into the statistics package SPSS 7.0 and statistical analysis was performed to examine differences between attenders and non-attenders, new patients and follow-ups. Follow-up cases were also compared with the control groups of follow-up attenders and non-attenders as described above and differences in subsequent attendance at the outpatient clinic and admission rates were examined. This second data set was analysed on an “intention to interview” basis, regardless of whether the follow-up cases had been interviewed or completed a postal questionnaire. This was because all patients recruited into the study could be regarded as participants in a randomised controlled trial, regardless of whether they received the “intervention” of the research interview or not.

The Chi-squared statistic and odds ratios with 95% confidence intervals were used to examine differences in proportions and the Mann-Whitney U-test and Student’s t-test were used to examine differences in continuous measures. The level of α used as a test of statistical significance was 0.05. A logistic regression model was constructed to investigate possible predictors of outpatient non-attendance and admission. Variables used were those where data

was available for the whole study population, including non-responders (age, gender and diagnosis).

Chapter 6

Results of Study 2

6 Results of Study 2

6.1 Recruitment

During the study period 1678 follow-up appointments were attended and 982 were not (a non-attendance rate for follow-up patients of 37%). Of the new patient assessment appointments, 105 were attended and 60 were missed (a non-attendance rate for new referrals of 36%). The fact that the non-attendance rates for new patients and follow-up patients during the study period were similar to those for the whole financial year (see Section 5.1.3) provides some confidence in considering the study population to be representative of the outpatient population as a whole.

The numbers of patients recruited into each study group were as follows:

All 59 new patient non-attenders (randomisation ratio 1:1)

41 new-patient attenders (randomisation ratio 1:3)

129 follow-up non-attenders (randomisation ratio 1:5 then 1:3)

136 follow-up attenders (randomisation ratio 1:10 then 1:7)

The total number of subjects recruited into the study was therefore 365.

Data on follow-up patients' previous attendance showed that non-attenders on the day of inclusion in the study had attended an average of 2.5 (SD 1.96) of the previous six appointments and attenders had

maintained an average of 5.3 (SD 1.31). This provides support for the use of attending behaviour at a single appointment to define the attender and non-attender groups as this reflected their usual attendance behaviour.

A number of subjects were not located because the communication sent to them about the study was returned by the Post Office as "unknown at this address" or, on visiting the address to interview the subject the property was obviously uninhabited or had been boarded up. If no alternative address was recorded at other sources (such as in the general practitioner's notes or with social services) then these subjects were defined as untraceable and could not be included in the study. This was the case for 12 (20%) new patient non-attenders, 15 (12%) follow-up patient non-attenders and two (1%) follow-up patient attenders.

The response rates (the number of subjects interviewed) for each group are as follows excluding these "untraceables":

New patient non-attenders = 29/47 (62%)

New patient attenders = 28/41 (68%)

Follow-up non-attenders = 76/114 (67%)

Follow-up attenders = 91/135 (67%)

The total response rate was therefore 224/337(66%).

If there was any suggestion from the case file that a home visit would be unsafe, the case was discussed with the patient's psychiatrist and an alternative arrangement was made. Three subjects (two follow-up non-attenders and one follow-up attender) were considered too dangerous to visit and did not respond to requests for an alternative interview arrangement. They were included in the figures for the non-responders and refusals. A breakdown of the response rates is shown in Table 6.1.

Table 6.1 Response rates

	New patient non-attenders	New patient attenders	Follow-up non-attenders	Follow-up attenders	Total
Population randomly selected	59	41	129	136	365
Total untraceable	12	0	15	1	28
Total eligible	47	41	114	135	337
Refused or no response	18	13	38	44	113
Interviewed	29	28	76	91	224
Response rate of those traceable %	62	68	67	67	66
Response rate overall %	49	68	59	67	61

6.2 Place of interview

The total number of interviews carried out was 224. Of these, 173 (77%) patients were seen at home, 21 (10%) were interviewed over the telephone, 12 (5%) were seen in the outpatient department, 15 (7%) completed and returned postal questionnaires and three (1%) were seen on the psychiatric ward. The places in which patients from each study group were interviewed are shown in Table 6.2.

Table 6.2 Place of interview

Place of interview	New patient non-attenders n = 29 (%)	New patient attenders n = 28 (%)	Follow-up non-attenders n = 76 (%)	Follow-up attenders n = 91 (%)
Home	21 (72)	22 (79)	58 (76)	72 (79)
Telephone	6 (21)	4 (15)	5 (7)	6 (7)
Outpatient clinic	0	1 (3)	6 (8)	5 (6)
Postal	2 (7)	1 (3)	5 (7)	7 (8)
Ward	0	0	2 (3)	1 (1)

6.3 Demographics

Of the 224 patients interviewed, 173 (78%) described their ethnic group as white European and 60% were classified as being in socioeconomic class 2 or 3. The mean age was 39 years (SD=12.2). These results are presented in Table 6.3

New patients were younger than follow-up patients (mean age 35 [SD=11.2] vs 40 [SD=12.2], $t=0.004$, 95% CI of the difference in proportions 1.71 to 8.94). Non-attenders (both new and follow-up) were younger than attenders (mean age 37 [SD=11.6] vs 41 [SD=12.4], $t=0.031$, 95%CI of the difference in proportions 0.33 to 6.69).

Non-responders (including subjects who refused consent, those who were untraceable and those who made no response) were younger than those who took part in the study (mean age 36 [sd=12] vs 39 [sd=12], $t=0.005$, 95% CI of the difference in proportions 1.09 to 6.23).

6.4 Gender

There were 60 (57%) men amongst the non-attenders compared to 53 (45%) amongst the attenders ($\chi^2=3.5$, $df=1$, $p=0.06$). These results are shown in Table 6.3. There was no gender difference between new patients and follow-up patients nor between subjects interviewed and non-responders.

6.5 Employment

Eighty-three percent of the study population were unemployed.

Figures obtained from Camden Social Services for the financial year 1995-1996 showed that 12% of the general population in north Camden (the catchment area of the Royal Free Hospital) were unemployed. New patients were as likely to be unemployed as follow-up patients (44 [77%] vs 141 [84%], $\chi^2=1.6$, $df=1$, $p=0.213$) and non-attenders were as likely to be unemployed as attenders (88 [84%] vs 97 [82%], $\chi^2=0.2$, $df=1$, $p=0.651$). See Table 6.3.

6.6 Living situation and social support

Forty-eight percent of the study population lived alone, 14% percent with parents or siblings and 17% lived with a partner and/or children (Table 6.3). Using Fischer's Exact Test, follow-up non-attenders were more likely than follow-up attenders to be living in supported accommodation such as group homes or staffed hostels but the numbers of such patients were very small (8 [11%] vs 2 [2%], $\chi^2=3.7$, $df=1$, $p=0.044$).

New patients were more likely than follow-up patients to report that they had nobody in their life who they considered to be of support to them (12 [21%] vs 17 [10%], $\chi^2=4.5$, $df=1$, $p=0.035$). However, 24 [14%] follow-up patients had only professionals for support compared to only one [2%] new patient ($\chi^2=5.6$, $df=1$, $p=0.018$).

Table 6.3 Demographic characteristics

		New patient non-attenders n=29 (%)	New patient attenders n=28 (%)	Follow-up non-attenders n=76 (%)	Follow-up attenders n=91 (%)
Mean age (years)		33 (sd=10.6)	38 (sd=11.5)	39 (sd=11.7)	42 (sd=12.6)
Males		14 (48)	11 (39)	46 (61)	42 (46)
Ethnic group	White European	22 (76)	24 (86)	58 (76)	70 (77)
	White non-European	3 (10)	0	0	3 (3)
	Black-African	2 (7)	2 (7)	10 (13)	8 (9)
	Black-Caribbean	0	1 (3)	1 (1)	2 (2)
	Indian	0	1 (3)	2 (3)	3 (3)
	Pakistani	1 (3)	0	1 (1)	1 (1)
	Chinese	0	0	1 (1)	2 (2)
	Other	1 (3)	0	3 (4)	2 (2)
SEC	1	0	0	1 (1)	5 (6)
	2	8 (28)	7 (25)	13 (17)	23 (25)
	3	12 (41)	12 (43)	30 (40)	30 (33)
	4	3 (10)	4 (14)	14 (18)	13 (14)
	5	6 (21)	5 (18)	18 (24)	20 (22)
Employment	Unemployed	21 (72)	23 (82)	67 (88)	74 (81)
Living with	Alone	13 (45)	16 (57)	35 (46)	43 (47)
	Parents/siblings	2 (7)	4 (14)	10 (13)	16 (18)
	Partner +/- children	6 (21)	4 (14)	12 (16)	16 (18)
	Children only	3 (10)	1 (3)	4 (5)	11 (12)
	Flat-share	4 (14)	3 (11)	7 (9)	3 (3)
	Supported accom.	1 (3)	0	8 (11)	2 (2)
Social support	Nil	5 (17)	7 (25)	5 (7)	12 (13)
	Family	11 (38)	14 (50)	27 (36)	27 (29)
	Friends	7 (24)	3 (11)	13 (17)	16 (18)
	Family & friends	6 (21)	3 (11)	18 (24)	25 (28)
	Professionals only	0	1 (3)	13 (17)	11 (12)

6.7 Diagnosis

There were marked differences between new patients and follow-up patients in terms of their mental disorder. New patients predominantly had primary diagnoses of depression and anxiety, whereas follow-up patients were more likely to have a diagnosis of schizophrenia or bipolar affective disorder (Table 6.4). These differences were also apparent when comparing the diagnoses of untraceable patients. The likely diagnoses of the 12 untraceable new patients were as follows: one appeared to have a panic disorder; six a mild or moderate depressive episode; two a severe depression, one with psychotic features; and three had either a personality disorder, substance abuse problem or no psychiatric illness at all.

Two of the 15 untraceable follow-up patients who missed their appointments had a diagnosis of schizophrenia; four a severe depressive episode; two a psychotic depression; three had a diagnosis of personality disorder; two had substance misuse problems; and two had no clear diagnosis.

The only significant difference in diagnosis between all non-responders (including untraceable patients, those who did not respond to requests for an interview and those who refused consent) and those interviewed was a lower prevalence of bipolar affective disorder among the follow-up non-responders than among those in the follow-up group who were interviewed (5 [5%] vs 30 [18%], $\chi^2=8.91$, df 1, $p=0.003$).

There were no statistically significant differences in diagnostic profile between new patient attenders and non-attenders and follow-up attenders and non-attenders.

Table 6.4 Diagnoses of new patients and follow-up patients

Diagnosis	New patients n=57 (%)	Follow-up patients n=167 (%)	χ^2	p value
Depression	30 (53)	43 (26)	13.3	<0.001
Anxiety	12 (21)	16 (10)	21.6	<0.001
Bipolar affective	3 (5)	30 (18)	4.7	0.031
Schizophrenia/ schizoaffective	2 (4)	63 (38)	8.8	0.003
Substance abuse	4 (7)	4 (2)	5.9	0.015
Personality disorder	3 (5)	11 (7)	0.2	0.700
No psychiatric illness	3 (5)	0	11.8	<0.001

6.8 Mental state and social functioning

Table 6.5 presents details of participants' mental health as measured by the Manchester Scale and Table 6.6 social functioning as measured by the Social Adjustment Scale. Scores are presented in quartiles as the data did not have a normal distribution. For this reason, Mann-Whitney U tests were performed. Follow-up patients were more psychiatrically ill than new patients and follow-up non-attenders scored significantly higher for both mental disorder and social impairment than follow-up attenders.

Table 6.5 Severity of mental disorder

Study group	Manchester psychiatric symptom scale score					Mann Whitney test
	0	1-8	9-16	17-24	25-32	
All new patients n=54 (%)	7 (13)	47 (87)	0	0	0	p=0.046
All follow-up patients n=155 (%)	29 (19)	97 (63)	25 (16)	4 (2)	0	
New patient non-attenders n=27 (%)	3 (11)	24 (89)	0	0	0	p=0.965
New patient attenders n=27 (%)	4 (15)	23 (85)	0	0	0	
Follow-up non-attenders n=71 (%)	10 (14)	43 (61)	17 (24)	1 (1)	0	p=0.031
Follow-up attenders n=84 (%)	19 (23)	54 (64)	8 (10)	3 (4)	0	

Table 6.6 Social functioning

Study group	Marks' social adjustment scale score					Mann Whitney test
	0	1-8	9-16	17-24	25-32	
All new patients n=57 (%)	9 (16)	20 (35)	12 (21)	12 (21)	4 (7)	p=0.366
All follow-up patients n=167 (%)	23 (14)	41 (25)	51 (31)	36 (22)	16 (10)	
New patient non-attenders n=29 (%)	6 (21)	10 (34)	7 (24)	3 (10)	3 (10)	p=0.554
New patient attenders n=28 (%)	3 (11)	10 (36)	5 (18)	9 (32)	1 (4)	
Follow-up non-attenders n=76 (%)	8 (11)	14 (18)	26 (34)	18 (24)	10 (13)	p=0.018
Follow-up attenders n=91 (%)	15 (16)	27 (30)	25 (27)	18 (20)	6 (7)	

6.9 New patients

Seventy-three percent of new patients had been referred to see the psychiatrist by their general practitioner and the remainder by hospital doctors. No referrals were reported to have been prompted by the patient or their family ("self" referrals) but this result could be misleading since patients were not specifically asked about this in the interview. There was no statistically significant difference in the numbers of attenders and non-attenders who had agreed to the referral (25 [89%] versus 20 [69%], $\chi^2=2.4$, $df=1$, $p=0.120$).

Most attenders (93%) and non-attenders (86%) considered that the reason for referral had been clearly explained to them. Attenders were more likely than non-attenders to have been prescribed psychotropic medication by their general practitioner prior to referral (20 [71%] compared to 11 [38%], $\chi^2=6.4$, $df=1$, $p=0.011$). There were no statistically significant differences between attenders and non-attenders in whether they had told somebody about the referral (22 [76%] vs 20 [71%], $\chi^2=0.7$, $df=1$, $p=0.410$). They had a similar rate of previous contact with psychiatric services (19 [68%] attenders vs 14 [48%] non-attenders, $\chi^2=2.2$, $df=1$, $p=0.134$).

The majority (73%) of new patients had been offered an appointment to see the psychiatrist within four weeks of referral. Non-attenders had waited no longer for their appointment than attenders. Both attenders and non-attenders had similar expectations of the help they were likely

to receive from the psychiatrist, with 16 (55%) non-attenders and 13 (46%) attenders expecting to receive some form of counselling or “talking treatment”. Only one (3%) non-attender and three (11%) attenders expected to be treated with medication only.

The scores for assessment of referral letters did not have a normal distribution and these data were therefore analysed using the Mann-Whitney U test. The referral letters from general practitioners for new patients were of equal quality (non-attenders (n=29), mean rank 27.8, attenders (n=28), mean rank 30.3; Mann-Whitney U test , p=0.560).

6.10 Follow-up patients

More non-attenders than attenders (38 [50%] versus 31 [66%], $\chi^2=4.3$, p=0.037) had a previous history of admission under the Mental Health Act, 1983. There was no significant difference between attenders and non-attenders in the duration of their outpatient care (42% of non-attenders and 36% of attenders had been clinic patients for over 5 years) or the frequency of their appointments, with 92% of both attenders and non-attenders stating that they were offered an appointment every one to three months. The majority of follow-up patients were usually seen in the clinic by the junior doctor (49 [64%] follow-up non-attenders and 47 [52%] follow-up attenders, $\chi^2=2.8$, df=1, p=0.095).

6.11 Non-attenders

New patient non-attenders and follow-up non-attenders gave a range of different reasons for missing their appointment (Table 6.7). Each patient gave only one reason despite being given the option of stating more than one reason if appropriate. Fourteen percent of both new patients and follow-up patients who missed their appointment reported that they did not attend due to symptoms of their psychiatric problem, stating, for example, that they felt too paranoid to leave the house or too depressed to get to the hospital. Over one quarter (27%) of follow-up patients had forgotten about their appointment compared to only 3 (11%) new patients. Clerical error was also a common reason for missing appointment for both new and follow-up patients with 12% of non-attenders stating that they missed their appointment due to errors such as receiving the appointment after the arranged time, or the appointment never reaching their home address. Five (17%) new patients did not attend as they (17%) were unhappy about the referral and three (11%) were afraid of admission. No follow-up patients stated that they were afraid of admission, perhaps because, by definition, they were more familiar with psychiatric services and therefore less likely to be afraid of admission.

Other reasons that were more commonly given by follow-up patients than new patients included: "loss of appointment card"; "no need to attend as not unwell"; "couldn't be bothered" and "overslept". Along with "forgetting the appointment", these differences in reasons given by

new and follow-up patients may reflect their different diagnostic profiles, with follow-up patients having more serious mental illnesses, reduced organisational skills and a lack of insight about the need for treatment.

Table 6.7 Reasons given for missing appointments

Reason for missing appointment	New patient non-attenders n = 29 (%)	Follow-up non-attenders n = 74 (%)
Psychiatric illness	4 (14)	10 (14)
Clerical error	4 (14)	8 (11)
Forgot	3 (11)	20 (27)
Felt better	1 (3)	1 (1)
Afraid of admission	3 (11)	0
Unhappy with referral	5 (17)	0
Physical illness	1 (3)	1 (1)
Lost appointment card	1 (3)	3 (4)
Other commitment	3 (11)	6 (8)
Travel problem	0	3 (4)
Unhappy with treatment	1 (3)	6 (8)
No need to attend as no problem	0	5 (7)
Poor weather	1 (3)	0
Couldn't be bothered	1 (3)	5 (7)
Overslept	1 (3)	6 (8)

6.12 General practitioners' response rate

Telephone interviews were successfully carried out with the general practitioners of 210 of the study population (94%). Of the remaining 14 patients in the study, two general practitioners refused to be interviewed, one patient refused to give permission for their general practitioner to be contacted and the other 11 were not registered with a general practitioner. In total, 70 general practitioners were interviewed and the maximum number of patients in the study registered with the same general practitioner was six.

6.13 Practice data

Patients in the study were registered at 32 different general practices in north Camden. Ten of these were single-handed practices, nine had two partners, five had three partners, three had four partners and five had five or more partners. There were no statistically significant differences between attenders and non-attenders in the size of practice with which they were registered (Table 6.8).

Table 6.8 Characteristics of general practices

	New patient attenders n=27 (%)	New patient non-attenders n=27 (%)	Follow-up attenders n=86 (%)	Follow-up non-attenders n=70 (%)
Single handed	5 (18)	6 (22)	21 (24)	12 (17)
Group practice	22 (81)	21 (78)	65 (75)	58 (83)
χ^2	0.1		1.4	
p	0.786		0.239	

Subjects had visited their general practitioners an average of four times during the preceding 12 months (SD=1.43) and there was no difference between attenders and non-attenders, new patients or follow-up patients in the number of consultations or the time since they were last seen by their general practitioner.

6.14 Prescribing practices of general practitioners

General practitioners were prescribing no medication for 14 (9%) follow-up patients compared to 18 (33%) new patients ($\chi^2=18.4$, $df=1$, $p=0.001$). New patients were much more likely to be prescribed an antidepressant alone than follow-up patients (17 [31%] versus 14 [9%], $\chi^2=16.2$, $df=1$, $p=0.001$) whereas follow-up patients were more likely to be prescribed a combination of psychotropic drugs (86 [55%] versus 12 [22%], $\chi^2=17.5$, $df=1$, $p=0.001$). There were no statistically significant differences in the classes of medication prescribed for non-attenders and attenders but non-attenders were more likely than attenders to be prescribed no medication at all (21[22%] vs 11[10%], $\chi^2=5.7$, $df=1$, $p=0.017$). See Table 6.9.

Table 6.9 Medication prescribed by general practitioners

Type of Medication	New patient non-attenders n = 27 (%)	New patient attenders n = 27 (%)	Follow-up non-attenders n = 70 (%)	Follow-up attenders n = 86 (%)
Nil	12 (44)	6 (22)	9 (13)	5 (6)
Antidepressant	5 (19)	12 (44)	6 (9)	8 (9)
Antipsychotic	1 (4)	1 (4)	11 (16)	13 (15)
Mood stabiliser	0	0	1 (1)	7 (8)
Anxiolytic	0	1 (4)	1 (1)	2 (2)
Combination of psychotropic	7 (26)	5 (19)	38 (54)	48 (56)
Non-psychotropic	2 (7)	2 (7)	4 (6)	3 (4)

6.15 Psychiatrists' communication with general practitioners

In 94% of cases the general practitioners reported that the communication they received from the psychiatrists regarding their patient's outpatient appointment was by letter. They were more likely to state that they had received communication from the psychiatrist regarding new patients than follow-up patients (43 [80%] vs 89 [57%], $\chi^2=8.8$, $df=1$, $p=0.003$). Despite this discrepancy, in 77% of cases the general practitioners interviewed felt that the communication they received from the psychiatrist was generally adequate. In five (2%) cases they felt it was overinclusive. There was no statistically significant difference in the degree of satisfaction with communication reported by general practitioners working single-handedly and those in group practices (34 [77%] vs 127 [77%], $\chi^2=0$, $df=1$, $p=1.0$).

The researcher's assessments of psychiatrists' letters substantiated the general practitioners' reports. Psychiatrists wrote letters regarding 50 (87%) new patients and 107 (64%) follow-up patients.

Psychiatrists' letters regarding new patients were more likely to be rated as adequate than those regarding follow-up patients (46 [81%] vs 101 [60%], OR = 2.73, 95%CI 1.26 to 6.05). Psychiatrists were more likely to write to the general practitioner if a new patient missed their appointment than if a follow-up patient did not attend (24 [83%] versus 43 [57%], OR = 3.68, 95% CI 1.16 to 12.39). See Table 6.10.

Table 6.10 Adequacy of psychiatrists' letters

	New patient non-attenders n = 29 (%)	New patient attenders n = 28 (%)	Follow-up non-attenders n = 76 (%)	Follow-up attenders n = 91 (%)
Adequate score	24 (83)	22 (79)	43 (57)	58 (64)
Inadequate score	0	4 (14)	0	6 (6)
No letter written	5 (17)	2 (7)	33 (43)	27 (30)

6.16 General practitioners' opinions about appropriate action following non-attendance

In response to the question “do you think that your patient should be sent another appointment?” the general practitioners replied “Yes” in 59 (84%) cases of follow-up non-attendance and 15 (56%) cases of new patient non-attendance ($\chi^2=8.9$, $df=1$, $p=0.003$). The views of the four options for the most appropriate course of action for their patient are presented in Table 6.11. General practitioners were more likely to feel that a repeat appointment was the appropriate course of action for a follow-up patient who had missed their appointment than a new patient non-attender. They reported that no further action on the part of the psychiatric services was more likely to be appropriate for new patient non-attenders than follow-up patient non-attenders. In only four (5%) cases of non-attendance did a general practitioner think they should contact the patient themselves.

Table 6.11 General practitioners' opinions of most appropriate course of action following non-attendance

	New patient non- attenders n = 27 (%)	Follow-up non- attenders n = 70 (%)	Difference in proportion (95% CI)	χ^2 (*Yate's correction)	df	p value
No action	11 (41)	6 (9)	32.2 (12.5 to 51.8)	14.0	1	0.001
Another appointment	12 (44)	47 (67)	-22.7 (-44.4 to -1.0)	4.2	1	0.040
CPN visit	2 (7)	15 (21)	-14.0 (-27.8 to 0.2)	1.8*	1	0.184
GP to contact patient	2 (7)	2 (3)	-4.4 (-22.6 to 13.9)	0.14*	1	0.713

6.17 Six and twelve month follow-up

In the first six months following their recruitment into the study 24 (19%) follow-up non-attenders and 23 (17%) follow-up attenders were admitted to the psychiatric inpatient service ($\chi^2=0.13$, $df=1$, $p=0.718$). However, by 12 months, the number of admissions among follow-up non-attenders had increased by 18 and was much higher than the number for follow-up attenders (42 [33%] vs 27 [20%], $\chi^2=5.5$, $df=1$, $p=0.018$).

Ninety-two (68%) follow-up attenders were still attending the clinic after six months compared with 47 (36%) follow-up non-attenders ($\chi^2 = 25.9$, $df=1$, $p=0.001$) and by twelve months these figures had barely altered (97 [71%] vs 46 [36%]).

At the six month follow-up point, two new patient non-attenders and one attender had been admitted to the inpatient unit. By twelve months only four new patients had had an admission, two attenders and two non-attenders.

At six months 18 (44%) new patient attenders were still in contact with the clinic compared to 4 (7%) new patient non-attenders ($\chi^2 = 17.3$, $df=1$, $p=0.001$). This difference persisted at twelve months, although four non-attenders had started to attend the clinic again (19 [46%] attenders vs 8 [14%] non-attenders: $\chi^2 = 13.2$, $df=1$, $p=0.001$).

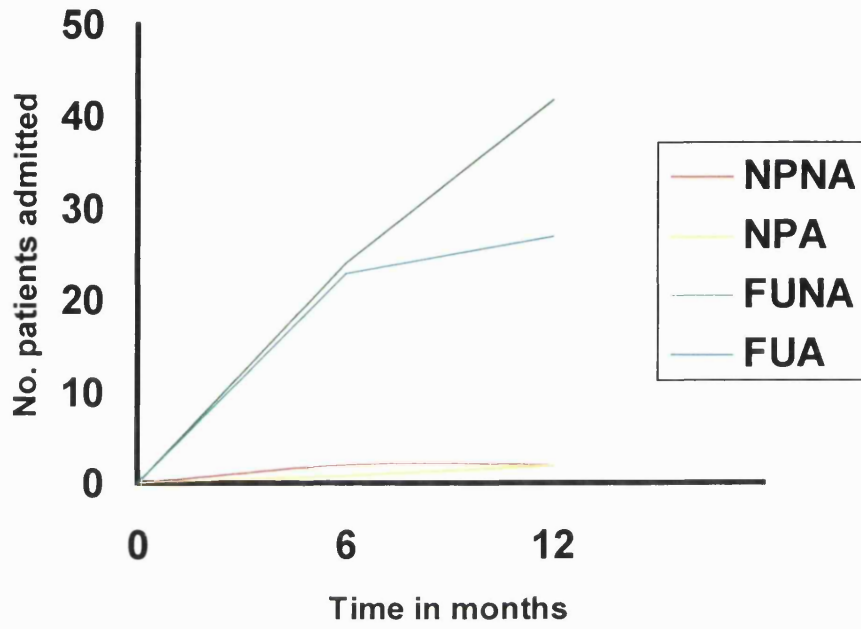
Outcome data for the four study groups are shown in Table 6.12.

The number of patients in each of the four study groups who were admitted to the inpatient unit at the six and twelve month follow-up points are also presented in Graph 6.1.

Table 6.12 Six and twelve month outcome

Study group	Outcome period in months	Attending no admission	Attending Admission	Not attending no admission	Not attending admission	Discharged no admission	Discharged admission	Died
New patient non-attenders n=59 (%)	6	4 (7)	0	9 (15)	1 (2)	44 (75)	1 (2)	0
	12	8 (14)	0	3 (5)	1 (2)	46 (78)	1 (2)	0
New patient attenders n=41 (%)	6	17 (42)	1 (2)	1 (2)	0	22 (54)	0	0
	12	17 (42)	2 (5)	0	0	22 (54)	0	0
Follow-up non-attenders n=129 (%)	6	41 (32)	6 (5)	19 (15)	17 (13)	44 (34)	1 (1)	1 (1)
	12	36 (28)	10 (8)	3 (2)	29 (23)	46 (36)	3 (2)	2 (2)
Follow-up attenders n=136 (%)	6	69 (51)	23 (17)	4 (3)	0	39 (29)	0	1 (1)
	12	71 (52)	26 (19)	2 (2)	1 (1)	35 (26)	0	1 (1)

Graph 6.1 Number of admissions over time



6.18 Impact of the study

One hundred and fifty-two follow-up non-attenders were selected into the control group and compared with the 129 follow-up non-attenders included in the original study. Case note data on subsequent outpatient attendance and admissions to the inpatient unit were available for all subjects.

6.18.1 Attendance at the outpatient clinic

There was no statistically significant difference between follow-up non-attender cases and controls regarding their attendance at their next appointment with 51 (40%) cases and 62 (41%) controls attending ($\chi^2=0.7$, $df=1$, $p=0.706$).

In the six months following their missed appointment 48 (37%) cases and 54 (36%) controls had attended at least 50% of their appointments ($\chi^2=0.7$, $df=1$, $p=0.719$). There was no statistically significant difference in the mean number of appointments they attended (cases' mean attendances: 1.39 [SD 1.4], controls' mean attendances: 1.35 [SD 1.4], Student's t-test for difference in means, $t=0.86$, $p=0.819$)

6.18.2 Admission to the hospital

At the six month follow-up point, 24 (20%) follow-up non-attender cases and 11 (7%) controls had had an admission to the psychiatric unit ($\chi^2=8.3$, $df=1$, $p=0.004$). Of the admissions amongst cases, one

was a prearranged voluntary admission for the patient to be commenced on clozapine treatment, 16 were emergency voluntary admissions (10 self referrals to casualty, three referrals from the community psychiatric nurse, one from the general practitioner, one from the police and one from the day hospital) and there were seven emergency admissions under the Mental Health Act, 1983. Four of these were Section 3 assessments carried out at the patient's home and one was carried out in the police station. In casualty there was one Section 136 converted to Section 2 and one further admission under Section 2.

Amongst the controls there was one prearranged admission for alcohol detoxification and nine emergency voluntary admissions (five self referrals to casualty, one referral from the general practitioner, two referrals from the outpatient clinic, and one patient was brought to the hospital by the police). There was one emergency admission under Section 2 of the Mental Health Act, 1983 following a community assessment.

6.18.3 Admission of follow-up attenders

The higher rate of admission amongst follow-up non-attender cases detailed in Section 6.18.2 required further investigation and it was decided to select a control group of follow-up attenders who had not been included in the original study for comparison with those who had. As for the follow-up non-attenders, a 2:1 case:control ratio was used to

randomly select 148 controls who were compared with the 136 follow-up attender cases. At the six month follow-up point, 23 (17%) follow-up attender cases and 7 (5%) controls had had an admission to hospital ($\chi^2 = 11.1$, $df=1$, $p=0.001$).

6.18.4 Predictors of admission and attendance

The logistic regression model revealed that attender/non-attender status at recruitment predicted admission at 12 months (OR 1.87, [95% CI 1.03 to 3.38], $p=0.039$). Age, gender and diagnosis were not found to predict admission or attendance status.

6.19 Summary of the results of Study 2

- Non-attenders were younger than attenders and non-responders were younger than subjects who took part in the study.
- There was a very high rate of unemployment in the study population and around half of all subjects lived alone.
- New patients were likely to have diagnoses of depression or anxiety whereas follow-up patients were likely to have diagnoses such as schizophrenia or bipolar affective disorder.
- 60% of follow-up patients were seen by the junior doctor.
- Follow-up patients who missed their appointments had more severe symptoms and poorer social functioning than those who attended. They were also more likely to have a previous history of involuntary admission.
- The most common reasons patients gave for non-attendance were: feeling psychiatrically unwell; clerical error; and forgetting about the appointment.
- General practitioner referral letters were of equal quality for attenders and non-attenders.
- Psychiatrists were less likely to write to the general practitioner about a follow-up patient than a new patient and least likely to write about a follow-up non-attendance.
- For follow-up patients, a single missed appointment predicted drop-out from the clinic and admission to the inpatient unit by 12 months.
- Being included in the study did not improve subsequent attendance but increased the chance of admission.

Chapter 7

Discussion

7 Discussion

7.1 Overview of the discussion

- Summary of the main findings from Studies 1 and 2.
- The limitations of the studies are presented.
- The results from Studies 1 and 2 regarding factors associated with appointment keeping are compared with the findings from previous research.
- The implications of the reasons given by patients for missing appointments and the findings regarding mental state and social functioning are discussed.
- Appropriate liaison between psychiatrists and general practitioners and the potential impact of recent directives from the General Medical Services Council to general practitioners are considered.
- The impact of the study on subsequent admission is discussed with regard to the exposure of hidden psychiatric morbidity in the community.
- Finally, the future of the outpatient clinic is considered.

7.2 Main findings

The most striking findings of Study 2 were that follow-up patients who missed appointments were more unwell, more socially impaired and had a greater chance of subsequent admission than follow-up patients who kept their appointments. The findings from Study 2 also supported previous research which has shown that patients who remain under the care of the psychiatric outpatient clinic (follow-up patients) have more severe mental health problems than patients newly referred for psychiatric assessment (new patients). The six and twelve month outcome data from Study 2 showed that a single missed appointment predicted drop-out from the clinic for both new and follow-up patients, but that this appeared to have more serious consequences for the follow-up population.

In Study 1, over 90% of patients who responded to the study reported high levels of satisfaction with their treatment, whether they kept their appointment or not. This suggested that non-attenders were not “voting with their feet”. However, the limitations of satisfaction surveys in general (see Section 2.13) and the specific limitations of Study 1 (see Section 7.3) mean that these findings need to be interpreted with caution.

The results of Study 2 showed that there appeared to be adequate communication from general practitioners to patients and psychiatrists at the point of referral but there were important deficiencies in

communication from psychiatrists to general practitioners following clinic appointments, particularly after follow-up non-attendance. The results also suggested that general practitioners did not identify a role for themselves in contacting patients who had failed to attend their appointments. Both these difficulties could lead to patients who need psychiatric treatment becoming lost to follow-up.

7.3 Limitations

High levels of satisfaction were reported by the majority of attenders and non-attenders of follow-up appointments (Study 1), but the relatively low response rate meant that it was not possible to conclude that all follow-up patients were satisfied with the outpatient service. Forty-six percent of non-attenders failed to return the postal questionnaire and the response rate of attenders was only 63%. Another reason why the high levels of satisfaction reported may be misleading was that those patients who were happy with their care may have been more inclined to take part in the study, thus biasing the results favourably. It was also possible that patients felt a need to be seen to be appreciative of the service offered, particularly since the study was carried out by a member of the hospital staff (HK) and attenders handed their questionnaires in to outpatient staff. This bias was addressed to some extent by the anonymity of the questionnaire.

Study 2 is the first to provide systematic, prospective data comparing the nature of attenders and non-attenders at a psychiatric outpatient clinic. However, since it was carried out in a single inner city area there may be limitations in generalising the results beyond similar populations with comparable models of service provision.

Nevertheless, the inner city is of particular clinical and policy interest since high morbidity, high need and failures of community care have been identified (Ritchie, Dick and Lingham, 1994; Johnson and Lelliot, 1997). The outpatient setting was chosen as it has less variability than other elements of mental health service provision and is a commonly used setting for the review of patients in the community.

One important limitation was the relatively low response rate (detailed in Table 6.1) which may have introduced non-response bias into the data presented. Non-response was predicted to be a potential problem given that the study was of people who were non-compliant with clinical follow-up plans. This source of bias was minimised by making repeated attempts to contact the subjects and by the use of face to face interviews. This approach seems to have met with some success in that the response rates reported here are higher than those in other studies of clinic non-attendance where postal questionnaires were used. For example, a response rate of only 40% was achieved for psychiatric attenders and non-attenders in the study reported by Hillis and Alexander (1990). Studies of non-psychiatric clinics where postal questionnaires were used have also reported response rates of only 43% (Lloyd *et al*, 1993; Potamatis *et al*, 1994). The response rate

for postal questionnaires in Study 1 was relatively high at 54% which may be due to the fact that non-attenders were mailed twice. This is still lower than the 59% achieved by face to face interviews with follow-up non-attenders in Study 2.

One reason for the relatively low response rates in Study 2 was the large number of patients who could not be traced. When these “untraceable” patients were excluded the response rates approached 70% for new patient attenders and follow-up patients. The lowest response rate was for the group of new patient non-attenders which also had the highest proportion (20%) of patients who were “untraceable”. The implications of the large numbers of untraceable patients are discussed in Section 7.4.6. Despite the limitation of a relatively low response rate, the main outcome measure was admission to the psychiatric inpatient unit and therefore outcome data were available on all subjects including those who were “untraceable”.

Non-response bias was investigated by collecting basic demographic data (age and sex) and diagnosis from the case notes on all subjects. Non-responders (including subjects who refused consent, those who were untraceable and those who made no response) were compared with those who took part in the study to assess whether patients who agreed to be interviewed were representative of the outpatient population as a whole.

When all non-responders were compared with all those who agreed to be interviewed, non-responders were found to be younger. This difference disappeared when the mean ages of all new patients, all follow-up patients and each of the four study groups were compared with those of the non-responders in each group. Younger age was also found to be associated with non-attendance, so this result may reflect a general lack of co-operation with services, characteristic of younger patients. This is discussed further in Section 7.4.1.

Another difference between responders and non-responders was found in the follow-up group. Only five non-responders (5%) had a diagnosis of bipolar affective disorder compared to 30 (18%) in the interviewed group. All other diagnostic categories were equally represented amongst interviewed and non-responder patients. This may indicate differences in the natural progression of this condition as compared to schizophrenia or schizoaffective disorder. Since bipolar affective disorder is characterised by recurrent relapses and periods of respite, patients with this diagnosis may retain more insight and organisational skills than patients with schizophrenia and may therefore be more likely to agree to take part in research. However, this would suggest that they might also be more likely to keep appointments, but there was no difference in the number of attenders and non-attenders who had a diagnosis of bipolar affective disorder in the study population.

A further limitation of Study 2 was the low recruitment to the new patient groups. From the hospital audit data (detailed in Section 5.13) it was expected that there would be 375 new patient assessment appointments during the study period. In fact there were only 165 which meant that the number of new patients available for recruitment was lower than expected. This may have been due to inaccuracies in the audit data or because the study period included both the Christmas and Easter holiday periods when the clinic was less busy. The number of follow-up appointments was also lower than expected (2,660 rather than 3,375) but this did not impair adequate recruitment since only 75 attenders and non-attenders were needed to ensure adequate statistical power to test the primary hypothesis.

Another limitation of Study 2 was that time and resource constraints meant that psychiatrists were not interviewed regarding their opinions about communication to and from general practitioners. This would have added useful information about the quality and flow of communication between referrer, patient, and psychiatrist. For example, the finding that psychiatrists were less likely to write to general practitioners about follow-up patients than new patients could be a consequence of a) psychiatrists feeling that follow-up patients are their responsibility and that the general practitioner does not need to be bothered about the outcome of every outpatient appointment or b) previous experience of general practitioners' reluctance to become involved in the management of follow-up patients.

7.4 Discussion of the results of the studies

7.4.1 Demographics

The results for this study population concurred with previous larger studies in finding that non-attenders were younger than attenders (Baekland and Lundwall, 1975; Carpenter *et al*, 1981; Frankel *et al*, 1989; Lloyd *et al*, 1993; Myers, 1975). The findings from this study also showed that newly referred patients were younger than follow-up patients and non-responders were younger than those who agreed to take part in the study. One possible explanation for this is that younger patients may be at an early stage in the natural progression of their psychiatric illness (hence the difference in age between new and follow-up patients) and may therefore have less experience of the usefulness of regular monitoring of their condition. Alternatively, they may be at a stage of denial of their illness and wish to distance themselves from psychiatric services. Older patients who have experienced recurrent relapses and episodes of hospital admission may have learnt that regular monitoring of their condition can be helpful. Another possible explanation is that older patients' symptoms may have progressed through the "active" stage into a more chronic state, making them more passive and more agreeable to attend appointments and to take part in research.

In keeping with previous research there was no gender difference between attenders and non-attenders (Carpenter *et al*, 1981; Lloyd *et al*, 1993; Hillis and Alexander, 1990; Pang *et al*, 1996; Lister and Scott,

1988; Bender and Pilling, 1985). This study population consisted mostly of people in socioeconomic groups II or III and the majority were white European which reflects the demographics of the general population living within north Camden. In keeping with previous studies of general psychiatric patients, non-attenders were not found to be of lower socioeconomic status than attenders (Carpenter *et al*, 1981; Koch and Gillis, 1991).

7.4.2 Employment

There was a very high unemployment rate amongst all psychiatric outpatients compared to the general population in north Camden. However, non-attenders were no more likely to be working than attenders. This implies that for this study population, non-attendance was unlikely to be related to difficulty in taking time off work and that “out of hours” clinics to encourage those who are working to attend may have little impact on overall attendance rates. This is in keeping with the findings of previous studies of the reasons for non-attendance at outpatient clinics where “difficulty in getting time off work” has been reported by non-attenders at medical clinics (Frankel *et al*, 1989, Verbov, 1992, Potamatis, 1994) but not at psychiatric clinics (Carpenter *et al*, 1981, Sparr *et al*, 1993, Pang *et al*, 1996). The high prevalence of unemployment amongst new patients as well as follow-up patients suggests that this group may be unable to seek or maintain employment, perhaps because of the symptoms of their psychiatric disorder. However, this similarity between new and follow-up patients

was not illustrated in the assessment of social functioning (which included a rating of work impairment due to psychiatric symptoms). Unemployment does, however, equate with reduced income. Recent research suggests a complex relationship between income and common mental disorders, with areas where there is high inequality in income (such as north Camden) having increased psychiatric morbidity from common mental disorders (Weich *et al*, 2001).

7.4.3 Social support

Almost half of the study group were living alone and no association between marital status and attendance was found. New patient attenders were more likely than any of the other three groups to report that they had no social support. This might have led to them being more likely to keep their appointment, perceiving themselves as alone and in need of help from some form of professional agency. However, the follow-up non-attenders were more likely to report that their main or only social contact was with professionals as compared to any of the other study groups. Therefore, in terms of social networks they appear to be the most isolated.

This finding is in keeping with previous work on social support which has shown that the perception of support received among people suffering from “neurotic” disorders is likely to be lower than the actual amount of support received (Stansfeld *et al*, 1998). The findings of this study concur, in that the new patients in this study population had a

high prevalence of “neurotic” disorders and reported that they were socially unsupported yet the follow-up population had a high proportion of people with a diagnosis of a major mental illness and were, objectively more socially isolated than the new patients. Socially stressful environments increase the likelihood of relapse in patients with schizophrenia (Vaughn and Leff, 1976) and it follows that such individuals might avoid social contacts and become socially isolated due to the discomfort of emotional closeness. The finding that follow-up patients, who had a higher prevalence of schizophrenia than new patients, were quite socially isolated is therefore not surprising. Forgetting appointments was commonly reported by follow-up patients as a reason for non-attendance and it follows that, since this group were also socially isolated, they may have been more likely to miss their appointment simply because they had nobody at home to remind them about it.

7.4.4 Diagnosis

The data from this study suggest that patients newly referred to psychiatrists have less severe psychiatric disorders than those already engaged with mental health services. The diagnoses of new patients and follow-up patients in this study were in keeping with Johnson’s report (1973a) which showed that the majority of new referrals have a diagnosis of depression or anxiety but that those who remain under the care of psychiatric services have serious mental illnesses such as schizophrenia or bipolar affective disorder. This appears logical, since

patients with more serious mental illnesses are likely to need longer term treatment.

Having said this, the diagnoses of the new patient non-attenders were made solely from the referral letters and may therefore be subject to error. Also, it would be unusual for a diagnosis of a major psychiatric illness to be made after the first assessment unless the case was very clear cut so the rates of schizophrenia and bipolar affective disorder amongst new patients may appear lower at initial assessment than if the diagnoses were reassessed some months later.

In contrast to previous research (Smyth et al, 1990; Bender and Pilling, 1985; Baekland and Lundwall, 1975), subjects with a diagnosis of personality disorder were not common among the non-attenders. In fact there were low rates of this diagnosis in all four study groups. For patients newly referred this may reflect a hesitancy to make such a diagnosis on first assessment. For the follow-up group it may be that these patients are more likely to come into contact with psychiatric services at times of crisis (often through the accident and emergency department outside of clinic hours) and tend not to engage well with a system of regular appointments in the outpatient setting. It is possible that they may therefore not have been offered further follow-up outpatient appointments which could account for the low prevalence.

7.4.5 Past psychiatric history

In contrast to previous research (Carpenter *et al*, 1981; Hillis and Alexander, 1990) there was no association for new patients between past psychiatric contact and likelihood of attending psychiatric outpatient appointments. However, follow-up non-attenders were more likely to have had a previous admission to hospital under the Mental Health Act (1983) than follow-up attenders. This may have been a negative or coercive experience which contributed to their non-attendance at the outpatient clinic, or it could be a marker for those patients with more severe illnesses who may find it difficult to keep appointments for reasons related to their symptoms which are outlined below.

7.4.6 Reasons that patients gave for missing appointments

Despite considerable efforts a number of non-attenders could not be traced. It is impossible to give any definite comment on this phenomenon as only limited data could be gathered about this particular group. All 12 untraceable new patients had missed their appointment. Using the referral letters, their likely diagnostic breakdown revealed that only two appeared to be suffering from a severe depressive episode (one with psychotic features) and the rest had less serious sounding problems.

There was no difference in the diagnostic groupings of new patients who were interviewed and those who were not (which included those

who were untraceable, those who refused to take part in the study and those who did not respond to the interview appointment letter and were not in when visited at home). These results suggest that strenuous efforts to trace such patients may not be absolutely necessary since they did not appear to be suffering from serious mental illnesses. Obviously the attempts one would make to contact a newly referred patient who missed their appointment would depend on the concerns about risk raised in the referral letter and any other relevant information. One would clearly wish to pursue the referral of the patient who appeared to be suffering from a severe psychotic depression.

The untraceable follow-up patients are much more worrying as they may represent individuals with serious mental health problems who are not receiving appropriate community follow-up. Eight of the 15 untraceable follow-up patients who missed their appointment had a diagnosis of either schizophrenia or severe depression (four with psychotic features). It is evident from these data that most of these patients ought to be receiving psychiatric follow-up. Lamont *et al* (2000) found that patients admitted to a psychiatric unit in London were twice as likely to have moved address in the year prior to admission than a comparison group of patients under the care of the community mental health team. The results from Study 2 appear to reflect the high levels of geographical mobility amongst individuals suffering from serious mental illnesses, particularly in inner London.

The large number of patients who were found to be untraceable highlighted the inaccuracies of hospital, general practice and social service records and emphasised the importance of checking the patient's address at each contact. This was illustrated by the finding that two follow-up patients who attended their appointment could not be traced for the research interview.

The proportion of untraceable follow-up patients who missed their appointment was lower than the 27% reported by Koch and Gillis (1991) in their study of patients discharged from an inpatient ward in South Africa. This may reflect the difference in follow-up arrangements between London and Cape Town. Alternatively, the difference may be accounted for by the fact that Koch and Gillis gathered follow-up data one year after discharge whereas the untraceable subjects in this study were identified soon after recruitment at the time of the home interview. It is likely that by one year even more subjects in this study population would have been untraceable.

A common reason given by both new patient and follow-up patient non-attenders for missing their appointment was that they were troubled by the symptoms of their psychiatric disorder (e.g. feeling too "paranoid" to go out or too depressed to get up). This is obviously of concern and such patients may best be seen at home. Among the follow-up patients reasons such as "couldn't be bothered", "overslept" and "lost appointment card" may also indicate apathy and reduced organisational skills as part of their mental health problem.

The follow-up patients who saw no reason to attend as they did not consider themselves to be unwell may represent a particular group of patients with limited insight who could benefit from further discussion about the usefulness of psychiatric interventions to help them with their symptoms. Only 8% of follow-up patients stated that the reason they missed their appointment was that they were unhappy with their treatment. This finding concurs with the results from Study 1 where more than 90% of follow-up non-attenders reported that they were satisfied with their treatment and the service they received from the outpatient clinic. The results from Studies 1 and 2 do not support the idea that non-attenders at the psychiatric clinic were “voting with their feet”.

Over twice as many follow-up patients said that they forgot their appointment (27%) as compared to the new patients (11%). In other studies of non-attendance at medical outpatient clinics (Verbov, 1992, Potamatis, 1994) the rates of forgetting an appointment have been reported as between 10 and 18%. The results from this study are in keeping with Sparr *et al's* (1993) findings, where 25% of their study population said that they had simply forgotten their appointment. It therefore seems that psychiatric follow-up patients who do not keep their appointments are more forgetful than outpatients in other specialties, perhaps because of their general disorganisation secondary to their psychiatric symptoms. This is in keeping with the findings of this study, since follow-up patients who missed their

appointments had more severe psychiatric symptoms than those who attended. As previously stated, these patients were also more likely to be living alone and to have nobody to remind them about their appointment.

As described in the literature review, systems for reminding patients newly referred to the psychiatric clinic about their appointments have been reported to improve attendance (Rusius, 1995). Telephone prompting may be less useful than postal reminders if the population is of lower socioeconomic status and unlikely to have a telephone (Burgoyne *et al*, 1983). There has been no research examining whether postal or telephone reminding systems are of benefit to patients booked into follow-up appointments at the psychiatric clinic, but the results of the further data collection in Study 2 showed that being contacted about the study (which may have acted as a form of reminder) did not increase attendance over the subsequent six months.

In Study 1, the most commonly reported criticism of the service was that junior medical staff changed every six months which, presumably, led to a sense of discontinuity of treatment for patients. Discontinuity of care has also been reported as being an important factor in non-attendance at non-psychiatric outpatient clinics (Deyo and Inui, 1980). However, it has particular significance in psychiatry due to the disclosure of more personal details by the patient and the development of a trusting relationship with the doctor over time. This issue was

examined in Kaesar and Cooper's (1971) classic study of referrals to the Maudsley Hospital. They showed that by the time a patient had had six or more outpatient appointments, 45% had been seen by four or more doctors. Little seems to have changed in the intervening years. The results from both Study 1 and Study 2 showed that the majority of follow-up patients were seen by the junior doctor, so a patient who is seen every three months will have been treated by at least two different doctors over one year and possibly more if one includes locum doctors covering when the junior is away on annual leave or study leave. Since the results of Study 2 showed that these patients have more serious mental disorders and more severe psychiatric symptoms than new patients, it appears illogical that they should be reviewed in the clinic by the least experienced medical professional in the team.

A simple solution to this problem is not easy given the training requirements of junior doctors and the numbers of patients under the continuing care of the outpatient service. However, since 80% of respondents in Study 1 stated that they would like to see the consultant sometimes, a regular review by the consultant every six months or so would improve continuity of treatment. The care plan approach (Section 2.15.7.3) would appear to provide a possible mechanism for regular consultant reviews of some outpatients to take place and is discussed further in Section 7.5.

7.4.7 Mental state and social functioning

Follow-up patients were more severely ill than new patients and follow-up patients who missed their appointments were more unwell and more socially impaired than follow-up patients who attended the clinic. The first finding is in keeping with the different diagnostic profiles of the new and follow-up patients. However it is unfortunate that those follow-up patients who are most unwell and most socially impaired and disorganised are least likely to attend psychiatric outpatient appointments. It may be that it is the attending that keeps the “attenders” well as they are seen regularly and both medical and social management can take place. Alternatively, it may be that the outpatient contact does not affect the course or severity of the illness but that patients whose illnesses are less severe are simply more able to attend as they are less impaired by their symptoms. To date there have been no studies that have examined the effectiveness of outpatient treatment for mental disorders, and, as such, the outpatient model is not evidence based.

7.4.8 Factors related to the referral process

None of the new patients interviewed were “self” referrals. This may be because the patient was not aware that their family had prompted the referral or it may be that self referrers were represented in the non-responders’ group. It was a limitation in the design of the study that neither patients nor general practitioners were specifically asked whether the referral had been prompted by the patient or family.

Patients were simply asked who had referred them to see the psychiatrist. A specific question to the general practitioner about whether the referral was prompted by anybody else may have helped to clarify this issue.

A number of new patients failed to attend because they were unhappy with the referral. Compared to new referrals who did attend, they were less likely to have agreed to the referral even though they were as likely to have understood the reason for referral. Therefore this group may be either inappropriate referrals where the referrer feels unable to help further, or they might be individuals who do require assessment from psychiatric services but where some further explanation of the need for referral may increase the likelihood of their attending. There was no difference in severity of psychiatric symptoms between patients who agreed to the referral and those who did not.

In contrast to Hillis and Alexander's findings (1990), stigma about referral to see a psychiatrist did not appear to be a reason for non-attendance among new patients in this population as those who attended were as likely to tell somebody about the referral as those who missed their appointment. Being embarrassed about seeing a psychiatrist therefore did not appear to be an important issue. However, this one question was a very imprecise measure of stigma and more specific questions about the patient's feelings about being referred to a psychiatrist would have assessed the issue more thoroughly.

New patients who did keep their appointments were more likely than non-attenders to have been prescribed psychotropic medication (usually an antidepressant) before they were seen by the psychiatrist. This could have been because their general practitioners felt more confident in making a psychiatric diagnosis and instigating treatment, or because these patients had a clearer diagnosis than new referrals who did not attend. The ability and confidence of the general practitioner in prescribing psychotropic medication may have been a sign of their general interest in psychiatric illnesses and this may have meant that the patient would have been able to discuss the problem more easily with them. The general practitioner might then have been able to explain the reason for psychiatric referral and reassure them about any concerns. This could then account for the higher rate of prescriptions in the attender group.

Alternatively, prescribing an antidepressant may have been a sign of the general practitioner responding in as easy a way as possible to a lengthy interview with a distressed patient. The patient may have then been more likely to attend their appointment than those who were not prescribed medication as they expected the psychiatrist to give them more time. Another possible explanation is that patients who were prescribed medication prior to seeing the psychiatrist had an improvement in their symptoms secondary to the medication and were then more organised and able to attend than patients who received no

medication, but equally they might have been less likely to attend as their symptoms had improved.

These suggestions are difficult to substantiate without a more in-depth interview with the general practitioners. However, since the referral letters were of equal quality for attenders and non-attenders and both groups were seen a similar number of times by their general practitioners before referral, it appears that there was no difference in the general practitioners' interest in psychiatry for attenders and non-attenders.

In contrast to many previous researchers (Burgoyne *et al*, 1983; Carpenter *et al*, 1981; Lister and Scott, 1988; Grunebaum *et al*, 1996; Chen, 1991; Lloyd *et al*, 1993; McGlade *et al*, 1988; Deyo and Inui, 1980), new patients who did not attend had waited no longer for their appointment than those who came. The rates of clerical error leading to missed appointments were around 12%, considerably lower than the 33% reported in other medical specialties (Potamatis *et al*, 1994; Verbov, 1992) but higher than the 5% reported in Sparr *et al*'s (1993) study of a military veterans' psychiatric clinic.

This suggests that the particular outpatient clinic in this study was working quite efficiently. Having said this, clerical error ought to be an avoidable cause of missed appointments. Although external postal systems are outside the control of the outpatient clinic, postal systems within hospitals are notoriously slow. Sending appointments out in

good time, or, where possible, telephoning patients about appointments that are arranged at short notice could reduce this source of error considerably.

7.4.9 Liaison between psychiatrists and general practitioners

The psychiatrists were more likely to communicate with the general practitioners about new patients than follow-up patients and they were more likely to communicate when a new patient missed their appointment than when a follow-up patient did not attend. The majority of general practitioners felt that this amount of communication was adequate, preferring not to be told about each visit to the clinic unless there was a change in the patient's management.

The lack of communication about follow-up patients who missed appointments was rather alarming given that the general practitioner provides a vital link between the hospital and the patient in the community. Follow-up patients who missed their appointments had the most severe symptom ratings of all the outpatients studied and were most likely to suffer relapse of their mental illness and require subsequent admission. It would therefore seem advisable to ensure that the general practitioner is informed about whether a patient keeps their appointment or not.

7.4.10 The potential for psychiatric patients to “slip through the net”

Following non-attendance general practitioners were more likely to consider that a follow-up patient should be sent another appointment than a new patient. They also had an awareness that other services such as the community psychiatric nurse might be appropriate. They did not believe it was the psychiatrist's responsibility to make contact with new patients who missed appointments, but neither did they see it as their own, preferring to wait and see whether the patient re-attended their surgery before reorganising any further assessment by the psychiatrist.

These findings appeared to highlight a gap in service provision, in which neither psychiatrists nor general practitioners saw it as their responsibility to contact newly referred patients who missed their appointments. This clinical “buck passing” could have serious consequences for this group of patients who may not re-present to their general practitioner. Having “slipped through the net”, they may remain untreated with gradually worsening symptoms. Since the psychiatrist will not have met the patient and the general practitioner will, in most cases, have previous knowledge of them in order to have made the referral, it seems logical that the responsibility for following up such patients ought to remain with the general practitioner. However, recent directives to general practitioners suggest that once the referral to a psychiatrist is made the general practitioner is

absolved of all clinical responsibility. This issue is discussed further in Section 7.4.11.

Usual practice in north Camden when a new referral fails to attend an appointment is for the psychiatrist to write to inform the general practitioner, handing the patient back into their care and offering to see the patient if the general practitioner re-refers them. However, the general practitioners in this study did not then contact the patient. This may well be appropriate if the general practitioner feels confident that the patient does not have a serious mental illness. However such certainty is not always available and it may be safer for the general practitioner to contact the patient and suggest that they attend the surgery to discuss the need for referral.

7.4.11 Recent directives for general practitioners

The General Medical Services Committee (GMSC) is a committee of the British Medical Association which deals with all matters affecting NHS general practitioners. It is currently known as the General Practitioners' Committee (GPC). In 1996, the GMSC issued guidelines to general practitioners regarding the assessment and continuing care of patients with mental disorders stating: "In the case of the severely mentally ill, general practitioners discharge their obligation once they make a competent assessment and identify a need to refer" (GMSC, 1996). The guidelines went on to suggest that the further management and prescription of psychotropic drugs should become the

psychiatrist's sole responsibility. There have been no amendments to these guidelines since they were issued.

Hillam and Warner (1996) challenged these guidelines as being likely to lead to disintegration of "psychiatric primary care services". They argued that since general practitioners prescribe drugs and supervise treatment at the recommendation of other hospital specialists it seemed illogical to single out psychiatry in this way. In 25-40% of cases patients with serious mental illnesses have no contact with specialist services and rely on their general practitioner for their psychotropic medication (Kendrick and Burns, 1996).

The GMSC stated that psychiatrists were not seeing enough patients and referred to Goldberg and Huxley's (1991) model of the pathways to psychiatric care which showed that out of 1,000 individuals at risk of mental disorder in the community per year, 23 were referred to psychiatric services. However, the GMSC failed to make the distinction between severe mental disorder and common mental disorder. Goldberg and Huxley's (1991) model showed that the "filters" between identification of mental illness and referral to psychiatric services were more permeable to individuals suffering from severe mental disorders. This can be partly explained by the difficulty that general practitioners have in identifying mental disorder (Section 2.7.9).

The findings of Study 2 and Johnson's analysis of psychiatric outpatient services (1973a) showed that the patients that psychiatrists treat on an ongoing basis in their clinics are the minority of those referred but one which has the most serious mental illness. The GMSC's guidelines did not suggest that psychiatrists should assess more patients, but that they should take over the ongoing care of all patients referred to them once the general practitioner had identified severe mental illness. The GMSC's definition of "severely mentally ill" was unclear and it could be argued that such a term could not be applied without an assessment by a psychiatrist after, rather than at the point of, referral by the general practitioner.

If psychiatrists are to be held clinically responsible for all patients referred to them, mental health services, which are already under serious pressure, will become overloaded with patients who have less serious complaints and who can be adequately treated by the general practitioner with or without guidance from the psychiatrist. A more realistic approach would be for psychiatrists to provide more assessments and advice to general practitioners about the management of patients with common mental disorders. This would allow psychiatrists and general practitioners to develop "a mutual working understanding of their respective contributions to the care of the mentally ill" (Kendrick and Burns, 1996). This is discussed further in Section 7.5.

7.4.12 Six and twelve month outcome

The results of this study showed a clear sequence of events for follow-up patients, where a single missed appointment predicted drop out from the clinic by six months and admission to the inpatient unit by twelve months. The time of first attrition may therefore be an important point at which to intervene in order to try to reduce or prevent serious negative outcome, particularly considering the geographical mobility of this population (Section 7.4.6). For new patients, drop-out from the clinic was also predicted by a single missed appointment, but this led to less serious consequences than for the follow-up patients in terms of subsequent admission since the new patient group were suffering from less serious mental illnesses.

The findings from this study support those of Koch and Gillis (1991) and show the importance of actively engaging patients in post-discharge planning. They showed that where the patient's family was aware of outpatient follow-up plans, the patient was more likely to keep his or her appointment and the chance of readmission for those who attended the follow-up clinic was reduced threefold. Discharge planning and care planning meetings for patients, relatives, friends and professionals need to take into account not only the patient's needs as defined by professionals but also the patient's and carers' views on acceptable follow-up plans and community support.

7.4.13 Exposing hidden psychiatric morbidity

The finding that follow-up patients who were recruited into the study had a greater chance of admission by twelve months than those who were not recruited was rather puzzling. This difference was most marked for admissions to hospital under the Mental Health Act.

We have no reason to suspect that the follow-up patients in the study group differed from controls in their socioeconomic or diagnostic profiles as they were all randomly selected from the same sampling frame, although this was not checked. There is a remote possibility that receiving letters and undergoing a research interview which involved a mental state assessment was a stressful event which led to relapse. Another possible explanation is that contact with the interviewer made the psychiatric services appear more approachable at a subsequent time of crisis, yet this was not supported by the large numbers of patients who were admitted under the Mental Health Act. None of the patients appeared acutely unwell at the time of the interview and there was therefore no need for contact between the interviewer and the treating team which might otherwise have precipitated assessment and subsequent admission, thus explaining these results.

An alternative explanation is that the telephone interviews with each patient's general practitioner could have alerted the general practitioner to any potential difficulties experienced by the patient. This in turn could have led to an activation of services and subsequent

admission. However, this was not reflected in the patients' recorded modes of entry into hospital as few patients were referred for admission by their general practitioner.

Community psychiatric services which adopt an "assertive community treatment" style of working may find a paradoxical increase in the number and length of admissions to psychiatric inpatient facilities amongst their clients (Tyrer, 1995 and 1998). One explanation is that active follow-up of outpatient non-attenders may be identifying the psychiatric morbidity in the community and leading to an increase in admission rates. This may explain the findings from Study 2 outlined above, although the exact mechanism which led to an increased admission rate in the intervention group is not at all clear. The concept of hidden morbidity is quite complex and the distinction between common and severe mental disorders needs to be understood.

Estimates of the proportion of the population suffering from common mental disorders who do not seek help from their general practitioner (and can therefore be considered as "hidden psychiatric morbidity" have been made (Goldberg and Huxley, 1991). Among those with severe mental disorders there may be a group whose symptoms and risk to self or others would fulfil criteria for admission to hospital under the Mental Health Act but who are disengaged from, or have never been known to, psychiatric services. The proportion of individuals in this category is unknown but, by definition, consists of individuals at the most severe end of the spectrum of psychiatric illness.

It may be that Study 2 identified some of the disengaged individuals in this category, resulting in admission to hospital under the Mental Health Act.

This finding has implications for future service planning as it would seem to show that as more resources are directed towards the provision of community based psychiatric programmes with an emphasis on outreach models for vulnerable individuals, this may in turn lead to an increase in the number of inpatient facilities required. One could argue that a new service which is specifically designed to identify individuals who have difficulties in engaging with existing mental health services is bound to unearth the hidden psychiatric morbidity in the community. Despite increased service costs, the development of such interventions is to be welcomed if it leads to the alleviation of distress amongst isolated individuals who have previously been receiving inadequate levels of care.

The number of seriously mentally ill individuals who have disengaged from statutory psychiatric services and who are likely to be taken on by assertive outreach teams appears to be relatively finite. Therefore it is likely that after the initial period of identification and engagement of such individuals, the need for admission will gradually reach a plateau and possibly decrease. Given the relatively lengthy time frames involved in successful assertive outreach work, this plateau is likely to be reached in years rather than months and may therefore not appear in the early stages of evaluation.

7.5 The future of the outpatient clinic

The findings of this study raise the question of whether outpatient clinics are an appropriate model for follow-up of psychiatric patients. Psychiatric illnesses are not equivalent to medical or surgical illnesses where a brief history, examination and review of the results of investigations is managed within as short a time as possible and where non-attendance is accepted as an active choice on the part of the patient. In psychiatric clinics, patients who are anxious or depressed or in some other distress often require extended interviews whether new to the clinic or attending follow-up appointments. Attempting to hurry a patient who is expressing his or her distress or disclosing intimate worries is unsatisfactory and may be detrimental to the therapeutic relationship between doctor and patient.

As a consequence, patients with serious mental illnesses who are unforthcoming, particularly in the outpatient setting, may be seen in as short a time as possible. Their reticence may be due to negative symptoms of schizophrenia such as poverty of thought content, or due to fears of increased doses of medication being prescribed if they admit to active psychotic symptoms. A thorough exploration of their medical, psychiatric, social and economic needs is unlikely to take place in such a setting if they are unforthcoming themselves and in the absence of carers and professionals who can relay the relevant information. For such patients, regular care planning meetings at which all those involved in the patient's care can be present seem to

be a more appropriate form of community management and have been described in the literature review (Section 2.15.7.3). In other words, patients with serious mental illnesses and complex needs may be better served by community mental health teams. This would allow regular review by the consultant of these patients through the CPA system which would increase continuity of care and avoid the problems of successive junior doctors monitoring such patients through the outpatient clinic (section 7.4.6).

This would also release clinic time for the assessment of new patients and the treatment of patients who do not require the services of the community mental health team. Junior doctors could be appropriately involved in these outpatient duties, under the supervision of the consultant, and in the short term follow-up of patients discharged from the inpatient unit. Coupled with inpatient duties, this would provide a comprehensive clinical training.

The outpatient clinic could then operate more like medical and surgical clinics, providing expert assessment and advice on new referrals for general practitioners and other referrers. Patients with less complex needs could be seen and managed in the short term in the clinic, but those who were likely to require further community support (such as from a community psychiatric nurse or mental health social worker) could be managed by the community mental health team and their regular review would be ensured within the structure of care planning meetings.

The referral of a new patient to a psychiatrist for a detailed assessment and accurate diagnosis could help to address the difficulties that general practitioners encounter in identifying those patients who present to them in psychological distress and require psychotropic medication and those who might benefit from counselling.

As described in Section 2.15.7.1, psychiatric liaison clinics held in general practitioners' surgeries are becoming increasingly popular as an alternative model for the assessment and treatment of patients with mental health problems. They also have the advantage of allowing less formal communication between the general practitioner and psychiatrist than is achieved through outpatient clinic letters (King and Pullen, 1994).

Tyrer (1984) investigated patients' opinions of such clinics and showed that the majority of patients preferred them to the hospital outpatient clinic, finding them easier to access and less stigmatising. He felt that these psychiatric liaison clinics were advantageous over hospital clinics for a number of reasons: they provided a more neutral setting for the patient in which he or she could feel relaxed and was therefore more likely to provide relevant information; they allowed the psychiatrist easy access to the patient's general practice files which could provide further important information; and they allowed the general practitioner to share clinical responsibility and take part in the patient's further management.

Such consultation-liaison schemes encourage more comprehensive discussions between the referring general practitioner and psychiatrist about individual patients than could possibly be construed from a referral letter to the outpatient clinic. The face to face contact between the general practitioner and psychiatrist adds invaluable information about individual cases, giving the psychiatrist the opportunity to gauge the reaction of the general practitioner to the patient and their reaction to the psychiatric advice offered. The psychiatrist can also advise and supervise the general practitioner's management of certain patients, thus reducing the need for every patient presenting with emotional or mental health problems to receive a psychiatric consultation. The general practitioner can also become more actively involved in the ongoing management of patients with psychotic disorders whose treatment might previously have been supervised solely by the hospital based psychiatrist. Of course, general practitioners' time constraints have to be borne in mind when considering the degree to which they can become involved.

Community mental health nurses, based in community mental health teams, are increasingly forming links with general practices, providing a liaison service for the assessment of new patients and the review of those with serious mental illnesses. Such liaison schemes help to encourage discussion and communication between primary and secondary care and allow for a more flexible approach to community care planning for these patients.

Chapter 8

Conclusions

8 Conclusions

8.1 Conclusions from the study results

The results from Study 2 have shown that new patients and follow-up patients are quite distinct groups with differences in their diagnoses and degree of mental illness. This investigation into the outpatient population has identified a group of particularly vulnerable follow-up patients who have diagnoses of schizophrenia, schizoaffective disorder or bipolar affective disorder. Once they miss one appointment they are likely to drop out of treatment and further contact with mental health professionals becomes increasingly unlikely. These patients have severe psychiatric symptoms and a higher rate of relapse and admission than those who attend their appointments. They tend to be young, socially isolated, living in supported accommodation and they have a higher rate of previous involuntary admission to the psychiatric ward than patients who attend regularly. Their psychiatric symptoms seem to contribute in three main ways to their non-attendance: a) active symptoms such as paranoia; b) negative symptoms such as apathy and reduced organisational skills; and c) lack of insight.

The findings from Study 2 show that it is imperative that patients with major psychiatric illnesses who stop attending are not “lost to follow-up” but their attrition is noted and appropriate action taken at the earliest opportunity. The study results showed that the majority of outpatients are seen by a doctor training in psychiatry rather than the consultant and since these posts are held for only six months, it is vital

that junior doctors adequately hand over information to their successors at the end of each post.

Moreover, the results of this study suggest that the outpatient setting is not the most appropriate model for the management of patients with serious mental illnesses in the community and that an alternative approach to follow-up is required for this group. The needs of these patients may be better met by the community mental health team, incorporating home visits rather than clinic appointments when appropriate. The Care Programme Approach has encouraged the development of this model over recent years which encourages closer liaison and more coherent care planning between carers and professionals involved in the support and treatment of individuals with serious mental illnesses. Home visits from the community mental health team and psychiatrist are not only important for patients who have missed an outpatient appointment but are also useful for most patients with a diagnosis of a serious mental illness. Clearly patient choice is important here as some patients will prefer to be seen in the clinic and others will prefer to be visited at home. However, community psychiatric practice that incorporates at least one initial home visit adds valuable information about the patient's domestic and social situation which is unavailable when the patient is only ever seen in the outpatient clinic.

The recent Government White Paper which outlines the proposed reforms to the 1983 Mental Health Act suggests that provisions will be

made to allow care and treatment orders to apply to patients outside hospital. The details are not yet known, but this implies that patients who are reluctant to engage with psychiatric services may be legally required to do so. The ethical implications of these "community treatment orders" are a subject for wider debate beyond the scope of this thesis, but the White Paper states that "there will be no powers for patients to be given medication forcibly except in a clinical setting". It is however possible that such orders will require patients to accept home visits or enforce their attendance at outpatient appointments. New models of care such as assertive community treatment are gaining popularity in the United Kingdom and may prove to be an effective form of community intervention for certain patients with serious mental illnesses who have a history of difficulty in engaging with psychiatric services. How far assertive outreach teams will be expected to incorporate "community treatment orders" into their work remains to be seen.

The results of Study 2 have also shown a shortfall in the adequacy of communication between the psychiatrist and general practitioner, particularly with reference to these more vulnerable patients. Given that this is a group who can be very difficult to engage with services, all those who are likely to come into contact with them should be working together in close liaison and sharing information so that their mental health can be monitored as optimally as possible. It might therefore be appropriate for a letter to be written to the general practitioner after every outpatient appointment, even if the

management plan for the patient has not changed, so that a breakdown in communication does not occur and the psychiatrist and general practitioner can both be clear about the patient's attendance.

The question of how best to deal with new patient non-attenders remains open to debate, but this study has shown that these patients are less mentally unwell than those already engaged with the service. Therefore, given the current pressures on mental health services it may be that the onus should be placed on the general practitioner to contact them and reassess their need for psychiatric assessment. Primary care psychiatry liaison clinics have been discussed and provide an alternative setting for discussion about and possible assessment of patients who are reluctant to attend the outpatient clinic. Simple interventions such as providing a clear explanation of the reason for referral and giving the patient a printed "orientation statement" in order to reassure them about what to expect from a psychiatric assessment may also encourage attendance at initial appointments.

Studies 1 and 2 tested the hypotheses described in Chapter 3. In Study 1, the hypothesis that defaulters from follow-up appointments were less satisfied with their treatment than patients who kept their appointment was not supported. In Study 2, the results supported all three hypotheses, namely:

1. Defaulters from outpatient follow-up had a higher chance of subsequent admission to inpatient services than patients who kept their appointments.
2. The factors associated with non-attendance differed between patients newly referred to the psychiatric clinic and those with follow-up appointments, specifically diagnosis and severity of symptoms.
3. Communication between the psychiatrist and general practitioner about defaulters differed between those newly referred and those with follow-up appointments. Psychiatrists were more likely to write to general practitioners about new patients than follow-up patients and least likely to inform the general practitioner when a follow-up patient did not attend.

In summary, psychiatric outpatient clinics are an important component of current mental health service provision. They remain in widespread use in the United Kingdom, providing a cheap and almost ubiquitous model for the assessment and treatment of mental disorders. They are low profile, provoking very little discussion in the psychiatric literature. They are generally viewed as simple, but in fact they are anything but, with complex processes between general practitioners, patients and psychiatrists at work. A number of inadequacies in the quality of service being provided have been identified through this study. These include: the lack of coherent systems to respond to non-attendance; inadequate communication from psychiatrists to general practitioners,

particularly about patients who are most likely to relapse in the community; the gap in service provision at the interface of primary and secondary care for new patients who fail to attend; the fact that junior doctors see the majority of the most seriously unwell patients; and clerical error. In an era where the efficacy of medical service provision is under close scrutiny, these issues deserve to be addressed and appropriate guidelines developed through the process of clinical governance in order to ensure that serious discontinuities in care are avoided.

8.2 Further research

Results from Studies 1 and 2 have suggested that an alternative approach to psychiatric service provision is required for patients with serious mental illnesses who are living in the community. The outpatient model appears to be particularly inadequate for patients with more severe symptoms. The CPA model may be able to provide a more comprehensive and integrated approach for the assessment and delivery of care to patients with high levels of need. However, it has to consist of more than a “paper exercise” in form filling and rubber stamping of unimaginative treatment plans. Therefore it is worthy of research in order to assess whether it represents any improvement on the outpatient system.

It would be worthwhile to carry out an initial survey of patient attendance at CPA meetings. This information is fairly readily available since the CPA form includes whether the patient themselves attended the review. One would expect a high level of attendance since the meetings are arranged by the keyworker in discussion with and on behalf of the patient. The attendance rate at CPA meetings over a one year period could be compared with the attendance rate reported for the sample from whom the study population of follow-up outpatients were recruited at the Royal Free Hospital. A more precise measure would involve gaining at least diagnostic data to ensure that the two groups are similar in their prevalence of serious mental illness.

Diagnosis is also given on the CPA form and tends to be gleaned from case summaries making comparison with the study population of outpatients fair. CPA forms are monitored and collated by an administrator so the availability of this data is ensured.

More in depth analysis of the efficacy of the CPA system could include patient interviews assessing the level of need in different areas of the patient's life and an assessment of functioning. CPA plans could be monitored and analysed in relation to the implementation of agreed plans and any improvement in patient functioning and quality of life measured.

With the introduction of the CPA and the gradual integration of health and social service professionals into single community mental health teams, it is likely that the profile of the outpatient service will change. Further monitoring and evaluation of this process would be useful and informative. It may be that the outpatient service will become more focussed on assessment and short term treatment and that the bulk of the continuing community care of the seriously mentally ill will shift to the community teams. General practitioners may increase their direct referrals to community teams, perhaps facilitated by link workers or liaison clinics.

With the establishment of primary care trusts, it is expected that general practitioners will be requesting more help in the assessment, advice and treatment of patients with less serious mental illnesses

such as depression, anxiety and substance misuse. It is unclear how the current structure of psychiatric service delivery will be able to meet such demands. Clearly these developments will be rich in research possibilities which will help to map the changing service and inform the most appropriate alterations to service delivery.

I am currently employed as the main researcher carrying out a randomised controlled trial of assertive community treatment versus standard community care for patients with a history of serious mental illness and difficulty in engaging with psychiatric services. One of the main outcomes is admission frequency and length which will be compared between the two groups with the hypothesis that the intensive community support available to the group who receive assertive community treatment will be able to prevent relapse and reduce admissions to hospital. This study follows on from the prospective study of psychiatric outpatient non-attendance in that the clients recruited are likely to be those who would previously have dropped out of outpatient treatment, becoming lost to follow-up, suffering probable relapse and requiring admission.

It would also be interesting to investigate whether the simple intervention of sending out a written orientation statement with new patient appointments increases the attendance rate in this department. This could be easily researched using a randomly selected sample of newly referred patients and comparing their attendance at the initial appointment with a randomly selected control group who are not sent

an orientation statement. The effect of interventions such as prompts and reminders to increase follow-up patient appointment keeping could also be investigated using a simple randomised controlled trial design.

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8.7 Appendix

8.7.1 Manchester Scale (Krawiecka *et al*, 1977)

0 = Absent 1 = Mild 2 = Moderate 3 = Marked 4 = Severe

Depression

- 1 = Fed up, not clinically depressed
- 2 = Mild clinical depression or occ. depressive episodes in last week
- 3 = Moderate clinical depression or frequent depressive episodes in last week
- 4 = Severe clinical depression (suicidality)

Anxiety

- 1 = Minor degree, perhaps due to interview
- 2 = Mild clinical anxiety or tension or occasional anxious episodes in last week
- 3 = Moderate clinical anxiety or frequent anxious episodes in last week
- 4 = Severe anxiety +/- agitation which may have interrupted interview

Beliefs

- 1 = Eccentricity / superstitious / spirituality
- 2 = Overvalued ideas / ideas of reference / special meanings
- 3 = Delusions / delusional perception recently or not unshakeable
- 4 = Definite delusions held

Perceptions

- 1 = Non-pathological eg. hypnogogic
- 2 = Pseudohallucinations eg. post bereavement
- 3 = Infrequent but do occur
- 4 = Current or frequent

Affect

- 1 = Habitually flat
- 2 = Mildly flat / incongruous
- 3 = Moderate flattening / lack of warmth / incongruity
- 4 = Very flat / incongruous

Psychomotor retardation

- 1 = Habitual
- 2 = Mildly lacking in reactivity / spontaneity
- 3 = Obviously unreactive / slow to answer
- 4 = Very obviously retarded

Thought disorder

- 1 = Odd but not formally thought disordered
- 2 = Occasional formal thought disorder during interview
- 3 = Frequent formal thought disorder but can understand what patient means
- 4 = Word salad

Poverty of thought (Stream of speech)

- 1 = Only speaks when spoken to
- 2 = Occasional gaps / vague / brief answers
- 3 = Monosyllabic / repetitions / meaningless
- 4 = Mute / constantly muttering

8.7.2 Work and Social Adjustment Scale (Marks, 1986)

Rate on a scale of 1 to 8 the amount that your mental health problem affects the following areas in your life:

Degree of impairment

NOT AT ALL	SLIGHTLY	DEFINITELY	MARKEDLY	VERY SEVERELY				
0	1	2	3	4	5	6	7	8

work

home

social

leisure

8.8 Publications from this study

Killaspy, H., Banerjee, S., King, M. & Lloyd, M. A prospective controlled study of psychiatric outpatient non-attendance: characteristics and outcome. *British Journal of Psychiatry*, 2000, **176**, 160-165.

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