

What is interfering with attendance in adult psychiatric out patients clinics?

Riyadh A. Alnamlah, DPMPsych, SSCPsych.

ABSTRACT

Objective: To identify the characteristics of non-attenders in a psychiatric outpatient setting.

Methods: A retrospective study evaluates patients' attendance for one year after the initial visit to the outpatient clinic in Al-Amal complex for mental health in Riyadh, from 30th July 2003 to 22nd January 2004. Information including sociodemographic data and other factors such as psychiatrist grade and nationality, type of medication, and so forth, were analyzed.

Results: The total sample was 73 patients, and the non-

attendance rate was 34.2%. The study showed the difference between attenders and non-attenders for some factors, but it was not statistically significant.

Conclusion: Although the result was not significant from the statistical viewpoint, it sheds light upon important confounding factors that need to be evaluated thoroughly, such as stigma, which characterizes mental health practice in particular.

Neurosciences 2006; Vol. 11 (4): 293-296

Patients that neither keep nor cancel their scheduled appointments in advance are commonly called "no-show" or "non-attender" patients. These patients disrupt the health care delivery system at various points.¹ The disruption of scheduling, the waste of professionals' time, and the subsequent under utilization of resources makes the already overburdened mental health services more inaccessible to many other potential patients.² Noncompliance with psychiatric treatment is associated with increased clinical, social, and economic costs, and it is closely linked to relapse, rehospitalization, and poor outcome among patients with a major mental illness.³ Identification of non-attenders, is an important step towards treating the problem and reducing the time, effort, and financial losses.^{4,5} Considering that the psychiatry clinic is a referral one, we assume that the appointment failure

rate will be less than that in primary care clinics, due to the severity of the case and the management difficulties at home. However, the stigma associated with psychiatry may be considered as a discouraging factor.⁶ Traditional healing plays a great role in our community, and it was found that more than half of the patients (more female) who visited the psychiatric clinic for the first time had previously used traditional healing providers.^{7,8} We aim, in this study, to identify the sociodemographic characteristics of non-attenders in new psychiatric outpatient clinics at Al-Amal complex for mental health, concentrating on initial appointments as they are more frequently missed and less often rescheduled.⁹

Methods. The study was conducted at Al-Amal complex for Mental Health in Riyadh, which is the only specialized hospital for psychiatry and addiction

From the Psychiatric Department, Al-Amal Complex for Mental Health, Riyadh, Kingdom of Saudi Arabia.

Received 25th October 2005. Accepted for publication in final form 4th January 2006.

Address correspondence and reprint request to: Dr. Riyadh A. Alnamlah, Consultant Psychiatrist, Al-Amal Complex, PO Box 2810, Riyadh 11427, Kingdom of Saudi Arabia. Tel. +966 (1) 4864611. Fax. +966 (1) 4864602. Email: ranamlah@hotmail.com

in the capital city of Saudi Arabia. Its capacity is more than 500 beds and caring for a population of more than four million residents. Outpatient clinics receive patients through referrals from primary health care centers and hospital emergency departments. In this study, we included all patients who were seen in a new adult male psychiatric clinic, from 30th July 2003 to 22nd January 2004. For one year starting from the date of first visit, we evaluated retrospectively the frequency of follow up visits, accordingly, patients were categorized into 2 groups: “non-attenders” and “attenders”. The latter included all patients who had at least one visit after the first one. The data were collected through a designed sheet that included “patient factors” involving sociodemographic characteristics; and “non-patient factors,” involving the rank and nationality of the psychiatrist who saw patients at the first visit, and type of medication, if given during the first visit. This sheet was manually completed by the author. The information was extracted from the patients’ out-patient department files in which the sociodemographic data were doubled registered by the receptionist as well as the psychiatrist in 2 separate papers. We defined 2 different age groups: the 18-35 years group and the >35 years group, in order to achieve the required expected cell frequency of more than 5 in X²-test. All statistical procedures were performed using the Statistical Package for Social Sciences (version 12.0).

Results. Seventy-three patients were seen in the adult male psychiatric new clinic during the 6 month study period. At the follow up visit, 48 patients (65.8%) were seen at least once, and 25 (34.2%) did not appear. The sociodemographic data revealed that most of the subjects were single, 51 (70%), with no job, 53 (72.6%), less than 35 years old, 56 (76.7%), and referred mostly from primary care centers, 59 (80.8%). We found that more non-attenders in comparison with attenders were single, 19 (76%) versus 32 (66.7%), from outside the city, 6 (24%) versus 9 (19%), more educated 15 (60%) versus 23 (48%), and unaccompanied 16 (64%) versus 23 (48%). Both groups had almost similar results in the remaining factors, that most of the non-attenders and attenders were less than 35 years old [19 (76%) versus 37 (77%)], most were unemployed [18 (72%) versus 35 (73%)], and referred mostly from primary care centers [20 (80%) versus 39 (81%)]. However, all these factors appear to carry no statistical significance in differentiating between the 2 groups. Regarding non-patient factors, we found that 57 (78%) received drug therapy at the first visit, the rest of the patients were given other modalities such as psychotherapy,

or the decision to give medications was delayed until further assessment. Regarding type of medications among those who had received drug therapy, 42 (56%) were given new antidepressants (namely, non tricyclics) or second-generation antipsychotics, and overall, 31 (54%) received antipsychotics. We found that non-attenders in comparison with attenders were more seen by residents, 20 (80%) versus 31 (64.6%), and prescribed non-antipsychotic medications, 12 (60%) versus 14 (37.8%). Again, our study revealed no significant differences between attenders and non-attenders in respect to non-patient factors.

Discussion. To comply with recommended treatment is important, but is not the sole step in disease management. Maintaining adherence is an essential pace to sustain improvement, particularly in chronic illnesses, like most of the psychiatric disorders. A person may be willing to receive medication for a short period despite his dissatisfaction, obviously the case is quietly different if that person needs to take treatment for long time, yet he is uncertain about its dire need. So, one can easily expect the tremendous damage of poor or non-attendance not exclusively over the patient, but its impact extends also to his family and society. Such damages and losses include potential dangerousness of the disturbed patient toward himself or others, need for hospitalization, and need for excessive medications, and so forth. This study explored the extent of this problem in psychiatric clinics, focusing particularly on those not attending after the first visit to the clinic. After the initial visit, 34.2% did not attend and this figure is comparable with another study.⁹ However, this is higher than the rate of non-attendance in a local study of primary care patients, which was 29.5%.¹⁰ Beside the methodological difference, the variation between the upper 2 figures can be explained by various reasons, first is the negative attitude toward mental illnesses in general. Secondly, this may be due to the great effect of traditional healing in our community.⁸ The third possible affecting factor is transportation, as Al-Amal mental hospital is the only free hospital specializing in psychiatry in Riyadh, and is located in the far west part of the city. Conversely, primary care centers are distributed in different areas, so they are more reachable. The fourth reason is related to the belief of some people that mental health treatment is relatively ineffective.¹¹ Moreover, the response or therapeutic lag that is the time (days to several weeks) required until psychotropic medications start their therapeutic action, makes patients conclude wrongly that drugs are ineffective. With respect to the sociodemographic factors analyzed in this

study, none showed a significant difference between attenders and non-attenders, however, Edlund et al¹¹ found that characteristics of non-attendance included, young age, and low income. Another study showed that poor compliant patients tended to be less educated.¹² Sharp and Hamilton¹³ concluded that the main associations with hospital non-attendance are reported as being male, youth, the length of waiting time, and deprivation.

Regarding non-patient factors, a Canadian study¹⁴ found that patients who were scheduled to see a resident physician were at a greater risk of missing their appointments. Another study¹⁵ showed that the rate of non-attendance for patients seen by a consultant psychiatrist was 18.6%, while it was 34% for those seen by specialist registrars, and 37.5% for those seen by senior house officers. As with patient factors, our study revealed a difference between attenders and non-attenders in some of the non-patient factors, but again it is not statistically significant. Diagnosis is an important relevant factor, but because of the study design, it was not included as it will be based on the impression of the psychiatrist who saw the patient, which could be neither consistent nor sensitive in a retrospective study. However, the type of prescribed medications would generally provide a clue about the nature of illness (for example psychotic versus nonpsychotic).

Despite the negative results of the study, it does shed light upon important issues; factors that affect attendance in psychiatric clinics differ from those affecting other health specialties. At least in this study, the level of education the patients hold, vocational status or the distance from the clinic, and so forth, do not affect attendance as they do in other nonpsychiatric clinics as shown in previous studies.^{10,16} One of the possible influential factors that distinguish psychiatry in particular, and seems to interfere with the compliance of mental ill patients across different cultural background is the stigma associated with psychiatric illnesses.⁶ Our psychiatric patients in particular may be greatly affected by this negative view since mental illnesses in our community are mostly attributed to the devil.⁸ Unfortunately, the effect of stigma in the attendance rate was not investigated in this study.

Another important confounding factor is forgetfulness. It was found to be the most common reason for missing an appointment,¹³ and it is found that twice as many psychiatric follow up non-attenders said that they had forgotten their appointments compared with the proportion reported by other medical outpatients.¹⁷ Therefore, our patients might benefit from a system of active reminding, which is not

available in the clinic where this was study conducted, however, the issue of confidentiality of telephone calls should be examined. Whatever the reasons that exist behind non-attendance, it was suggested that the first episode of non-attendance may be an important time to intervene to attempt to prevent loss to follow-up of those with serious mental illnesses.¹⁸

Finally, these results should be interpreted with sets of limitations in mind, such as the study design, the broad definition of attendance that it might include those who have poor attendance, relatively small sample size, and limited generalisability, as the study was carried out in a single hospital. Therefore, we recommend further examination of the characteristics of non-attenders in a prospective study, taking into account the drawbacks mentioned above and to evaluate the reasons of non attendance as this will be helpful in planning solutions to this problem.

Acknowledgment. I would like to thank Dr. Hadeel Daghush for her valuable help in data analysis.

References

1. Goldman L, Freidin R, Cook EF, Eigner J, Grich P. A multivariate approach to prediction of no-show behavior in a primary care center. *Arch Intern Med* 1982; 142: 563-567.
2. Barron William M. Failed appointments who misses them, why they are missed and what can be done. *Prim Care* 1980; 7: 563-574.
3. Centorrino F, Hernan MA, Drago-Ferrante G, Rendall M, Apicella A, Langar G, et al. Factors Associated with noncompliance with Psychiatric outpatient visits. *Psychiatr Serv* 2001; 52: 378-380.
4. Frankel S, Farrow A, West R. Non-attendance or non-invitation? A case-control study of failed outpatient appointments. *BMJ* 1989; 298: 1343-1345.
5. Ashley R. Rationing out-patients: A defense of the waiting list. *Br J Psychiatry* 1976; 128: 138-141.
6. Al-Subaie AS. Overview: Psychiatry in Saudi Arabia: Cultural Perspectives. *Transcultural Psychiatric Research Review* 1989; 26: 245-262.
7. Al-Subaie AS. Traditional healing experiences in Patients attending a University outpatient clinic. *Arab Journal of Psychiatry* 1994; 5: 83-91.
8. Hussien Faraj M. A Study of the role of unorthodox treatments of psychiatric illnesses. *Arab Journal of Psychiatry* 1991; 2: 170-184.
9. Kruse GR, Rohland BM, Wu X. Factors associated with missed first appointments at a Psychiatric Clinic. *Psychiatr Serv* 2002; 53: 1173-1176.
10. al-Shammari SA. Failures to keep primary care appointments in Saudi Arabia. *Fam Pract Res J* 1992; 2: 171-176.
11. Edlund M, Wang P, Berglund P, Katz S, Lin E, Kessler R. Dropping out of mental health treatment: Patterns and predictors among epidemiological survey respondents in the United States and Ontario. *Am J Psychiatry* 2002; 159: 845-851.
12. Jellinek M. Referrals from a psychiatric emergency room: relationship of compliance to demographic and interview variables. *Am J Psychiatry* 1978; 135: 209-213.

13. Sharp DJ, Hamilton W. Non-Attendance at general practices and outpatient clinics. *BMJ* 2001; 323: 1081-1082.
14. Campbell B, Staley D, Matas M. Who misses appointments – an empirical analysis. *Can J Psychiatry* 1991; 36: 223-225.
15. Ronan M, Emma EK. Non-Attendance rates among patients attending different grades of psychiatrist and a clinical psychologist within a community mental health clinic. *Psychiatric Bulletin* 2004; 28: 5-7.
16. Al-Shammari SA, Ali M, Al-Shammary AR, Armstrong K. Prevalence of no-shows at family practice clinic, King Fahad National Guard Hospital, Riyadh. *Saudi Med J* 1993; 14: 527-531.
17. Killaspy H, Banerjee S, King M, Lloyd M. Prospective controlled study of psychiatric out-patients non-attendance. Characteristics and outcome. *Br J Psychiatry* 2000; 176: 160-165.
18. Tyrer P. Non-attendance, non-residence, non-acceptance. *Br J Psychiatry* 2000; 176: 596.

**Do you have any comments or questions?
Agree or disagree with published articles?**

The correspondence section within the journal is a forum to comment on any of the articles published in the journal. Correspondence will not be sent for peer review, and will only be edited for the use of appropriate language. All correspondence should be submitted and published within 6 months from the date of the original publication.

Please submit your correspondence through the journal website (www.neurosciencesjournal.org), and don't forget to clearly state the title of the original publication, and your contact details.