

WHY PATIENTS FAIL TO ATTEND PSYCHIATRIC OUTPATIENT FOLLOW-UP: A PILOT STUDY

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ABSTRACT

Patients who failed to attend psychiatric outpatient follow-up were compared with a group of comprising regular attenders. There were 71 defaulters out of 1,664 appointments given during the study period. Schizophrenia was the most common diagnosis. The defaulters did not differ from the controls in terms of age, sex, ethnicity, occupational or marital status. The unemployed were not more likely to be regular, instead, the better educated, shorter intervals between appointments and those given morning appointments were. Those solely on oral medication were more likely to default.

The largest proportion gave reasons of work commitments and of not being free to attend; others claimed they had forgotten their appointments or had lost their appointment cards. Patients who said they did not come because they felt well or still had medication were cause for concern because of possible lack of insight and non-compliance with their medication.

Keywords: *psychiatric outpatient clinic, non-attendances*

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INTRODUCTION

The importance of compliance to psychiatric outpatient follow-up cannot be over-emphasised. This is especially so in the case of patients suffering from psychotic illnesses in whom reliance upon outpatient services is desirable over a long term period. In these patients the risk of relapse is considerable when treatment is discontinued. This study examines the reasons why patients failed to keep their outpatient appointments.

The outpatient clinic in our study serves the eastern part of Singapore. Approximately 970 patients are registered with the clinic which is located within a primary health care facility. The clinic is open 2 days a week, and on each day there are morning and afternoon sessions.

Entry Criteria

The following categories of patients were deemed suitable for the study:

- (1) patients who failed to turn up for their appointment despite the allowance of a 2-week "grace period";
- (2) prior to their appointment or at any time within the 2 week "grace" period, they did not contact the clinic to cancel or postpone their appointment;
- (3) patients must have attended the clinic for at least 6 months before the period of the study. This was to allow us to assess the regularity of their attendances prior to the study period. It was also to facilitate the identification of a group of patients with no missed appointments to form a control. Had the

period been longer, fewer patients with a 100% attendance record would have qualified.

Exclusion Criteria

The following categories of patients were excluded from the study:

- (1) patients who had never attended the clinic despite having been referred previously;
- (2) patients who had attended the clinic for less than 6 months prior to the period of the study;
- (3) patients who had contacted the clinic before their appointments were due or during the 2-week "grace" period to postpone or cancel their appointment;
- (4) patients who arrived earlier than the scheduled date.

The 2-week grace period was allowed for the following reasons:

- (a) it was thought that a longer period would be unwise in view of a higher possibility of relapse;
- (b) patients who had missed their appointment could return to the clinic at the next available clinic day either during the week or on the following week. Therefore we would expect the patients to turn up or at least make contact within a 2-week time limit.

Regularity of attendance in the previous 6 months was judged according to the following criteria:

- | | |
|------------------|---------------------------------|
| very regular | : no missed appointments |
| regular | : missed 1 appointment |
| irregular | : missed 2-3 appointments |
| highly irregular | : missed 4 or more appointments |

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METHOD

All patients who had defaulted follow-up between 1 December

92 and 28 February 93 were identified. If, after 2 weeks from the date of their appointments, they had neither arrived nor made contact with the clinic, a telephone call or a letter offering another appointment would be sent. On the patients' subsequent arrival, a research questionnaire was administered.

Should the patient persist in not attending, or could not be contacted on the telephone, a community psychiatric nurse (CPN) would make a domiciliary visit to administer the questionnaire.

Of the total number of defaulters identified during the study period, fifty patients were randomly selected for further analysis. Another cohort of fifty patients, who had not missed any appointment during the period of 6 months prior to the study period, were selected at random to form a control group.

RESULTS

There were 71 non-attendances out of 1,664 appointments given during the study period, a rate of 42.7 per one thousand. The mean age of the defaulters was 46.9 years. Forty-two percent were males. Nineteen percent had received no education whereas 36% had primary and 38% secondary education. None of the patients had received tertiary education. The majority of the patients (85%) suffered from schizophrenia, the rest suffered from depression (8%), neurosis (2%), mental retardation (3%), organic brain disorder (1%) and substance abuse disorder (1%). Sixty-two percent were unemployed at the time of the study, only 27% were working full-time, 10% on a part-time basis. Of those who were working, 56% were occupied during office hours, the rest (44%) were working shift duties. The main types of occupations included machine operators, clerical jobs, sales assistants and security work. Eighteen percent attended the clinic during their off days whereas 14% attended during their working hours. Slightly more than half (54%) of the patients were single, 29% were married, 8% widowed and 3% divorced. The marital status of 6% of the defaulters was not known. Eighty-two percent were Chinese, 12% Malay, 3% Indian and 3% of other ethnic backgrounds. This corresponded fairly well to the ethnic distribution of the population of Singapore.

The defaulters did not differ from the controls in terms of age, sex, ethnicity, occupational history or marital status. Slightly more than half (51%) attended the clinic alone. These were not more likely to default compared to those who were accompanied on their visits. (Table I)

Table I - Reasons for non-attendance

Reasons for non-attendance	No. of patients
Lost appointment card or forgot appointment	12
Feeling well	10
Not free	9
Still have medication	8
Work commitments	6
Not well physically	6
On holiday	4
Refused interview	3
Died	2
Left home	2
Bad weather	1

The most frequent reason given for non-attendance was "forgetting the appointment" or "losing the appointment card". Six patients gave the reason as "work commitments", another 6

were feeling physically unwell, although none of this was related to side effects of psychotropic medication. Although there were many defaulters who gave reasons of work commitments, the unemployed were not more likely to be more regular.

During the study period, none of the defaulters was admitted to any general or psychiatric hospital in relapse. None of them had sought treatment from other psychiatric clinics either in the government or private sector. No patient had consulted any traditional healers during this period. But an unspecified number had seen their general practitioners and 2 had been hospitalised for physical disorders. Seven were admitted to Woodbridge Hospital between 3-7 months after the survey period. From the control group, 4 were admitted. None of these had relapsed during the survey period.

The regularity of past attendances of the defaulters was such that 80% had missed up to one appointment in the preceding 6 months. Sixteen percent were considered irregular and only 4% were highly irregular.

Those who were prescribed tablet medication seemed more likely to default compared to those who were on depot injections. However, the difference did not reach statistical significance ($\chi^2 = 2.45, p > 0.05$).

Patients who were given appointments at 4 weekly intervals or less did not seem as likely to default follow-up when compared with those given appointments at intervals greater than 4 weekly. Once again, the difference was short of statistical significance ($\chi^2 = 7.8, p > 0.05$).

Educational status showed an association with compliance to follow-up, with regular attenders tending to be better educated (Table II). Defaulters tended to be in positions of employment in contrast to the control group who had higher numbers unemployed.

Table II - Educational level of defaulters and controls

Educational Level	Defaulters	Controls
Primary	22	14
Secondary & Pre University	13	25

$\chi^2 = 4.26, p < 0.05$

Table III - Timing of appointments

Appointment time	Defaulters	Controls
Morning	9	20
Afternoon	36	28

$\chi^2 = 4.12, p < 0.05$

Those scheduled for morning sessions were less likely to miss their appointments compared to those given afternoon appointments (Table III).

DISCUSSION

The rate of non-attendance was generally low (42.7 per 1,000 appointments). Eighty percent of the non-attenders had been very regular 6 months prior to their default. In view of their excellent attendance record it is hardly surprising that the characteristics of the defaulters did not vary much from those of the control group.

Another study⁽¹⁾ had made use of a one-month default period. Any further extension of this period would be undesirable in view of an even greater likelihood of relapse. The present practice of allowing for a 2-week default period had not resulted in any

relapses requiring re-admissions. In fact the re-admission rates of defaulters were not significantly higher than those of the controls.

The better educated were less likely to miss their appointments, a finding compatible with the observations of Del Gaudio et al⁽²⁾, and Raynes and Warren⁽³⁾. Interestingly, morning clinic attenders were less likely to default compared to those given afternoon appointments. The precise reasons are unclear but it is possible that:

- (a) patients could have had more difficulty obtaining time off from work in the afternoon;
- (b) patients could have scheduled their activities in the afternoon, which coincided with their clinic appointments;
- (c) afternoon clinics were probably less popular because of the hot weather. However, only one of the non-attenders cited weather as the reason for not attending.
- (d) the same psychiatrist was on duty during both the morning sessions, whereas in the afternoon clinics patients would be followed-up by different doctors.

Chen⁽⁴⁾ in arguing for consistency and continuity of care, had suggested that it would be preferable for the psychiatrist who had treated the patient in the hospital to follow-up the patient in the outpatient clinic. Understandably, better rapport could be built up. Conversely, the patients would also be more familiar to the psychiatrist. In our clinic, having the benefit of seeing a familiar professional probably proved popular with the morning clinic attenders.

It has been recommended^(4,5) that the interval between appointments should not be too long. Some⁽³⁾ have demonstrated that a waiting period beyond 15 days adversely affected patient compliance. In our study, we found that defaulters were more often those with appointments scheduled at greater than 4 weekly intervals. Should appointments be given too far into the future, patients are more likely to forget the appointment date or lose their appointment cards.

The largest proportion said they were unable to attend because of work commitments or because they were not free. Assuming these were truthful responses, they would suggest that the patients were functioning fairly well and were engaged in purposeful activities. On the other hand, those who gave reasons of "feeling well" would be cause for concern. The implication would be that such patients did not see the need to attend outpatient clinic and might even hint at possible non-compliance with medication. By the same token, the case of patients who did not attend because they still had enough medication, would lead one to assume they were not taking their medication or they had not been taking their medication regularly or in the dosages prescribed. Such patients would be prone to relapses. In patients with schizophrenia, lack of insight, denial of illness and paranoid delusions had been cited as major causes of non-compliance⁽⁶⁻⁸⁾. Those who flatly refused to be interviewed at home and were uncooperative when visited by the CPN probably reflect the type of patients described as "hostile" by Amdur⁽⁹⁾. Such patients, together with those expressing "denial" and "ambivalence" were

also less likely to cooperate with treatment and therefore faced a greater risk of relapse.

In order to lessen the numbers of defaulters whose reason for not attending was that they had forgotten their appointments, Chen⁽⁴⁾ and Carr⁽¹⁰⁾ suggested the use of telephone calls to remind patients of their appointments. But Chen⁽⁴⁾ also pointed out, rightly so in our opinion, that this method was not cost effective. Others^(11,12) suggested the use of postal reminders. We feel that this procedure may be worth considering if it is applied to those who are known to be habitual defaulters and whose absenteeism from follow-up had led to previous relapses and admissions. It has been our experience that the majority of absent patients do turn up when they had received a telephone call or a letter offering them another appointment.

Perhaps, a future study involving a larger cohort of defaulters, in the context of repeated absences and allowing for a longer "grace" period might reveal greater differences between attenders and non-attenders.

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