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Why do psychiatrists have difficulty disengaging with the out-patient clinic?†

Invited commentary on … Why don't patients attend their appointments?

Helen Killaspy

Abstract In this issue of *APT* Mitchell & Selmes present an article detailing why patients miss appointments and how clinicians should respond. Many of the papers quoted relate to the psychiatric out-patient clinic. In this commentary, as well as picking up on some of the themes that emerge from their article, I explore the attachment that psychiatrists seem to have to this particular model of patient contact.

The evidence that non-attendance of patients at psychiatric out-patient clinics is a major problem that is highly wasteful of resources is unequivocal, but evidence-based guidance regarding what to do about missed appointments is much less clear. Up to 50% of people with any form of mental health problem miss an appointment either in primary or secondary care at some point during a treatment episode, around 30% of all psychiatric out-patient appointments are missed and somewhere between a quarter and a half of people who miss an appointment completely disengage from mental health services (Killaspy, 2006; Mitchell & Selmes, 2007, this issue). However, the consequences of missing an appointment are more serious for people with severe and enduring mental health problems such as schizophrenia, schizo-affective disorder and bipolar affective disorder, who are much more likely to require a subsequent admission than those with common mental disorders (Koch & Gillis, 1991; Pang *et al*, 1996; Killaspy *et al*, 2000). Most people being seen as follow-up patients have a diagnosis of a severe and enduring mental health problem, whereas newly referred patients generally have common mental disorders (Johnson, 1973; Morgan, 1989; Killaspy *et al*, 2000).

Response to missed appointments

It follows that the response of services to missed appointments should be in keeping with the seriousness of the consequences, yet current evidence for telephone prompts and other interventions to encourage attendance is equivocal at best and only relates to studies in newly referred patients (Macharia *et al*, 1992; Reda & Makhoul, 2001). Mitchell & Selmes (2007, this issue) state that 'Many [patients] who miss appointments because of slips and lapses later rearrange without adverse consequences'. If this were true, there would be no indication for these authors' recommendation that further clinic appointments be sent after a non-attendance without first awaiting contact from the patient. However, the study on which this statement is based (Sparr *et al*, 1993) was carried out in a military clinic for combat veterans in the USA and had several methodological limitations such that the results have to be interpreted with caution: the non-attendance rate was particularly low (9%); data were collected retrospectively from the treating clinician without corroboration from the case notes; and no definition of what was meant by an 'adverse outcome' was given. Sparr *et al* 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. However, in our prospective study of non-attenders at a psychiatric out-patient clinic in London, we found that both new and follow-up patients who missed a single appointment were very

†See pp. 423–434, this issue.

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unlikely to re-engage with the clinic (Killaspy *et al*, 2000), and one study from outside the UK found that only half those who missed an appointment re-engaged (Pang *et al*, 1996).

These 'slips and lapses' are a combination of clerical error on the part of the clinic and, with regard to follow-up patients, social disorganisation secondary to the executive dysfunction and negative symptoms of the mental illness. Clerical error accounts for a lower proportion of missed appointments in psychiatric clinics (5–12%: Sparr *et al*, 1993; Killaspy *et al*, 2000) than in other medical specialties (28–33%: Verbov, 1992; Potamitis *et al*, 1994) but this is a potentially preventable cause of non-attendance. Although simple systems to remind patients about their appointments may appear to have face validity, they can only be effective for people who are contactable, such as those who actually have a working telephone (Burgoyne *et al*, 1983). The associated resources involved also have to be considered and there are currently no published examples of well-conducted cost-effectiveness analyses of telephone or other prompts to reduce non-attendance at mental health appointments in the UK. Written information leaflets and orientation statements, which are helpful in reducing anxiety about the appointment for newly referred patients, may be more effective at improving attendance rates than prompts (Kluger & Karras, 1983; Swenson & Pekarik, 1988).

Relevance of the out-patient model in contemporary mental health services

Last year I was invited to write a review article for *APT* on the origins and future of the out-patient clinic in contemporary mental health services (Killaspy, 2006). This article detailed the history of how the model developed some 300 years ago from a vehicle to triage new admissions to asylums and later became a replica of the approach used in other medical specialties for patient assessment and review. Given the consistently high non-attendance rates and evidence of poor outcomes for non-attenders with severe and enduring mental health problems, I suggested that it might be time to review the usefulness of the clinic model for this client group. I explored an alternative approach that could be integrated within our existing and highly developed community mental health services to facilitate assessment and brief interventions for newly referred patients with common mental disorders and that would provide appropriate triage for patients requiring longer-term care from secondary mental health services.

New Roles for Psychiatrists (National Working Group on New Roles for Psychiatrists, 2004) and the *Mental Health Policy Implementation Guide: Community Mental Health Teams* (Department of Health, 2002) have far reaching implications and contain detailed guidance on the delivery of assessment services for patients newly referred to mental health services and on ongoing treatment for patients with severe and enduring mental health problems. Both documents describe a secondary mental health service that appears to have no out-patient clinics. So why, despite the relevant policy to support a new direction, are psychiatrists still inclined to use the clinic model? Is it because we see ourselves as hospital doctors whose activity is measured in the familiar approach of the out-patient clinic? Is it that we enjoy the only part of the job where we get to form a one-to-one therapeutic alliance with our patients, providing a welcome relief from our usual role of multidisciplinary team work? Are we underconfident in our non-medical colleagues' skills in assessment and one-to-one interventions? Are there some more-challenging patients that we feel only we have the experience to contain?

None of these possible explanations has been researched, but in exploring the issue of the therapeutic alliance, Mitchell & Selmes suggest that the patient's perception of the therapeutic alliance with the clinician and of the latter's helpfulness is important in preventing disengagement from the clinic ('Attendance at follow-up appointments is more a reflection of the patient's satisfaction with care than of the perceived need for further help'). However, the two large studies that have investigated satisfaction with psychiatric out-patient services have not found a statistically significant relationship between dissatisfaction with care and drop-out (Killaspy *et al*, 1998; Rossi *et al*, 2002), although considerable patient dissatisfaction has been expressed about being seen by the junior doctor rather than the consultant (Killaspy *et al*, 1998; McIvor *et al*, 2004). In fact, the content of the interaction between patients with psychosis and their psychiatrists appears to be rather unsatisfactory at out-patient appointments (McCabe *et al*, 2002).

The report on proposed new roles for consultant psychiatrists highlighted the problems of the out-patient clinic model:

> 'There was almost universal dissatisfaction with out-patient clinics. The doctor is isolated from the team and patients frequently do not attend. Patients may present very differently in the artificial environment leading to differences with staff who see the patient at home. Patients are brought back routinely so as not to lose touch with them rather than out of necessity' (National Working Group on New Roles for Psychiatrists, 2004: p. 12).

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Since out-patient non-attendance is no longer a Healthcare Commission performance indicator, it is likely that managerial attention on the out-patient clinic will fade. The evidence currently suggests that the out-patient model is best targeted at people who are most able and likely to keep appointments and that alternative approaches are indicated for those with more complex mental health problems, including assertive outreach for particularly 'difficult-to-engage' clients. A more radical review of the model could allow the integration of assessment and brief interventions for newly referred patients, and multidisciplinary triage of those requiring longer-term care under the care programme approach within the full range of community mental health services. Alternatively, we could continue to organise our services so that the most expensive member of the team sees the patients with the least complex problems and accept the resultant waste of resources when 1 in 3 do not attend.

Declaration of interest

None.

References

Burgoyne, R. W., Acosta, F. X. & Yamamoto, J. (1983) Telephone prompting to increase attendance at a psychiatric outpatient clinic. *American Journal of Psychiatry*, **140**, 345–347.

Department of Health (2002) *Mental Health Policy Implementation Guide. Community Mental Health Teams*. Department of Health

Johnson, D. A. W. (1973) An analysis of out-patient services. *British Journal of Psychiatry*, **122**, 301–306.

Killaspy, H. (2006) Psychiatric out-patient services: origins and future. *Advances in Psychiatric Treatment*, **12**, 309–319.

Killaspy, H., Gledhill, J. & Banerjee, S. (1998) Satisfaction of attenders and non-attenders with their treatments at psychiatric out-patient clinics. *Psychiatric Bulletin*, **22**, 612–615.

Killaspy, H., Banerjee, S., King, M., *et al* (2000) Prospective controlled study of psychiatric out-patient non-attendance. Characteristics and outcome. *British Journal of Psychiatry*, **176**, 160–165.

Kluger, M. & Karras, A. (1983) Strategies for reducing missed initial appointments in a community mental health centre. *Community Mental Health Journal*, **19**, 137–143.

Koch, A. & Gillis, L. S. (1991) Non-attendance of psychiatric outpatients. *South African Medical Journal*, **80**, 289–291.

Macharia, W. M., Leon, G., Rowe, B. H., *et al* (1992) An overview of interventions to improve compliance with appointment keeping for keeping medical services. *JAMA*, **267**, 1813–1817.

McCabe, R., Heath, C., Burns, T., *et al* (2002) Engagement of patients with psychosis in the consultation: conversation analytic study. *BMJ*, **325**, 1148–1151.

McIvor, R., Ek, E. & Carson, J. (2004) Non-attendance rates among patients attending different grades of psychiatrist and a clinical psychologist within a community mental health clinic. *Psychiatric Bulletin*, **28**, 5–7.

Mitchell, A. J. & Selmes, T. (2007) Why don't patients attend their appointments? Maintaining engagement with psychiatric services. *Advances in Psychiatric Treatment*, **13**, 423–434.

Morgan, D. (1989) Psychiatric cases: an ethnography of the referral process. *Psychological Medicine*, **19**, 743–753.

National Working Group on New Roles for Psychiatrists (2004) *New Roles for Psychiatrists*. BMA Publications.

Pang, A. H., Lum, F. C., Ungvari, G. S., *et al* (1996) A prospective outcome study of patients missing regular psychiatric outpatient appointments. *Social Psychiatry and Psychiatric Epidemiology*, **31**, 299–302.

Potamitis, T., Chell, P. B., Jones, H. S., *et al* (1994) Non-attendance at ophthalmology outpatient clinics. *Journal of the Royal Society of Medicine*, **87**, 591–593.

Reda, S. & Makhoul, S. (2001) Prompts to encourage appointment attendance for people with serious mental illness. *Cochrane Database of Systematic Reviews*, issue 2. Oxford Update Software. Art. no.: CD002085. DOI: 10.1002/14651858.CD002085.

Rossi, A., Amaddeo, F., Bisoffi, G., *et al* (2002) Dropping out of care: inappropriate terminations of contact with community-based psychiatric services. *British Journal of Psychiatry*, **181**, 331–338.

Sparr, L. F., Moffitt, M. C. & Ward, M. F. (1993) Missed psychiatric appointments: who returns and who stays away. *American Journal of Psychiatry*, **150**, 801–805.

Swenson, T. R. & Pekarik, G. (1988) Interventions for reducing missed initial appointments at a community mental health centre. *Community Mental Health Journal*, **24**, 205–218.

Verbov, J. (1992) Why 100 patients failed to keep an outpatient appointment – audit in a dermatology department. *Journal of the Royal Society of Medicine*, **85**, 277–278.

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