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Non-attendance rates among patients attending different grades of psychiatrist and a clinical psychologist within a community mental health clinic

AIMS AND METHOD

To examine non-attendance rates in patients seen by psychiatrists of different grades and a consultant clinical psychologist. Rates were obtained from the patient administration system over a 21-month period.

RESULTS

A planned linear contrast showed that the clinical psychologist's

patients had the lowest rate of non-attendance (7.8%), followed in turn by those of consultant psychiatrists (18.6%), specialist registrars (34%) and senior house officers (37.5%).

CLINICAL IMPLICATIONS

Factors such as continuity of care, perceived clinical competence and the provision of non-medical interventions might have an impact

on attendance rates. These results indicate the difficulty in reconciling the training needs of junior doctors with the provision of continuity and quality of care for patients. Reminder systems for people seeing training doctors might be an effective way of reducing non-attendance rates.

Non-attendance by psychiatric out-patients has an important impact on clinical and economic outcomes. The national rate for non-attendance at all types of out-patient clinic in the UK has been reported as 12% (Sharp & Hamilton, 2001), with rates varying depending on setting and speciality (Chen, 1991; Gatrad, 2000). Non-attenders are more likely to be young men from deprived socio-economic backgrounds who have had to wait a long time for their appointment (Lloyd *et al*, 1993; Beauchant & Jones, 1997; Killaspy *et al*, 2000). Rates of non-attendance at psychiatric out-patient clinics are thought to be double those seen in other medical specialities (Killaspy *et al*, 2000), with those not attending being more unwell, having greater social impairment and being more likely to require hospital admission. This may result in increased risk to self or others (Steering Committee of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People, 1996). The initial assessment appointment seems to be of importance in determining whether a patient returns, reflecting confidence in the therapist and satisfaction with therapy (McGuff *et al*, 1996). Missing subsequent psychotherapy appointments has been related to withdrawing from treatment (Berrigan & Garfield, 1981). Simply forgetting an appointment accounts for almost a quarter of non-attendance (Sparr *et al*, 1993; Killaspy *et al*, 2000).

Little research has been conducted into differences in patient non-attendance rates among professions and between different grades of medical staff. Delk &

Johnson (1975) found that patients seeing medical students were more likely to withdraw from treatment compared with those seeing staff members, and Pang *et al* (1996) showed that, in a Hong Kong setting, being seen by a more senior member of staff increased attendance rates. In light of this, we examined whether there were differences in non-attendance rates between different grades of medical staff, and between medical staff and a consultant clinical psychologist. It was predicted that non-attendance rates would be highest for junior medical staff.

Method

The study investigated patients of an inner-city community mental health team in south London. The patient administration system was used to obtain rates of attendance and non-attendance for 482 patients seeing the following members of staff: two consultant psychiatrists (167 patients), two specialist registrars (111 patients), two senior house officers (SHOs) (52 patients) and a consultant clinical psychologist (152 patients). The consultant psychiatrists and the clinical psychologist are permanent members of staff, whereas the specialist registrars and SHOs change every 12 months and 6 months, respectively as part of a training rotation. Cancellations were not included in the analysis, nor were non-attendance rates among new referrals. Data were collected for a 21-month

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papers**Table 1. Monthly non-attendance rates for the different professions over a 21-month period**

Profession (Patient <i>n</i>)	Mean (%)	Mini- mum (%)	Maxi- mum (%)
Clinical psychologist (<i>n</i> =52)	7.8	2	19
Consultant psychiatrists (<i>n</i> =167)	18.6	6	28
Specialist registrars (<i>n</i> =111)	34	28	51
Senior house officers (<i>n</i> =52)	37.5	21	59

period and analysed using the Statistical Package for the Social Sciences, version 10.

Results

Average non-attendance rates varied from 7.8% for the clinical psychologist to 37.5% for the SHOs (Table 1). The hypothesis was tested using a planned linear contrast ($F=287.491$, num. d.f.=1, den. d.f.=80, $P<0.001$). The non-attendance rate for the clinical psychologist was significantly lower than the rates for the medical staff, which increased progressively for consultant psychiatrists, specialist registrars and SHOs.

Discussion

Continuity of care, clinical competence and differences in clinical style are hypothesised to be the main reasons for the significant differences in non-attendance rates between groups. The consultant clinical psychologist and consultant psychiatrists saw most of their patients over long periods, which allowed the development of a good rapport and a positive, uninterrupted therapeutic relationship. Non-consultant medical staff, on the other hand, rotated every 6 or 12 months, resulting in interruption of clinical care. This change in medical staff might have adversely affected patients' willingness to attend their appointment.

Why did the clinical psychologist have a lower non-attendance rate than the psychiatrists? A contributing reason might be that clinical psychologists tend not to see people who are acutely ill; non-attendance has been shown to be related to severity of illness for patients with psychiatric problems (Lloyd *et al*, 1993; Killaspy *et al*, 2000). In addition, clinical psychologists are not involved in mental health assessments for compulsory admission or other practices perceived to be coercive, such as those relating to hospitalisation or medication. Psychology is perceived to be less stigmatising and more acceptable to the patient: the 'poor image' of psychiatry has been reported by patients as one of the main reasons for not attending appointments (Hillis & Alexander, 1990). Furthermore, clinical style may be important, with psychologists more likely to emphasise principles of therapeutic alliance, collaboration and education, factors that have been found to correlate positively with appointment-keeping and patient satisfaction (Fiester & Rudestam, 1975). Although we did not measure

frequency or length of appointments, contact with the psychologist might have been perceived as having a more defined therapeutic focus, with longer and more frequent (usually weekly) sessions encouraging engagement.

Overall, non-attendance rates for medical staff were high, with rates significantly lower with greater seniority. Experience and perceived clinical competence may be an important factor in non-attendance rates. Less experienced staff may not feel as competent in dealing with complex patient issues. Quality of care might thus be higher for patients seeing a consultant. In addition, patients may feel they are being given a better service simply by seeing a more senior member of staff.

Study limitations

We did not directly examine the reasons behind our findings. Frequent failures to attend by individual clients were not controlled for, and it is possible that a small number of patients who repeatedly failed to attend skewed rates. Furthermore, there may be differences between the patients seen, with consultant psychiatrists being more likely to see chronic attenders, and junior medical staff seeing patients with a range of clinical profiles, involving short-term interventions or longer-term work. As the study was conducted in a deprived inner-city area, it is possible that the findings are not representative.

Implications

Non-attendance rates have a significant impact on clinical and economic outcomes. If continuity of care and level of experience are possible factors influencing non-attendance rates, our findings reinforce the difficulty in reconciling the needs of medical training with the provision of patient care. Training doctors have to rotate between sub-specialities in order to gain necessary experience, and it is not possible for consultants to see everyone. Ideally, the same professional should see clients for the duration of their treatment, but clearly this is not always possible.

Effective strategies to reduce non-attendance rates include the use of telephone or postal reminders (Rusius, 1995; Read *et al*, 1997; Hardy & Furlong, 2001); offering patients a choice of time and date (Read *et al*, 1997); and writing a personal letter rather than a standard appointment card (Hillis & Alexander, 1990). Such interventions have reduced non-attendance by up to 60% (Read *et al*, 1997). These strategies should be targeted at people seeing staff below consultant grade. If non-attendance persists, a number of options are available to the team, including contact with the general practitioner, or an acknowledgement that the patient does not wish to be assessed or seen. If there is concern about the patient in relation to mental state or risk, then a home visit is indicated. The use of assertive outreach or assertive community treatment, if available, may be useful in this regard, although such programmes tend to focus on those with severe and enduring mental illness rather than those attending out-patient clinics only.



However, assertive outreach can facilitate contact with patients who are hard to engage (Lehman et al, 1997), and the development of such services has been encouraged in the UK (Department of Health, 1999).

Future research will examine non-attendance rates in patients seen by psychologists of different grades and by other members of the community mental health team.

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