

Study of factors associated with drop out after first visit to psychiatric clinic

Jaspreet Kaur, BS Chavan, Archana Sharma, Lok Raj, Chandrabala

Abstract : *Despite the availability of effective regimens of pharmacotherapy and psychotherapy, only a small fraction of patients with common mental disorders are adequately treated in a year. Dropping out of mental health services is very common. Identifying the extent and reasons for treatment dropout is a critical task. The present study was carried out at the Out Patient Department (OPD) of Psychiatry. The data of all new patients attending the clinic from January to December (1999) were scrutinized one year after the initial assessment (retrospective study). Study group included drop out patients after first visit to Psychiatry OPD (N=180) and control group comprised of 180 consecutive patients of same year who continued in treatment after first contact. The drop out patients were assessed for reasons for drop out. The highest number for drop out included patients who had improved and did not feel need for further treatment. Another three major reasons were migration and transfer, patient taking treatment from other hospital; stigmatization etc. Successful initiation and adherence to mental health treatments depend on patients' knowledge and awareness, clinician's timely treatment and advice, clinician's communication skills and less waiting period in OPD and simple treatment seeking procedures.*

Keywords : Reasons, Drop out, Psychiatry patients

JMHHB 2009; 14(2) : 87-94

INTRODUCTION

Despite the availability of effective regimens of pharmacotherapy and psychotherapy, only a small fraction of patients with common mental disorders are adequately treated in a year.¹⁻² Among those who enter treatment, 40 to 60 percent leave prematurely and against the advice of treatment providers. In the developing countries, 80 to 90 percent of the people with depression don't receive adequate treatment.³ The high rate of dropping out of treatment further reduces the number of families who receive care. Yet other consequences heighten the significance of dropping out of treatment. First, those who drop out are much less likely to improve, compared to those who remain in treatment.⁴⁻⁵ Second, those

who drop out tend to be significantly more impaired than those who remain in treatment,⁶ so that the cases in greater need are less likely to receive care. Third, dropping out of treatment increases the costs of providing clinical services. Multiple cancelled and missed appointments, more likely among those who eventually drop out, increase the costs of services and occupy treatment slots that might be provided to others.

Recent research has begun to shed light on some components of this problem, such as the failure of mentally ill people to recognize that they have clinically significant emotional problems, their failure to seek treatment once the need is recognized, and the failure of the treatment

system to provide adequate treatment.⁷⁻⁹ However, less is understood about the extent to which patients fail to adhere to full course of treatment. Prior studies of treatment dropouts have often been limited by small and restricted study groups, such as patients with single mental disorder or patients from single treatment setting. Perhaps because of such limitations, these studies have produced inconsistent findings regarding both the frequency and predictors of treatment dropout.¹⁰⁻¹¹

Identifying the extent and reasons for treatment dropout is a critical task for several reasons. Most importantly, mental health treatments that are delivered for inadequate durations are ineffective. Dropping out of mental health is very common, perhaps because of limited resources, impulsive or disorganized behavior, pessimism regarding treatment effectiveness and sensitivity to treatment side effects. Disagreement between parents and doctors over perception of their problems and proposed treatment strategies has been associated with drop out. In a study,¹² it was reported that families who dropped out were more likely to have been upset by the interpersonal aspect of the interview, suggesting that the sensitivity of the staff in their communication with the family is an important contributor.

In another study,¹³ authors followed up the adjustment of child psychotherapy patients four months after intake and found no significant difference between the drop out group and those who remained in treatment. Dissatisfaction with the service and environmental obstacles to continue treatment are both associated with poor outcome in those children who had dropped out.¹⁴ Certain other salient predictors of dropping out of treatment among patients include socio economic disadvantage, difficult living circumstances for the parent and child, family stress and life events.

Compliance with clinic attendance may also be affected by socio cultural factors and health belief models. The variables that are usually studied encompass broad characteristics that could promote dropping out for multiple reasons. These characteristics alone or in combination might be the basis for dropping out.

Information on the prevalence and determinants of treatment dropout is essential for designing and targeting interventions and health care policies to increase the proportion of patients who complete adequate course of care.

Keeping above review in mind, the objective of the present study was to study reasons of drop out from psychiatry clinic after the first visit.

METHODOLOGY

The present study was carried out at the out patient department of psychiatry. The data of all new patients attending the clinic from January to December were scrutinized one year after the initial assessment (retrospective study). Out of 1926 patients in the year 1999, 180 patients, who dropped out after first contact with psychiatry OPD, were contacted. Sample comprised of study group and control group with N=180 in each. Study group included drop out patients after first visit to psychiatry OPD, residing in and around Chandigarh. Control group comprised of 180 consecutive patients of same year who continued in treatment after first contact.

Drop out group was defined as patients who did not come after first visit for follow up. Treatment group (control) was defined as patients coming for subsequent follow-ups after first visit. The drop out patients were contacted and subsequently interviewed over the telephone and through home visit by medical social worker. Semi structured schedule consisting of 30 items was administered to assess reasons for drop

out. Socio demographic data was obtained for all the patients. Clinical variables like duration of illness, onset of illness, precipitating factor, course of illness, past history, associated medical illness and diagnostic categories were taken. Diagnoses were made as per ICD-10 criteria. Similar assessment was carried out for control group. Descriptive statistics was used for interpretation.

RESULTS

On comparing the socio demographic variables of the study group and the control group (Table 1), there was no difference in the mean age, marital status, occupation and education among the two groups. The number of males in control group was higher (64.4%) as compared to the females whereas males and females were

Table 1
Comparison of socio-demographic variables

		Study Group N = 180(%)	Control Group N= 180(%)
Age	Mean (SD)	32.75 (17)	32.56 (14.36)
Sex	Male	89 (49.5)	116 (64.4)
	Female	91 (50.5)	64 (35.6)
Marital status	Married	109 (60.6)	114 (63.3)
	Unmarried	71 (39.4)	66 (36.7)
Occupation	Unemployed	103 (57.2)	102 (56.7)
	Semi Professional	61 (33.9)	62 (34.4)
	Professional	16 (8.9)	16 (8.9)
Education	Illiterate	14 (7.8)	27 (15)
	Till Matric	86 (47.8)	87 (48.3)
	Above Matric	80 (44.4)	66 (36.7)
Income	Less than 2500	61 (33.9)	85 (47.2)
	2500-6000	56 (31.1)	47 (26.1)
	6000 & above	63 (35)	48 (26.8)
Religion	Hindu	124 (68.9)	123 (68.4)
	Sikh	51 (28.3)	53 (29.4)
	Others	5 (2.8)	4 (2.2)
Family type	Nuclear	106 (59)	103 (57.3)
	Extended	5 (2.7)	5 (2.7)
	Joint	69 (38.3)	72 (40)
Residence	Chandigarh/Punjab/Haryana	136 (75.6)	138 (76.7)
	Others	44 (24.4)	42 (23.3)
Locality	Urban	165 (91.7)	118 (65.6)
	Rural	15 (8.3)	62 (34.4)
Source of referral	Direct	80 (44.4)	98 (54.4)
	Other Departments	100 (55.6)	82 (45.6)
Informant	Present	146 (81.1)	150 (83.3)
	Absent	34 (18.9)	30 (16.7)

Table 2
Comparison of clinical variables

		Study Group N = 180(%)	Control Group N= 180(%)
Diagnostic categories	Substance Abuse Disorder	17 (9.4)	18 (10)
	Schizophrenia & Related Disorder	7 (3.8)	26 (14.4)
	Affective Disorder	52 (28.8)	51 (28.3)
	Neurotic Disorder	62 (34.4)	60 (33.3)
	Others	42 (23.6)	25 (14)
Associated medical illness	Present	43 (23.9)	29 (16.1)
	Absent	137 (76.1)	151 (83.9)
Family history	Present	42 (23.3)	43 (23.9)
	Absent	138 (76.7)	137 (76.1)
Past history	Present	27 (15)	39 (21.7)
	Absent	153 (85)	141 (78.3)
Duration of illness	< six months	65 (36.1)	69 (38.3)
	6 months-2 yrs	33 (18.3)	25 (13.9)
	> 2 years	82 (45.6)	86 (47.8)
Onset of illness	Acute	29 (16.1)	47 (26.1)
	Sub Acute	56 (31.1)	48 (26.7)
	Gradual	95 (52.8)	85 (47.2)
Precipitating Factor	Present	75 (41.7)	67 (37.2)
	Absent	105 (58.3)	113 (62.8)
Course of illness	Continuous	96 (53.3)	93 (51.7)
	Episodic	28 (15.6)	31 (17.2)
	Others	56 (31.1)	56 (31.1)

Table 3
Reasons for drop out

REASONS FOR DROP OUT	N (%)	REASONS FOR DROP OUT	N (%)
1. Patient improved and did not feel need for further treatment	58 (32.2)	13. Enough time was not spent with patient and his/her attendants	5 (2.5)
2. Patient migrated/shifted/transferred to other place	52 (28.8)	14. Arrangement for basic necessities like water, toilets etc was not available	5 (2.5)
3. Patient taking treatment from other hospital	47 (26.1)	15. Patient was informed that no further treatment is required	3 (1.6)
4. Other reasons like stigmatization, going to faith healers etc.	43 (23.8)	16. Prescribed drugs not available in the hospital	3 (1.6)
5. Complicated treatment seeking procedures	33 (18.3)	17. Investigation charges were too high	3 (1.6)
6. Long waiting period in OPD	33 (18.3)	18. Security personals were strict/ Medicines not available in hospital dispensary/death of patient	3 (1.6)
7. No improvement with treatment	28 (15.5)	19. Nature of illness was not explained	2 (1.1)
8. Hospital too far from home	14 (7.7)	20. Investigations/ Diagnostic tests were not advised	2 (1.1)
9. Patient suffering from other medical problems requiring early treatment	14 (7.7)	21. Certain treatment facilities like ECT, Psychotherapy not available	2 (1.1)
10. Patient unwilling to come	14 (7.7)	22. No attendant to bring patient to hospital	2 (1.1)
11. Misbehavior of doctors	13 (7.2)		
12. Prescribed drugs caused side effects	9 (5)		

Table 4
Analyses of reasons in relation to diagnosis

	Substance Abuse Disorder	Schizophrenia & Related Disorder	Affective Disorder	Neurotic Disorder
1. Patient improved & felt no further need for treatment	1 (1.7%)	1 (1.7%)	13 (22.4%)	28 (48.2%)
2. Patient shifted to other place	5 (9.6%)	1 (1.9%)	16 (30.7%)	22 (42.3%)
3. Patient going to other hospital for treatment	6 (13.1%)	4 (8.5%)	13 (27.6%)	10 (2.1%)
4. Other reasons like stigmatization etc.	8 (18.6%)	1 (2.3%)	10 (23.2%)	12 (27.9%)
5. Complicated treatment seeking procedures	3 (9%)	1 (3.1%)	11 (33.3%)	13 (39.3%)
6. Long waiting period in hospital	3 (9%)	2 (6%)	12 (36.3%)	10 (30.3%)
7. No improvement with treatment	3 (10.7%)	-	9 (32.1%)	11 (39.2%)

almost equal in number in the dropout group (49.5% and 50.5% respectively).

The comparison between the clinical variables of the two groups is depicted in Table 2. All variables were similar in the two groups except the control group had more patients with schizophrenia than the study group

Reasons for dropping out are given in Table 3. The highest number for dropping out included patients who had improved and did not feel need for further treatment (32.2%). Another three major reasons for drop out were of patients who had migrated, shifted, transferred to other place; patient taking treatment from other hospital; and other reasons like stigmatization etc (28.8%, 26.1%, 23.8%) respectively.

Table 4 shows the analysis of reasons in relation to diagnosis.

DISCUSSION

One of the major challenges of mental health professionals and policy planners is to improve treatment seeking behavior as 80 to 90 percent of mentally ill patients are not seeking treatment. On the other hand, patients who do seek treatment drop out of treatment after initial

contact. Due to chronic nature of mental disorders and long term treatment, retention of patients into treatment is very crucial. The reasons of early drop out need to be recognized and handled.

This study attempted to explore some of the reasons behind drop out from psychiatric clinic. In the current study, about 26% patients dropped out of treatment. In another study, drop out rates of 19% in the US and 17% in Ontario were comparable to the drop out rate of 17% recently observed in a study of mental health advocacy group members in 11 countries.¹⁵ However, most of the earlier studies including ours reported much higher rates of treatment drop out than these.¹⁶⁻¹⁷ The reason for this discrepancy may be the difference in the definition of drop out in different studies. In this study a more conservative definition of drop out than previous studies had been employed.

The current study showed drop out was not influenced by socio demographic and clinical variables. Authors of a study¹⁸ reported that variables such as gender, diagnosis, mode of admission, type of hospital ward, level of treatment, transfer in accordance with treatment needs and inappropriate transfer caused by the treatment system were non significant. In another

study¹⁹ income, gender and race did not seem to explain why subjects dropped out of treatment, nor did type of mental health problem though younger age was a factor in drop outs.

In our study 32 percent patients did not come back as they reported improvement. Most of them fell into the neurotic disorders category and it is possible that they required simple advice and brief intervention. In another study²⁰ authors examined relationship of client's reasons for dropping out of treatment to outcome and satisfaction. Problem improvement, environmental obstacles and dissatisfaction with treatment were the reasons most cited as dropping out. It has been argued that these patients may not be labeled as drop outs.

In our study, 28.8 percent discontinued treatment due to migration and change of residence. In patients who migrated it could have been difficult for them to maintain follow up due to distance to the hospital. Though, there are chances that patients who shift from one place to another due to any reason like job prospects, job transfer, family issues etc would avail treatment in the area they have migrated to. It has been suggested that labeling patients who are taking treatment from other setting as drop out is actually misclassifying them.²¹ Another example of patients not being actually drop outs could be that, many of them tend to do doctor shopping and are not interested in continuing treatment from one particular doctor.

In our study, 23 percent of patients dropped out due to stigmatization and influence of faith healers etc. Authors of a study⁷ reported that mental health advocacy group members observed that receiving such education from providers was critically important in facilitating patients' acceptance of treatments. Respondents in this study reported that feeling uncomfortable in mental health care setting was substantially more likely to lead to drop out than patients who

reported being comfortable. A likely explanation of this finding is that expressing greater discomfort with mental health treatment is a marker of perceived stigma or other psychological barriers. A wide range of professionals including psychiatrists, psychologists, faith healers and religious healers cater to the needs of mentally ill patients. Though, psychiatric facilities may be available, psychiatrists are least preferred due to stigma. In another study²² on help seeking behavior of psychiatric patients before seeking care at a mental hospital, it was found that wide range of services were used by the subjects from professional care to faith healers. Trust, easy availability and accessibility, recommendations by significant others and belief in supernatural causation of illness were the important reasons for choosing a particular facility. Thus, socio cultural factors appeared to influence the help seeking professional care. They concluded that patients suffering from severe mental disorders sought non professional care.

Authors of another study²³ found no significant difference in health seeking behavior of males and females, but education had significant effect on the health seeking behavior. In another study authors²⁴ reported that among the patients, help seeking behavior included traditional and religious healers (51.1%), presenting to medical doctors (19.3%), and visiting to a psychiatrist (65.9%). This study revealed that patients with low level of education were more prone to seek religious solutions and those with higher level of education preferred to visit a psychiatrist. It can be suggested that psycho educational programs for patients and families will be quite useful in ameliorating the problems caused by the disease. However in our study, there were more illiterate persons in the control group.

Complicated treatment seeking procedures and long waiting period were the concerns shown by good number of people in our study. It has been seen that in any busy clinic, it is always

not possible to explain adequately the need for detailed evaluation and need for subsequent visits. In anticipation of this, rather a little change in clinic practice can be introduced. A leaflet information can be introduced which contains information about routine of the clinic, the nature of help provided and necessity for detailed evaluation. It can be written in broad terms and simple language. Though a direct causal relationship cannot be assumed but it appears that simple measures in the clinic introduced to clarify the nature of service provided would be helpful. We could not find any other studies comparing reasons for drop out in different diagnostic groups.

There were certain limitation. It is a retrospective study. Patients were contacted after about one year of dropping out. Patient might not be remembering reasons accurately, hence, recall bias could be there. Moreover, no information is available about the total number of dropped out patients in the study year. Our definition of drop out depended heavily on a single criterion and did not take into account the various possible explanations/exclusions and hence may not have reported the true drop out rate. We could not find other studies which reported drop out after first visit.

It can be concluded that successful initiation and adherence to mental health treatments depend on patients' knowledge and awareness, clinician's timely treatment and advice, clinician's communication skills and less waiting period in OPD and simple treatment seeking procedures.

REFERENCES

1. Kessler RC, Zhao S, Katz SJ, et al. Past year use of outpatient services for psychiatric problems in the National Comorbidity Survey. *Am J Psychiatry* 1999; 156:115-23.
2. Regier DA, Narrow WE, Rae DS, et al. The de facto US mental health and addictive disorders service system: epidemiologic catchment area prospective one year prevalence rates of disorders and services. *Arch Gen Psychiatry* 1993 ; 50; 85-94.
3. Psychiatry News. Psychotherapy for all: an experiment. New York Times 2008.
4. Prinz RJ, Miller GE. Family based treatment for childhood anti social behavior: experimental influences on drop out and engagement. *J Consul Clin Psychol* 1994; 62:645-50.
5. Santisteban DA, Szapoeznik J, Perez VA, et al. Efficacy of intervention for engaging youth and families into treatment and some variables that may contribute to differential effectiveness. *J Fam Psychol* 1996; 10: 35-44.
6. Kazdin AE, Mazurick JL, Seigal TC. Treatment outcome among children with externalizing disorder who terminate prematurely versus those who complete psychotherapy. *J Am Acad Child and Adolesc Psychiatry* 1994; 33: 549-57.
7. Wang PS, Berglund P, Kessler RC. Recent care of common mental disorders in the US population : prevalence and conformance with evidence based recommendations. *J Gen Intern Med* 2000; 15: 284-92.
8. Wang PS, Demler O, Kessler RC. The adequacy of treatment for serious mental illness in the United States. *Am J Public Health* 2001; 92: 92-98.
9. Wells KB, Katon W, Rogers B, et al. Use of minor tranquilizers and anti depressant medications by depressed outpatients: results from the Medical Outcomes Study. *Am J Psychiatry* 1994; 151: 687-700.
10. Baruch G, Gerber A, Fearon P. Adolescents who drop out of psychotherapy at a community based psychotherapy centre. *Br J Med Psychol* 1998; 71: 233-45.
11. Paykel ES. Psychotherapy, medication combinations and compliance. *J Clin Psychiatry* 1995; 56: 24-30.
12. Singh H, Janes CL, Schechtman JM. Problem children's treatment attrition and parents' perception of the diagnostic evaluation. *J Psychiatr Treat Eval* 1982; 4: 257-63.
13. Pekarik G. Posttreatment adjustment of clients who drop out early vs late in treatment. *J Clin Psychology* 1992; 48: 379-87.
14. Pekarik G. Relationship of clients reason for dropping out of treatment to outcome and satisfaction. *J Clin Psychology* 1992; 48:91-98.
15. Wang PS, Gilman SE, Guardino M, et al. Initiation of and adherence to treatment for mental disorders:

- examination of patient advocate group members in 11 countries. *Med Care* 2000; 38:926-36.
16. Takeuchi DT, Sue S, Yeh M. Return rates and outcome from the ethnicity specific mental health programs in Los Angeles. *Am J Public Health* 1995; 85: 638-43.
 17. Toseland RW. Treatment discontinuance: grounds for optimism. *Soc Casework* 1987; 68:195-204.
 18. Tehrani E, Krussel J, Borg L, et al. Dropping out of psychiatric treatment: a prospective study of a first admission cohort. *Acta Psychiatr Scand* 1996; 94:266-71.
 19. Joan AT. Study seeks answers to treatment dropout. *Psychiatric News* 2002; 37:28.
 20. Pekarik G. Relationship of clients reasons for dropping out of treatment to outcome and satisfaction. *J Clin Psychol* 1992; 48: 91-8.
 21. Carpenter PJ, Del Guadio AC, Morrow GR. Dropouts and terminators from a community mental health centre: their use of other psychiatric services. *Psychiatr Q* 1979; 51:271-9.
 22. Chadda RK, Agarwal V, Singh MC, et al. Help seeking behavior of psychiatric patients before seeking care at a mental hospital. *Int J Soc Psychiatry* 2001; 47: 71-8.
 23. Ali F, Sami F, Rehman H, et al. Relation of gender education and health seeking behavior of the general population regarding psychiatric illness. *J Pak Med Assoc* 2007; 57:220.
 24. Unal s, Kaya B, Yalvac HD. Patients explanation models for their illness and help seeking behavior. *Turk Psikiyatri Derg* 2007;18: 38-47.
-

Jaspreet Kaur, Psychologist
BS Chavan, Prof. & Head
Archna Sharma, Psychologist
Lok Raj, Formerly Senior Lecturer
Chandra Bala, Social Worker
Department of Psychiatry, Government Medical College & Hospital, Chandigarh

Corresponding Author:

Jaspreet Kaur, Psychologist
Government Medical College & Hospital, Chandigarh
E-mail: jaspreetgmch@yahoo.co.in