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DROPOUT, EARLY TERMINATION AND DETACHMENT FROM A PUBLIC PSYCHIATRIC CLINIC

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SUMMARY

Background: *Dropout from an outpatient clinic is the loss of a patient to scheduled follow-up. Due to movement of mental health care to the community, adherence to ambulatory care is crucial to maintain stability among individuals with mental disorders. We hypothesized that patients drop out from ambulatory psychiatric care when regardless of the therapist's evaluation, they feel that they have recovered, or because they are dissatisfied with treatment. The aim was to examine the phenomenon of premature termination of treatment in a public community-based ambulatory psychiatric clinic serving a catchment area with a population of 200,000.*

Subjects and methods: *The study sample was drawn from patients who had at least one ambulatory therapy session during the previous five years, immediately or shortly following initial treatment and who were subsequently lost to follow-up. Participants completed a questionnaire that evaluated their satisfaction with treatment and described their reasons for early termination of treatment.*

Results: *The sample included eighty-two patients. Eighty percent of the responders (N=65) terminated therapy on their own, and twenty percent (N=17) decided to end treatment together with their therapists.*

Discussion: *Increased involvement of patients in treatment planning, duration and end of therapy, may improve attendance in ambulatory mental health care settings.*

Conclusions: *Though dropouts generally reported satisfaction with the ambulatory service, some explained early termination of treatment as being due to dissatisfaction with the therapist, the type of treatment or because of therapist turnover. Others terminated treatment because they felt their problems were solved or their conditions had improved, though therapists had determined otherwise.*

Key words: *psychiatry - ambulatory care – dropout - discontinuation of treatment*

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INTRODUCTION

There is a high rate of patient dropout from outpatient psychiatric clinics. Early termination of psychiatric care may lead to exacerbation of illness, and rehospitalization (Liu Siefert et al. 2005). Dropout is most commonly defined according to length of treatment; thus, a number of missed sessions may be arbitrarily chosen as a criterion for dropout. Alternatively, a patient who terminates therapy contrary to the therapist's judgment may also be considered a dropout (Baekeland & Lundwall 1975, Evans et al. 1984). Garfield (1986) defined a dropout as a person who was accepted for treatment, came to at least one session and ended treatment by failing to appear for the following sessions.

It has been reported that approximately fifty percent of new patients remain in contact with the clinic one month after their first appointment. About 25 to 40% of new patients remained in treatment for six months or longer (Bischoff & Sprenklle 1993, Lerner et al. 1993, Sledge et al. 1990).

In addition, it was found that two or more appointments devoted to assessment, and a shorter lapse of time between visits were associated with lower rates of dropout. Referral of patients to new therapists or a history of previous dropouts were

predictive of higher dropout rates (Good 1990). It is not unusual for a patient to discontinue treatment following the initial visit (Berghofer et al. 2002).

Dropout rates are reportedly higher among patients with low socioeconomic status (Armbruster & Fallon 1994), and among patients who lack social support (Self et al. 2005).

Contacting people who have rejected the service is often difficult (Pekarik 1992), thus the direct questioning of dropouts from treatment is challenging. The most common reasons for dropping out reported by patients who consented to discuss termination of treatment, were a feeling of improvement in their symptoms, concrete limitations (e.g. distance from the clinic, inconvenient hours, high cost, etc.) or dissatisfaction with the service (Berghofer et al. 2002).

We sought to determine predictors for dropout by using a structured questionnaire to interview patients who dropped out of treatment.

SUBJECTS AND METHODS

Premature termination of treatment was examined in an adult public clinic serving a catchment area of about 200,000. The clinic provides various treatment methods including individual, couple and family therapy, psychiatric counselling and medication. The professional staff includes psychiatrists, social workers, psychologists, nursing staff and an art therapist. There are two principal intake processes: a) immediate intake and commencement of treatment for emergency cases and for patients discharged after hospitalization, and b) routine intake and placement on a waiting list. We surveyed both systems.

Sample

The sample included all patients who attended at least one therapy session at the clinic throughout a five year period, but did not return for scheduled follow-up visits. A random sample of one hundred "dropouts" was asked by telephone if they would participate in the study by filling out a questionnaire. We reached 100 potential participants by taking every tenth patient file from the relevant patient file archives until we had 100 patients. For 96 of these patients, complete medical information was available in the patient database, and 82 of these patients consented to participate in the study. The ages of the sample population ranged from 22 to 90, with the average being 51.6 years. Thirty-eight were men and 59 were women. Sixty-seven were married.

Questionnaire

The questionnaire was prepared expressly for this study and included twelve multiple choice questions. The questionnaire examined the patient's satisfaction with treatment, why he/she stopped coming to the clinic, whether or not he/she tried to renew contact with the clinic, and what he/she expected from the clinic after breaking contact. Most of those who agreed to answer the questionnaire did so by telephone, though a small number chose to answer questions in a face to face interview.

Statistics

The relation between various data in the study was examined by Chi square test.

RESULTS

Thirty-three of the sample population initiated contact with the clinic. Forty-three were referred by their family physicians, and the rest were referred by the municipal department of social services, family or friends. Individual treatment was recommended for most of them.

Table 1. shows the number of sessions held before the patients dropped out. Most patients (64%) dropped out before attending ten sessions.

Thirty-six percent of the sample population was diagnosed as suffering from a psychotic disorder (including schizophrenia, schizoaffective, or brief psychotic disorder).

Table 2. presents the reasons given for drop out from treatment. Most of the sample population reported that their conditions had improved, that the treatment had helped them, and that they were satisfied with the treatment. Thirty percent reported that they dropped out of treatment because they felt they had received all that the treatment had to offer. All dropouts noted that had the clinic reached out to contact them, they may have reconsidered and continued treatment.

The question of who decided to terminate the treatment revealed that 80% of the respondents ended treatment on their own, and only 20% reported that the choice was based on a joint decision with the therapist.

Almost two thirds of the respondents were women. Twenty-five percent cited that stigma was the reason for terminating treatment. Thus, efforts to combat the stigma associated with mental health care may improve continuity of ambulatory mental health care.

Table 1. Number of sessions until treatment dropout

Number of sessions	0-5	6-10	11-15	16–20	21-30	31-40	41-50	51-80	Total
Number of patients	48	14	11	6	3	7	3	4	96
%	50.0	14.6	11.4	6.3	3.1	7.3	3.1	4.2	100%

Table 2. Reasons therapy was terminated N=82 patients who completed the questionnaires

	N	%	χ^2	p
Present problem condition:				
Improved	56	68		
Not improved	26	32	16.08	.0011
Influence of treatment:				
Helped	49	60		
Did not help	33	40	15.62	.0014
Patient's opinion of therapy end:				
Justified	55	67		
Not justified	27	33	14.79	.0220

The shorter the time from the application to the beginning of treatment, the higher was the rate of early termination of therapy (Table 2). Most patients who began treatment after waiting more than 30 days for treatment remained in treatment for a longer period of time.

There was no difference among those who received dynamic or supportive therapy, in comparison to cognitive or behavioural or other treatments. Patients receiving pharmacotherapy generally came to 6 or more sessions (N=40), whereas those who did not tended to drop out within 5 sessions (N=28) (χ^2=16.27; p<0.005) (Table 3).

An additional interesting finding is the association between the frequency of sessions and remaining in treatment. The less frequent the sessions, the lower the rate of dropout within 5 sessions, though the rate of dropout increases after 6 or more sessions (Table 3).

Table 3. Number of sessions before dropout in relation to other variables

Number of sessions	0-5	6-80	χ^2	P
Length of time until first session:				
Immediate	10	2		
1-10 days	21	19		
11-30 days	12	13		
31-70 days	5	14	9.74	.0209
Type of treatment:				
Dynamic	6	11		
Cognitive/behavioral	3	3		
Supportive	20	32		
Other	18	2	17.03	.0007
Medication recommended:				
Yes	7	40		
No	28	19	18.21	.0001
Frequency of sessions:				
Twice a week or more	3	2		
Once a week	14	16		
Once every two weeks	9	16		
Once a month	4	11		
Less than once a month	18	3	16.27	.0027
Change of therapist during the treatment				
Yes	1	20		
No	47	28	19.75	.0001>

DISCUSSION

Early termination of ambulatory treatment is not necessarily a treatment failure, but may rather represent the different perspectives of the patient and the caregiver.

In response to the question, "who should determine the end of therapy?": Similar to the previous findings (Berghofer et al. 1992, Renk & Dinger 2002, Todd et al. 2003) the overwhelming majority of patients in fact determined the end of therapy by not showing up for follow-up sessions, either because they felt their difficulties were resolved, or alternatively felt that therapy was no longer beneficial. This emphasizes the importance of dialogue between patient and therapist regarding the treatment duration. Should the patient determine, or should the therapist determine the end of treatment, or should it be a joint decision? Contrary to Todd et al. (2003), in our study, when the patient sensed improvement, treatment ended and the patient did not feel the need to end it "in an orderly manner". This is similar to when a patient comes for general medical treatment, and once the problem passes, does not come to say good-bye to the physician. The psychotherapeutic approach may propose that treatment should end in an organized manner, but in practice, the patients raise the question whether it is indeed necessary.

The finding that patients receiving medication remained in treatment for more sessions, contradicts the expectation that medication discourages people from coming for treatment. Perhaps patients who received medication were considered to have a more serious illness, so therapists invested more effort in retaining them in treatment. Patients may regard the prescription of medication as a message that continuing treatment is important, and may be expressing a preference for the biological medical model of treatment. It is also possible that patients in a public outpatient clinic expect treatment according to a medical model; pharmacotherapy and termination of treatment when the condition improves.

This approach is appropriate for non-psychotic patients, who were the majority of the participants in this study. In the case of psychotic patients the therapist has greater responsibility for facilitating continuation of treatment, and early termination by the patient in those cases may be considered treatment failures.

We revealed an association of lower dropout rates with long-term treatment for chronic psychotic patients, and high frequency short term therapy. This may be explained by earlier findings by Hyman (1990), who reported late terminators stopped treatment following improvement, and that early terminators reported that they ended therapy due to situational constraints and discomfort with services.

The impact of a therapist's initiative in "recruiting" a patient and "holding" him in treatment is crucial. The patients who reported that they would have returned to treatment had they been contacted emphasize the need for reaching out. Therapists often consider treatment as having failed because the patient dropped out, though the patient may have felt that the treatment had been completed, thus focused outreach to identify the reasons for missed therapy sessions may contribute to higher rates of follow-up care (Renk & Dinger 2002).

Limitations. This was a retrospective study, and most participants responded via the telephone, and only a minority participated in a face-to-face interview. The study population was heterogenic. And evaluation of dropout according to diagnostic groups is warranted.

CONCLUSIONS

In today's economic atmosphere, where there is emphasis on shorter duration of therapy, it is necessary to be attentive to the patient who by not showing up indicates that treatment has ended. Interpersonal processes are crucial to helping patient alliance (Johansson & Eklund 2006), thus the issue of duration of therapy should be openly discussed with the patient, and the circumstances for successful completion and renewal of treatment should be clearly defined in order to facilitate patient compliance and reduce the rates of dropout from therapy.

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