

Non-attendance at psychiatric outpatient clinics: communication and implications for primary care

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SUMMARY

Background. *What should happen when an outpatient fails to attend a psychiatric clinic? Guidelines from the General Medical Services Committee suggest that general practitioners (GPs) have no further responsibility of care for a patient once a referral to a psychiatrist has been made. This raises questions about the formulation of effective management plans for those patients with whom psychiatric services find it difficult to engage due to non-compliance with assessment and follow-up.*

Aims. *To investigate communication between GPs, patients, and psychiatrists at referral and following attendance or non-attendance at outpatient appointments.*

Method. *A prospective study of a random sample of attenders and non-attenders at psychiatric outpatient clinics. Patients and GPs were interviewed to obtain data about the referral process. GPs' views on communication from psychiatrists and the appropriate course of action following clinic non-attendance were investigated. The quality of referral and clinic letters for attenders and non-attenders was compared.*

Results. *There was no difference in the quality of referral letter for attenders and non-attenders. Psychiatrists were less likely to write to GPs about follow-up patients' appointments than new patients' appointments; communication was least likely when a follow-up patient missed their appointment. GPs considered follow-up non-attenders were more likely to need a further appointment than new patient non-attenders, but did not identify a role for themselves in engaging with follow-up non-attenders.*

Conclusion. *Communication between GPs and psychiatrists about new patients seems adequate. However, there are important deficits in communication from psychiatrists to GPs about follow-up patients, especially non-attenders who are often more severely ill and difficult to engage. An effective response for this group is likely to need cooperative health and social service action rather than rigid guidelines concerning clinical responsibility.*

Keywords: general practice; mental illness; outpatients; community care; referral; communication; clinical responsibility.

Introduction

NON-ATTENDANCE at psychiatric outpatient clinics is of concern, not only because of the waste of resources it represents, but also because it may signify a deterioration in the patient's mental state, with the subsequent possibility of risk of harm to themselves or others. When a patient misses an appointment, the psychiatrist has to decide what to do. For new patients this may be that the patient is not offered another appointment unless they or the referrer request one. For patients already known to the service (follow-up patients), the likelihood of their attending a further appointment is considered along with whether there is a need for a community mental health visit. This will depend on diagnosis and previous history, as well as the current level of concern from relatives and others involved in their care. The need for adequate sharing of information between primary and secondary care in these cases is clear.

In a controlled prospective study of psychiatric outpatient non-attendance,¹ it was found that new patients at psychiatric clinics had less severe mental disorders than follow-up patients, and that follow-up patients who missed appointments had more severe symptoms and a greater social impairment than follow-up patients who attended. For both new and follow-up patients, a single missed appointment predicted disengagement from psychiatric services and, for follow-up patients, it predicted a greater chance of unplanned admission to hospital compared with attenders. This suggests that there might be a case for differential management of new patients and follow-up patients not attending for their appointments. However, recent guidelines issued by the General Medical Services Committee (GMSC) on the mentally ill suggest that general practitioners (GPs) cease to have any clinical responsibility for a patient's mental health once they have made a referral to a specialist.² This may work against effective community care for the severely mentally ill, which depends on shared information and a jointly-owned management plan, especially for those patients with complex needs who are difficult to engage.

Good quality communication between GPs, patients, and psychiatrists is associated with outpatient attendance and is fundamental to good patient management³ — a clear explanation by the GP of the reason for referral increases the chance of the patient attending their first psychiatric appointment,^{4,5} especially if the symptoms are not particularly distressing for the patient.⁶ Regular communication from the psychiatrist to the GP helps to create a cohesive approach to patient management and reduces the chance of patients defaulting from treatment.⁷ Two studies have examined the quality of communication between psychiatrists and GPs.^{8,9} Both found that GPs' referral letters meet psychiatrists' needs but that psychiatrists' letters are too long and lack clear diagnoses, management plans, and prognoses. Lister and Scott reported new patient non-attenders to have poorer quality referral letters than attenders.¹⁰ Building on this, we carried out a study with three main aims: to assess communication

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Table 1. Assessment of the adequacy of psychiatrists' letters.

	New patient non-attenders n = 29	New patient attenders n = 28	Follow-up non-attenders n = 76	Follow-up attenders n = 91
Adequate score	24 (86%)	22 (79%)	43 (57%)	58 (64%)
Inadequate score	0 (0%)	4 (14%)	0 (0%)	6 (6%)
No letter written	5 (14%)	2 (7%)	33 (43%)	27 (30%)

Table 2. GPs' views of the most appropriate course of action following the non-attendance of a patient.

	New patient non-attenders n = 27	Follow-up non-attenders n = 70	Difference in proportion (95% CI)
No action	11 (41%)	6 (9%)	32.2 (12.5 to 51.8)
Another appointment only	12 (44%)	47 (67%)	-22.7 (-44.4 to -1.0)
Community psychiatric nurse visit	2 (7%)	15 (21%)	-14.0 (-27.8 to -0.2)
GP to contact patient	2 (7%)	2 (3%)	-4.4 (-22.6 to 13.9)

Overall $\chi^2 = 16.32$, $df = 3$, $P = 0.001$.

between GPs, patients, and psychiatrists at first referral, focusing on differences between non-attenders and attenders; to assess adequacy of psychiatrists' letters to GPs, for attenders and non-attenders; and to investigate GPs' views on communication from psychiatrists and their opinion about appropriate action following non-attendance.

Method

Subjects

The sampling frame consisted of all patients aged 18 to 65 years living in North Camden (the catchment area of an inner-London psychiatric service), with a general, adult psychiatric outpatient appointment between September 1996 and April 1997, and their GPs. The psychiatric outpatient department is in the main hospital building and serves approximately 3500 patients per year booked into approximately 8000 appointments. The large majority of patients receive their medical review in these clinics, with community teams providing further support as needed.

Subjects were randomly selected by use of computer-generated random numbers, with sampling fractions calculated on the basis of the previous six months of outpatient activity. The sampling fractions were:

- new patient non-attenders, 1:1;
- new patient attenders, 1:3;
- follow-up non-attenders, 1:7; and
- follow-up attenders, 1:12.

Patients whose appointments were cancelled were not included in the study. Patients were only eligible for inclusion in the study at their first appointment during the study period. They were defined as a new patient or follow-up and attender or non-attender at this first appointment.

Recruitment

Patients were sent a letter about the study within 48 hours of their appointment. One week later they were contacted to arrange a time for a home interview. If they were not at home at the time of this interview an alternative time was made after postal and telephone contact. If there was still no response, a second home visit was made. Those who had still not been seen were sent a postal questionnaire, which collected the same information concerning the referral. All GPs were contacted by telephone after

their patient had been interviewed, allowing at least two weeks for the psychiatrist's letter to have reached them.

Information collected from patients

In a semi-structured interview, new patients were asked the following about the referral process:

- who had referred them,
- whether the reason for referral had been clearly explained to them, and
- whether they had told anybody about the referral.

Information collected from GPs

The number of partners in the practice and whether it was fund-holding was recorded. In the telephone interviews, GP's provided the following patient-based details:

- the number of GP consultations in the past year,
- when the patient was last seen, and
- whether they had received communication from the psychiatrist about the patient's appointment.

The GP's opinion as to whether the communication from the psychiatrist was adequate, less than adequate, or over-inclusive was sought. If their patient had not attended their appointment they were asked whether they felt a further appointment should be arranged. They were then given four options about further action following non-attendance and asked which they felt to be appropriate (Table 2).

Quality of communication

A scoring system for the quality of the GPs' referral letters and the letters from the psychiatrist to the GP was devised, based on the method used in previous studies.^{8,9} GPs' referral letters were scored out of seven, according to whether or not they included the reason for referral, medication, past psychiatric history, current symptoms, duration of symptoms, relevant family history, and legibility. All letters were assessed independently by two researchers and, where there was disagreement, a consensus score was reached.

The letters written by the psychiatrists to the GPs after patients' clinic appointments were scored similarly according to the number of items included. Where no letter was written, a

score of zero was given. Non-attenders' letters had a maximum score of two and, to be rated as adequate, had to contain information about non-attendance and follow-up arrangements. For new patient attenders, letters had to score four to be rated as adequate and including a summary of the problem, diagnosis, treatment, and follow-up arrangements. Follow-up attenders' letters had to score at least three by including details on current mental state, medication, and follow-up arrangements.

Data analysis

Data were entered into the statistics package SPSS 7.0 and analysed using chi-squared tests and Student's *t*-tests to examine differences between attenders and non-attenders, new patients and follow-up patients; 95% confidence intervals (95% CI) were calculated using confidence interval analysis.

Results

Response rate

A total of 224 subjects were interviewed. The response rates for those who were traceable were: new patient non-attenders (29/47; 62%), new patient attenders (28/41; 68%), follow-up non-attenders (76/114; 67%), and follow-up attenders (91/135; 67%). Data on follow-up patients' previous attendance showed that, on the day of inclusion in the study, non-attenders had an average of 2.5 attendances out of the past six and attenders an average of 5.3. This provides support for the use of attendance at a single time point to define the attender and non-attender groups. Telephone interviews were carried out with the GPs of 210 (94%) of the 224 subjects. Two GPs, each with one patient in the study, refused to take part in the study; one subject refused to give permission for their GP to be contacted; and 11 subjects were not registered with a GP. In total, 70 GPs were interviewed, the maximum number of patients any GP had in the study was six.

Practice data

Patients were registered at 32 different general practices: 10 were single-handed practices, nine had two partners, five had three partners, three had four partners, and five had five or more partners. Three of the single-handed practices and one of those with two partners described themselves as fundholding. There were no statistically significant differences between attenders and non-attenders in the characteristics of the practices with which they were registered.

Referral data

Seventy-three per cent of new patients had been referred to see the psychiatrist by their GP and the remainder were referred by hospital doctors. Most attenders and non-attenders felt that the reason for referral had been clearly explained to them (26 [93%] versus 25 [86%]; $\chi^2 = 0.149$; *df* = 1; *P* = 0.70; difference in proportion = -6.7 [95% CI = -22.4 to 9.1]). There were no statistically significant differences between attenders and non-attenders in whether they had told somebody about the referral (22 [76%] versus 20 [71%]; $\chi^2 = 0.273$; *df* = 1; *P* = 0.60; difference in proportion = -9.6 [95% CI = -32.3 to 13.1]).

Patient contact with GP

Subjects were generally high users of primary care, having an average of four visits to their GP in the preceding 12 months. There were no statistically significant differences between attenders and non-attenders, new patients, or follow-up patients in the number of consultations or the time since they were last seen by their GP.

GPs' opinions about communication from psychiatrists

In over 90% of cases, the GPs reported that the communication they received from the psychiatrists regarding their patient's out-patient appointment was by letter. They were more likely to have received communication from the psychiatric service regarding new appointments than follow-up patients (43 [80%] versus 89 [57%]; $\chi^2 = 7.82$; *df* = 1; *P* = 0.005; difference in proportion = -22.6 [95% CI = -35.8 to -9.3]). Despite this discrepancy, in 77% of cases the GPs interviewed felt that the communication they received from the psychiatric service about their patient was adequate. Letters received by fundholding GPs were as likely to be reported to be satisfactory in quality as those received by non-fundholding GPs (21 [88%] versus 140 [67%]; $\chi^2 = 1.16$; *df* = 1; *P* = 0.282; difference in proportion = 12.2 [95% CI = -2.4 to 26.8]). There was no statistically significant difference in the satisfaction with communication between GPs working single-handedly and those in group practices (34 [77%] versus 127 [77%]; $\chi^2 = 0$; *df* = 1; *P* = 1.0; difference in proportion = -0.8 [95% CI = -14.7 to 13.2]).

Quality of communication

The referral letters from GPs for new patients were of equal quality (non-attenders: *n* = 29, mean rank = 27.8; attenders: *n* = 28, mean rank = 30.3; Mann-Whitney U test, *P* = 0.559). The letters that the psychiatrists wrote regarding new patients were more likely to be rated as adequate than those regarding follow-up patients (46 [80%] versus 101 [60%]; $\chi^2 = 6.83$; *df* = 1; *P* = 0.009; difference in proportion = -20.2 [95% CI = -32.9 to -7.6]). Psychiatrists were more likely to write to the GP if a new patient missed their appointment than if a follow-up patient did not attend (24 [86%] versus 43 [57%]; $\chi^2 = 5.77$; *df* = 1; *P* = 0.016; difference in proportion = -27.6 [95% CI = -45.3 to -10.0]). These results are presented in Table 1.

GPs' opinions about appropriate action following non-attendance

In response to the question 'do you think that your patient should be sent another appointment?', GPs replied 'yes' in 59 (84%) cases of follow-up non-attendance and 15 (56%) cases of new patient non-attendance ($\chi^2 = 7.37$; *df* = 1; *P* = 0.007; difference in proportion = 28.7 [95% CI = 8.1 to 49.3]). The results of their opinions on the four options about the most appropriate course of action for their patient are presented in Table 2. GPs were more likely to feel that a repeat appointment was the appropriate course of action for a follow-up patient who had missed their appointment than a new patient non-attender. Also, they reported that no further action on the part of psychiatric services was more likely to be appropriate for new patient non-attenders than follow-up patient non-attenders. They did not think that they should contact non-attenders themselves.

Discussion

The main findings from this study are that there appears to be adequate communication from GPs to patients and psychiatrists at the point of referral, but that there seem to be important deficiencies in communication from psychiatrists to GPs following clinic appointments, in particular after follow-up non-attendance. GPs did not identify a role for themselves in contacting patients who had failed to attend their appointments. Both these difficulties could lead to patients who need psychiatric treatment becoming lost to follow-up.

Limitations

The population studied was a typical inner-city area with a large number of single-handed practices. When compared with the national figures, this may reduce generalizability to smaller towns and rural areas. However, the inner city is an important population to study since it has a particularly high concentration of people with serious and enduring mental health problems. Within the resource constraints of the study we were unable to interview psychiatrists regarding their opinions about communication to and from GPs, so we are unable to comment on this important aspect of the interaction between primary and secondary care.

Communication from GP to patient

In contrast to earlier studies,³⁻⁵ the new patients in our study reported that their GPs had clearly explained the reasons for referral to them. Stigma about referral to a psychiatrist has been cited as a reason for non-attendance,⁴ but, in this population, those who attended were as likely to tell somebody about the referral as those who did not. It therefore seems that embarrassment about the referral was not an important factor in non-attendance.

Communication from psychiatrist to GP

Psychiatrists were more likely to communicate with GPs about new patients than follow-up patients, and they were more likely to communicate when a new patient missed their appointment than when a follow-up patient did not attend. The majority of GPs felt that this communication was adequate, preferring not to be told about each visit to the clinic unless there was a change in the patient's management. The lack of communication about missed appointments among follow-up patients is alarming. The GP provides a vital link between the hospital and the patient, and these patients are at particular risk of breakdown in the community.¹

Following non-attendance, GPs were more likely to express the view that follow-up patients should be sent another appointment than should new patients, and that other community psychiatric contact might be needed, such as a visit from a community psychiatric nurse. The GPs did not report that they felt it was the responsibility of the psychiatrist to make contact with new patient non-attenders, but neither did they see it as their responsibility. The majority expressed a preference to wait and see whether the patient reattended their surgery before organizing any further assessment by the psychiatrist.

The GMSC's guidelines to GPs regarding the assessment and continuing care of patients with mental disorders states, 'In the case of the severely mentally ill, general practitioners discharge their obligation once they make a competent assessment and identify a need to refer.'² The guidelines go on to suggest that the further management and prescription of psychotropic medication then becomes the psychiatrist's sole responsibility. These guidelines have been challenged as being likely to lead to a disintegration of 'psychiatric primary care services'.¹¹ Since GPs prescribe drugs and supervise treatment at the recommendation of other hospital specialists, it seems illogical to single out psychiatry in this way. In 25% to 40% of cases of mental disorder, patients have no contact with specialist services and rely on their GP for prescription of psychotropic medication.¹²

Usual practice when a new referral fails to attend a psychiatric clinic is for the psychiatrist to write to inform the GP, handing the patient back into their care. However, the GPs in this study did not then see it as appropriate to contact the patient. This may well be reasonable if the GP is confident that the patient does not

have a serious mental illness. However, such certainty is not always available and it may be safer for either the psychiatrist or the GP to contact the patient to suggest that they should attend the surgery to discuss the need for any further referral.

Conclusions

Psychiatrists and GPs need to be able to communicate efficiently and effectively if they are to fulfill their separate and joint roles in the management of the full spectrum of mental disorder. This study has demonstrated apparent weaknesses in the current system. There is a need for the development and agreement of locally relevant and jointly-owned strategies for communication about, and the management of, people with serious mental disorder. This is particularly relevant for those who are difficult to engage by either primary or secondary care services or both.

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