IN MY LIFE

Outpatient 'No Shows': Must I follow up?

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Introduction:

Every now and then a sensational story hits the news about some person with mental illness who has done something terrible and violent. This is understandably followed by attempts to sort out "what went wrong", with much attendant finger pointing aimed at "the mental health system" and doctors, and a subsequent scramble through the morass of inquests and legislation.

As psychiatrists, we feel the public response is sometimes distorted by false assumptions about preventability. Maybe nothing "went wrong" clinically or systemically. Maybe some poor soul's brain disease just got worse. Or maybe a competent adult simply decided to do something bad that produced horrible consequences. The armchair quarterbacks blessed with hindsight may miss the fact that most of the time skilled psychiatrists are very good at identifying and managing illness related risk and crises, and will intervene if possible.

A Case in Point:

Medical Post headline: "Lost to follow-up: If a psychiatric patient is a no show, what's your duty?"[1]

The article tells the story of a 46 year old woman with schizophrenia who became ill and missed her appointments with her psychiatrist. "He never called to find out how she was doing", it says. The patient felt he "should have followed up on her", but acknowledges that "she doesn't think it would have made a difference to her outcome".

The news report then goes on to discuss a high profile and tragic case of a man who was found NCR ('not criminally responsible due to mental illness') for the killing of his wife and children. He had been seeing his family doctor monthly for monitoring but missed appointments before the murders and his family doctor did not try to track him down when he didn't show up.

The key questions posed by the article are, "Is it a physician's responsibility to follow-up on **all** mentally ill patients who don't show up for appointments? And should the doctor be held liable if something bad happens as a result?"

Responsible Physicians vs Physicians held Responsible:

The no-show rates for outpatient psychiatry services are reported across a wide range of anywhere from 12 to 60% (Eytan A et al.). Given that persons living with psychiatric illness commonly do not attend all outpatient appointments, is it a doctor's duty to always follow-up? As we discuss below, it seems apparent to us that "always" is neither practical, nor clinically, nor ethically, necessary.

No one disputes we have to take care of people whose judgment is so impaired they can't take care of themselves. Most people who are clearly in this domain are already followed by specialty services (e.g. ACT Teams) or subject to restrictions (e.g. forensic/judicial order) that ensure follow-up regardless of patient cooperation or insight. But what about the huge majority of patients who are capable of consenting to (or refusing) treatment and who are followed in typical non-restrictive outpatient settings (hospital clinic, private office)?

We state the obvious when we say that these patients can experience complex illness trajectories that are sometimes punctuated by rapid and unpredictable deterioration that calls forth a duty of protective action. "Unpredictable" being the key word here. Statistically, however, only 5-10% of violence in a community can be attributed to those with mental illness (Walsh et al.; Fazel & Grann). And while figures vary, and definitions of what constitutes violence (vs aggression) vary, we interpret the literature as conservatively supporting a position that over 70% of persons living with mental illness will likely never be violent (Appelbaum et al.). In fact, community mental health agencies often highlight in their public education campaigns that persons living with mental illness are far more likely to be victims of violence than to be responsible for violence.

So with the odds in favour of the majority of outpatients never hurting anyone, we can reasonably defend a position of selective triage. That is to say, we need to sort out who is most likely to harm others. We know that acute psychotic symptoms, substance abuse, personality disorder, or a history of violence increases the likelihood of violence and we must of necessity be vigilant in

 (ISSN: 1916-2405)

response (Walsh et al.). However, we must not mistake or presume a conceptual understanding or relational/associative (rather than causal) model to entail unfailing predictive utility from the general to the particular. The public myth of behavioural predictability is simply not how brain disease plays out in the real or clinical worlds.

Please note, we are not saying that most people are ignorant of how volatile and unpredictable some persons living with mental illness can be. We are saying that psychiatrists seem to get blamed in hindsight by victims, patients' families, other caregivers, and in the court of public opinion, for not predicting what is inherently unpredictable.

We know past violence is a good predictor of future violence, but of course at some point in time a first violent act is just that, a first (and thus unpredictable). Under this cloud of uncertainty, we come full circle back to the challenge of pragmatic and fiduciary action in a clinical sluice where the burden of follow-up should perhaps most often rest with the capable patient and not the physician at all.

Responsible Patients:

Why is it not always (or even most of the time) a competent patient's responsibility to rebook a missed appointment? Furthermore, why do we seem to avoid talking about the responsibility of the competent patient, or their autonomy, in deciding to harm self or others? The very existence of mental illness in the background often seems to grant individuals a pass on personal responsibility even when the illness is neither active nor of a type or kind that would affect personal responsibility. (We have seen individuals not charged for crimes because the police say it is not worth pursuing when the person is "crazy", even when, from a clinician's perspective, mental illness is irrelevant in the particular circumstances.)

Some Reasons for why Patients do not Show up:

Resistance
There can be many reasons why patients do not show up including that they have had to wait a long time, they don't care, they were pressured by others to make the appointment, they disagree with the referral, they feel better, they don't believe it will help, or they feel ashamed seeking help.

Forgetting
In one study, "the most common stated reason for missing an appointment was patient error, such as forgetting, oversleeping, or getting the date wrong." (Sparr L, Moffitt M).

Transportation Barriers
Transportation costs and difficulties can also be a significant problem. (Carrion PG)

Clear Needs
Some authors identified that "those with the most clearly defined reasons for seeking help tend to show up, while those with the vaguest reasons tend not to." (Gould, R.; Paulson, I)

Demographics
"Patients who were younger, had a history of missed appointments, were scheduled to see a resident physician, had a routine appointment and lived a distance from the hospital, were at greater risk of missing their appointment." (Campbell B, Staley D, Matas M)

"The nonattenders were more likely to have had frequent changes of occupation or belong to families where this was the case with the family breadwinner, a history of court conviction, and a history of previous psychiatric treatment. They were less likely than controls to have improved since referral to the clinic and less likely to have a diagnosis of manic depressive psychosis, depressed type…There appears to be some self-selection, the most treatable patients keeping their appointments." (Whyte R)

Timing
People are more likely to miss appointments scheduled on Mondays (Eytan, Ariel; Gex-Fabry, M.; Ferrero, F.; Bertschy, G.) and are more likely to attend appointments on Fridays and in winter months. (Mitchell AJ; Selmes T)

Service Populations
Attendance is better "in geriatric psychiatry and highest for substance abuse services and in community psychiatry. In most services, attendance improved after the initial appointment, but in psychosomatic medicine and geriatric psychiatry this pattern was reversed." (Mitchell AJ; Selmes T)

Substance Use
Not surprisingly, "a high nonattendance rate was found among persons with drug and alcohol difficulties." (Mitchell AJ; Selmes T)

Referral Source
One study reported that no shows are "significantly more likely to be single, diagnosed personality disorder or substance abuse, and referred from the Emergency Department... Further analysis of emergency referrals, the single most significant predictor, indicated that patients from this referral source were more likely to be male, unmarried, unemployed or on welfare, and diagnosed personality disorder or substance abuse than referrals from general practice and internal sources." (Matas M, Staley D, Griffin W)

Diagnostic Categories
When considering diagnostic categories, among those "with diagnoses of schizophrenia, schizoaffective disorder, and delusional disorder …patients who missed 20% or more of their appointments were significantly younger, were more likely to abuse drugs and alcohol, and manifested lower levels of community functioning." (Coodin S, Staley D, Cortens B, Desrochers R, McLandress S)

"Patients with PTSD and/or substance abuse were significantly more likely than others to miss appointments, and those with major depression were somewhat less likely to do so." (Sparr L, Moffitt M)

Do Patients Rebook Missed Appointments?

Of great interest, "a prospective survey covering all individual outpatient visits to seven mental health clinic psychiatrists was conducted during a 3-month period…Of the 142 missed appointments, 71.1% were rescheduled spontaneously by the patients; of these, most (73.3%) were rescheduled within 2 weeks… Missed appointments for initial evaluation are not rescheduled most often" (Sparr L, Moffitt M).

If someone values the appointment, it seems reasonable to assume the likelihood of concomitant motivation to reschedule.

Standards for Follow-up?

The articles referenced above highlight the diversity of reasons for missing appointments. They also illustrate the complex challenge of delimiting or proscribing universal follow up practices or policies for 'no shows'.

In one survey, with 356 clinicians responding, "psychiatrists tended to be initially less active in pursuing patients than were nonphysician therapists and internists. A number of clinical variables were associated with clinicians' responses including the perceived risk of a bad outcome, hospital site, support staff availability, and billing practices…The results suggest that clinicians' responses to missed appointments are determined by a complex mixture of influences rather than adherence to a readily definable "standard of care."" (Smoller J, McLean R)

While caregivers have disparate views, professional bodies appear silent on what amounts to a matter of 'point in time', situation specific, clinical judgment. What is clearer and easier to do is finger pointing after a catastrophic event. Forensic or retrospective adverse event analyses may highlight or mandate practice changes, but we are unaware of any that necessitate universal follow-up for 'no shows'.

In Outpatient Psychiatry, What Counts as Adequate "Follow-up"?

Answer: A phone call to the patient that is answered.

Our comment: This is not necessarily adequate. Suicidal or homicidal patients may lie and say they are fine. But surely it is better than nothing and assures the doctor that the patient is at least alive, and if the patient is well known to the physician then the tenor of the conversation may be suggestive of a heightened risk of possible harm to self or others and it may trigger other more interventionist actions.

The reality: Many patients and family members seem to view this as the least an outpatient psychiatrist should do. However, an outpatient psychiatrist at a busy community hospital may see about 25-40 patients a day, or up to 200 per week. For purposes of this discussion, let's assume a modest average outpatient no show rate of about 20%. If we called all patients who did not show up, it would mean that in any given week we could be chasing down, on average, 40 people.

This means getting the phone number(s), calling, having a conversation that supports the therapeutic alliance, documenting it, and dealing with the content (e.g. support, medication discussion, booking another appointment). If this conservatively averaged 10 minutes per person doing this, we would spend nearly 7 hours a week on this activity. Given long wait times for new patients, psychiatrist shortages, and the inevitable urgent/emergent demands with patients who do show up, calling every 'no show' patient is simply not a practical plan, despite how simple, commonsensical, and an apparently ethical bare minimum that this approach seems on the surface of it to be. It is in fact a complicated and scarce resource depleting expectation.

So why not have someone else call, like your secretary? The short answer is an inadequate skillset to make the necessary assessment and judgments. But of course secretaries rebook appointments all the time and can at least report on obvious oddities in exchanges with patients. Is the onus on the secretary to call every time, or for an assumed competent patient to take some personal responsibility for initiating the rebooking of the missed appointment?

What about a psychiatric nurse calling? Fine, but this is also a resource being redirected from other tasks unless this is part of his or her job. So why don't we do it this way, with a nurse, all the time? Because it is still very time consuming and expensive. But isn't it worth it if lives are saved, catastrophes averted, and better subsequent appointment compliance is fostered? Sure, if these are the things that actually follow from such an effort. Other than partial better appointment compliance, it is unclear what other benefits follow. To improve attendance, it certainly can help to offer new appointments to the people who did not show up (Glyngdal, Pia; Sørensen, Per; Kistrup, Kristen). However, not surprisingly, "patients who have already defaulted have a higher risk of defaulting again" (Chariatte V; Berchtold A; Akré C; Michaud PA; Suris JC).

Follow-up Efforts: How Much is Enough?

1. What if there is no answer to the phone call made to the no show patient. How often do you call back? You can document you tried; is trying good enough? (What if the patient has no phone? Not uncommon for people living in poverty.)

2. What about a phone call and a message left on an answering machine asking the patient to call back and let the doctor know he/she is alright? (Unfortunately, this is as likely to be ignored as the initial appointment was.)

3. How about a phone call to a family member (if you have permission)? This might worry family members unnecessarily and anger the patient.

4. If the patient has a community case worker, then how about a phone call to the caseworker (e.g., ACT, Community Mental Health Association)? Is this simply offloading responsibility to someone else? How do you provide risk information if the person was fine the last time seen?

5. Perhaps a phone call to the police asking them just to check up on a particular patient? Realistically, police usually do not act without specific and imminent risk data, or without a committal document in hand. Given the volume of 'no shows', this is also a highly impractical use of a precious resource.

In fact, all of the above may happen, but there are many other elements of the patient- psychiatrist relationship that may colour the selection and persistence of follow-up attempt(s).

The Relationship is Critical:

1. I do a risk assessment with every patient I see, every time I see him or her, and I gear my responses to a subsequent 'no show' accordingly. Unless I have new information between visits (e.g., a call from a family member, a note left in my mailslot at work, a phone/page message), then my assumption about a person's present status on the 'no show' day is based on the last contact (which might be over a month ago) and the richer context of an ongoing relationship and known clinical history. Clinical judgment is imperfect but it is what we must rely upon.

2. The better and longer I know someone, then true, the better able I am to make a judgment call about necessary vs optional follow-up (but still false, the notion that relationship knowledge is always adequately predictive.) My knowledge of previous suicide attempts or suicidal thinking, a prior history of violence, my awareness of patterns of medication non-compliance, knowledge about a particular individual's rate of decompensation, my awareness of high risk periods (e.g., post inpatient discharge, anniversary of loss, etc.) or a history of high risk behaviours – all are important data when known or reasonably knowable.

3. Chronically suicidal patients (e.g., with Borderline Personality Disorder illness) who are testing their therapists out of fear of abandonment for example, are a special challenge because of the necessity of maintaining clear therapeutic boundaries. It is very hard for non-clinicians who are unfamiliar with 'affect dysregulation' (the person's mood system not working properly and leading to extreme and nonsensical emotional reactions) to understand or accept that calling a 'no show' patient in this diagnostic category may at times be more distressing and ego fragmenting than simply holding to the previously stated expectation that they will attend their (next) scheduled appointment and follow a prearranged safety/crisis plan.

   It is common to develop of a specific safety plan in high risk patients that can kick in independently of the psychiatrist (e.g., the patient calls a crisis counselling service or a family member, or goes to the ER).

4. Some outpatient treatment services have a written service agreement up front that stipulates not that you will be called if you don't show up for an appointment, but rather that you may be billed for a missed appointment, or that you will be discharged after missing a certain number of appointments (e.g., three in a row). Inherent in this approach is a presumption of capacity and the fostering of a sense of personal responsibility.

Shared Responsibility: The Critical Role of Community Supports

If someone suddenly becomes too mentally ill to attend an appointment, then there is a necessary reliance on family, friends, or community caseworkers to intervene through the legal means available to them (e.g., asking a Justice of the Peace for a Certificate of Committal). The greatest ongoing burden of oversight actually falls to the patient's natural envelope of support.

What about other Mental Health Care Providers?

The above discussion is from an outpatient psychiatrist's perspective. The "system" however, is more complex and nuanced. Different types of caregivers in different types of settings have different duties of response.

We believe that the following have no general obligation to follow-up on 'no show' psychiatric patients (i.e., low-medium risk) without specific new knowledge of imminent heightened risk or vulnerability since the patient was last seen:

a) Family doctors and Nurse Practitioners.

b) Family Health Teams (even with a mental health counsellor as a team member).

c) Private practice psychiatrists.

d) Hospital outpatient psychiatrists working without a shared care team.

We believe the following have a lower response threshold for following up with medium and high risk 'no show' patients precisely because their service models are designed to entail such added responsibility of monitoring. Indeed, it is commonly because patients are in a sustained higher risk category that they were referred to these more intensive services in the first place:

a) Outpatient psychiatrists with a team that includes community caseworkers.

b) Community mental health services with community caseworkers.

c) Assertive Community Treatment Teams.

d) Hospital or agency based community crisis intervention teams.

Of note, Community Treatment Orders (partial outpatient committal orders) have seemingly demonstrated that when patients feel cared for, they do better, and perhaps someone chasing them down following a 'no show' may bear intangible fruit in the long run. However, the CTO represents an advance directive or legislative mandate, and therefore means that the particular patient has already been identified as high risk.

Conclusion:

We don't hold mechanics responsible for a brake failure when they haven't inspected the car recently. Taking the analogy further, brakes can even fail immediately following a competent inspection, because in the real world sometimes things just do breakdown suddenly. Yet when something goes horribly wrong with an entity as variable and complex as a person living with psychiatric illness, family members and patients sometimes believe that doctors should have seen it coming in their infallible crystal ball. But this is just not realistic.

At the end of each day, we psychiatrists must live with the burden

of uncertainty that pervades even the best and most experienced clinical judgment. The emotional and moral fallout when things go terribly wrong usually does not mean a clinical mistake was made. It means real life is complicated, messy, unpredictable, and that sometimes patients hide their real intentions from everyone.

There are many reasons that a patient may not show up to an appointment and most of these reasons are life and circumstance related and they are not related to the patient being in a state of increased risk of harm to self or others.

All caregivers have an obligation to follow-up on high risk patients when the risk is known. We do not believe anyone should be held liable for what cannot be known in advance, or for what could not have reasonably been anticipated in the particular patient at that point in time. The public seems to undervalue a clinician's craft knowledge before a catastrophe occurs and then overvalue it in hindsight.

Endnotes:

1. Medical Post, Nov. 18, 2008; The Rogers Newspaper for Canada's Doctors.

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Acknowledgements:
Our thanks to Cathy Ward, Samantha Forde and Mark Graham for their kind assistance with background research.

Competing Interests:
Both authors serve as editors with the JEMH. The views expressed in this article are exclusively the authors' own opinions and are not endorsed by the JEMH.

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Published: December 31 2011