Factors Associated with Dropout from Outpatient Tertiary Mental Health Services

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FACTORS ASSOCIATED WITH DROPOUT FROM OUTPATIENT TERTIARY MENTAL HEALTH SERVICES

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ABSTRACT

Background and objective:
There is a paucity of mental health hospital-based studies from Pakistan that have observed the contributing factors of dropout. This study aims to understand contributing factors to dropouts from mental health services.

Method:
This telephonic survey was conducted as a cross-sectional study from dropout outpatients of Karwan-e-Hayat Institute for Mental Health Care, a tertiary mental care hospital in Karachi, Pakistan. Using a simple questionnaire to assess socio-demographic variables, psychosocial assessment, and patient perspectives on treatment termination. A total of 158 participants out of 200 patients provided insight into their dropout experiences.

Result:
Results revealed that younger adults, particularly those aged 18-40, demonstrated a greater tendency to discontinue treatment. Level of education was also associated with dropout rates, with uneducated and less educated individuals showing greater tendencies to drop out of treatment than their educated counterparts. Schizophrenia emerged as a leading psychiatric diagnosis associated with high dropout rates. Lack of insight into psychotherapy, patient dissatisfaction, and geographic distance from treatment centers were identified as key contributors to dropout.

Conclusion:
Factors such as age, educational status, diagnosis, insight into the disease, dissatisfaction with the treatment and distance from the treatment center were related to the dropout rate. Insights gained from this investigation advocate for tailored interventions focusing on education, patient satisfaction, and proximity to treatment facilities.

Key words: Dropout factors, psychiatric care, outpatients, tertiary mental health services

INTRODUCTION

Dropouts can be defined as the termination of contact with services when there is no clinical resolution.1 Dropouts are generally those patients who either (a) refuse to return to the therapist after an initial or specific number of visits, (b) or refuse to return for any reason excluded from treatment, or (c) those who wish to return if there is a waiting list, but as a result fail to visit.2 Treatment drop-out is one of the main issues arising for mental health professionals, both inpatients and outpatients show some risk of treatment dropout before completion.3 Drop out of mental health services can be a major problem for people with mental illness, which can have devastating consequences such as increased psychological symptoms, frequent hospitalizations, homelessness, violence against others and suicide.4,5

Previous research suggests that socioeconomic factors such as age, marital status and living conditions may be important to anticipate a dropout.6-8 Other predictors of dropout include clinical setting, patient satisfaction, and severity of clinical condition, which have been described previously.6,7,9

It has also been observed that patients discontinue their treatment after receiving symptomatic relief, although they have not fully recovered from a
therapist’s point of view.2 Rosenthal and Frank reported that 32.5% of patients did not attend more than five OPD follow-ups when they were discharged after Hospital.10

Several studies from developed countries report the correlates of dropping out from psychiatric care.11-14 World Mental Health Survey carried out by the World Health Organization comparing the dropout between high-income and lower-income countries found that the dropout rate was higher in the low income countries.15 Although dropout from mental health care is common in Pakistan, there is a paucity of mental health hospital based studies from Pakistan that have observed the contributing factors of dropout. This study aims to contribute toward reducing this gap.

METHODS
This telephonic survey was conducted as a cross-sectional study from dropout outpatients of Karwan-e-Hayat Institute for Mental Health Care, a tertiary mental care hospital in Karachi, Pakistan. Ethical approval was obtained from the institutional ethics committee. Study period was three months (from January to March 2022). All participants aged ≥18 years were recruited after obtaining telephonic informed consent.

To be included in the study, the participants were required to be aged ≥18 years and diagnosed with one of the mental disorders. Patients with an exclusive diagnosis of substance abuse or dependence, intellectual disability, significant cognitive impairment due to organic brain syndromes, not diagnosed with any psychiatric disorder, who did not complete all assessments, those who had no access to a phone, and who had registered but were not seen a psychiatrist at least once were excluded. A convenient sampling method was used.

Dropouts included patients who registered with psychiatric services as “regular attendants” and attended psychiatric services at least one to three times for treatment, but after six months of the last visit to the clinic, did not come back. The hospital records (walk-in performa/work-up file/in-patient file) of these patients were reviewed to draw such a conclusion. Apart from this, data was extracted from the registration counter to cross-check the data. Patients considered to be ‘dropouts’ were contacted telephonically and informed about the study. They were invited to participate in a telephonic survey to participate in the study. Those who consented were again briefed about the study and verbal informed consent was obtained prior to recruitment. A total of 200 patients were approached, of whom 158(79.5%) agreed to participate.

The socio-demographic variables considered in the study were: age, sex, marital status, living arrangements (alone, with family or children, with biological family, with other relatives, in sheltered accommodation), level of education (no education, primary studies, secondary studies, and university studies), and occupation, occupational status (active, unemployed, pensioner, student, and domestic tasks). The dropout reason was evaluated using an open-ended question, in which the patients were asked to give one or more reason(s) for dropping out from treatment. Descriptive analysis was carried out using mean and standard deviation with range for continuous variables. Frequency and percentages were calculated for discontinuous variables.
RESULTS

Table 1 shows the demographic data of dropout patients.

Table 1: Demographic features of the patient

<table>
<thead>
<tr>
<th>Socio-demographic Factor</th>
<th>Age Group</th>
<th>No. of Cases (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>18-30</td>
<td>49 (31%)</td>
</tr>
<tr>
<td></td>
<td>31-40</td>
<td>52 (32.9%)</td>
</tr>
<tr>
<td></td>
<td>41-50</td>
<td>34 (21.5%)</td>
</tr>
<tr>
<td></td>
<td>51-60</td>
<td>20 (12.7%)</td>
</tr>
<tr>
<td></td>
<td>61-Above</td>
<td>3 (1.9%)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>49 (31%)</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>109 (69%)</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Single</td>
<td>78 (49.4%)</td>
</tr>
<tr>
<td></td>
<td>Married</td>
<td>66 (41.8%)</td>
</tr>
<tr>
<td></td>
<td>Divorced</td>
<td>8 (5.1%)</td>
</tr>
<tr>
<td></td>
<td>Widow</td>
<td>4 (2.5%)</td>
</tr>
<tr>
<td></td>
<td>Separated</td>
<td>2 (1.3%)</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Uneducated</td>
<td>52 (32.9%)</td>
</tr>
<tr>
<td></td>
<td>Primary</td>
<td>19 (12%)</td>
</tr>
<tr>
<td></td>
<td>Secondary</td>
<td>51 (32.3%)</td>
</tr>
<tr>
<td></td>
<td>Intermediate</td>
<td>21 (13.3%)</td>
</tr>
<tr>
<td></td>
<td>Bachelor &amp; Master</td>
<td>15 (9.5%)</td>
</tr>
</tbody>
</table>

The most common psychiatric diagnosis leading to dropout was schizophrenia (65.2%) followed by bipolar affective disorder (20.9%), depression (17%) and anxiety (3.2%). Figure 1 demonstrates the factors associated with dropout. The most common reason of psychiatric patients dropout was “Patients was unwilling to come /aggression” (26.6%).
DISCUSSION
Socio-demographic analysis found that younger adults were more likely to drop out of treatment than older adults. Results showed that 63.9% of youth dropped out of treatment. This has been observed before and is partly explained by the fact that youth often have to rely on others around them to seek treatment. Adolescents’ greater likelihood of dropping out of treatment may account for greater morbidity, dysfunction, and a worse longitudinal course than has been observed in patients with early-life onset. Similarly, another study has reported young patients under 40 years have a low compliance rate. Younger patients were found to have more level of noncompliance; this implies that younger patients may have a more negative perception of medicine, perceiving them to be more harmful and viewing themselves as possessing greater personal control over how to best manage their condition.

The Study showed that the uneducated and low-educated people dropout rates were higher than those educated people. Similar factors were observed in medicine compliance before. This is consistent with earlier studies, showing that education had a positive relationship with compliance. Better compliance in psychiatric population is pertinent considering higher education obviously promotes insight into the illness and a better account for the need for the treatment.

In our study, the psychiatric diagnosis of schizophrenia was the high drop-out rates as compared to other psychiatric diagnoses. Correspondingly, a study carried out in the US reported that schizophrenia patients had higher drop-out rates than those with other illnesses. However, four European studies reported that patients with a diagnosis of schizophrenia and other psychoses were more likely to continue their treatment than patients with neurotic and personality disorders. A diagnosis of schizophrenia was found to greatly increase the chance of continuing treatment in the study by Rossi et al.

The results of the present study clearly show that those

Figure 1: Factors associated with dropout
who drop out of treatment do not have much insight into psychiatric treatment. Most of the reasons are that the patient is unwilling to come or aggressive and the patient is better or the patient does not need treatment. Studies from the west have also shown that poor insight was a consistent predictor of missed appointments/dropout from treatment.\textsuperscript{31,32} These findings suggest that while evaluating new patients, clinicians should give due importance to the evaluation of insight and those with poor insight, should receive proper psycho-education to reduce the chances of dropout from treatment.\textsuperscript{33} These findings suggest that clinicians should spend additional time and effort to educate their patients concerning the effectiveness of mental health treatments. In a recent study of mental health advocacy group members, it was observed that receiving education from care providers was critically important in facilitating patients’ acceptance of their treatments.\textsuperscript{33}

Another important reason for dropout in this study was patient dissatisfaction with treatment. Similarly, the results of the previous study showed that patients in the "dropout" group had lower levels of satisfaction with various aspects of the treatment process. Studies in the west show that missed appointments and dropouts are more often associated with non-collaborative decision-making.\textsuperscript{34} Previous studies from India also suggest that long waiting times, fewer attending physicians and staff attitude further determine compliance with appointment.\textsuperscript{35,36} Accordingly, the satisfaction levels of patients and caregivers need to be improved. Distance was another factor in dropout that was highlighted in the present study. Previous studies have also shown higher dropout rates to be associated with greater distance of residence from the treatment facility.\textsuperscript{37}

**Study Limitations**

I. Limited resources and the specific nature of the outpatient setting limited the sample size.

II. Due to complete reliance on telephonic surveys, individuals without access to a telephone could not participate in this study.

III. Due to limited resources and difficulties in community services, telephonic consent was obtained, which cannot fully replicate the comprehensive nature of traditional written consent.

**CONCLUSION**

Dropout from psychiatric care negatively affects the outcomes of mental disorders. In the present study, it was found that some factors such as age, educational status, diagnosis, insight into the disease, dissatisfaction with the treatment and distance from the treatment center were related to the dropout rate. Insights gained from this investigation advocate for tailored interventions focusing on education, patient satisfaction, and proximity to treatment facilities. Replication of this study in diverse settings could facilitate formulating comprehensive strategies to mitigate dropout rates, thereby optimizing mental health care delivery.

**REFERENCES**


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Authors’ contributions:
Nasir Mahmood; Concept, data analysis, manuscript writing, manuscript revision
Uroosa Talib; data collection, data analysis, manuscript writing,
All the authors have approved the final version of the article and agree to be accountable for all aspects of the work.

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