STUDY OF DROPOUTS FROM A PSYCHIATRIC CLINIC OF A GENERAL HOSPITAL

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SUMMARY

During the study period of three months, out of 425 patients attending the psychiatric clinic of a general hospital, for the first time, 163 (38.8%) did not complete the treatment as prescribed by the doctors and were considered as dropouts. They were contacted at their homes to find out the reasons of the dropping out, were compared with patients, who completed the treatment fully on socio-demographic variables and attitude towards treatment. Dropouts significantly differed from treatment acceptors regarding their income, place of domicile and occupation. Maximum number of patients (59.9%) dropped out after the first visit. Dropouts were the maximum among epileptics, and minimum among the mentally retarded patients. Dropouts were dissatisfied with their experience at the clinic as treatment advised was not of their choice, and they feared bad side effects from ECT and drugs. Long distance of residence from clinic was an important reason for dropping out, besides social and economic reasons.

Though a wide disparity between the presently available trained psychiatric personnel and the need for mental health services in India has been well documented by Bajardia (1971), Vidya Sagar (1973), Wig (1974), yet it is less recognised that utilisation of the meagre available psychiatric services from mental hospitals, general hospitals, psychiatric units, and private psychiatrists is far from ideal. The ratio of psychiatrists to general population is little over one psychiatrist to every one million people. Hence, it is all the more important to find out if the existing facilities are being utilised to the optimum. In this context the problem of the large number of dropouts from treatment in psychiatric clinics needs closer scrutiny to find out its causes and thus maximise the use of the existing resources.

Dropouts are generally taken as patients who either (a) refuse to return or fail to return to the therapist after the initial or a specified number of visits; (b) or are expelled from treatment programme due to any reason; or (c) those, who seek appointment in case there is a waiting list, but subsequently fail to make a visit. It has been observed that dropping out from treatment generally depends on three variables which relate to (a) the patient; (b) the therapist; and (c) the clinic setting. Patients characteristics include his socio-demographic status, first or subsequent contact, expectation of patient from the therapist and nature of illness. Therapist's training to handle a particular type of patients and his personality and treatment approach in general also influence the dropout rate. Clinic characteristics include whether it is a walk-in-clinic or has a waiting list, has simple or a lengthy admission procedure, clinic's staff patient ratio, treatment methods used and finally its criteria for selection of patients.

Further, it has been observed that end point of therapy may be different for the patient and therapist. The patient may terminate therapy after getting symptomatic relief, though he is not fully recovered from point of view of the therapist. Rosenthal and Frank (1958) reported that 32.5%
patients did not attend more than 5 sessions, once they had been discharged as improved. Unlenhuth and Duncan (1968) found that among neurotic outpatients symptomatic improvement is seen during the first 4 weeks, while other symptoms improve much later. In some cases the degree of improvement may be related to the length of treatment as in alcoholics, a positive relationship between long-term outcome and length of hospitalisation has been found (Moore et al., 1960; Katz, 1966; Pembourten, 1967; Brown 1964) as well as contact with the patient in outpatient after hospitalisation (Fox and Smith, 1959; Thomas, 1959; Ritson, 1969). Further it cannot be assumed that patients who are dropouts are a total loss. Frank (1963) who gave placebo to a group of outpatients found that most of symptoms decreased and improvement occurred following placebo administration. It has been observed that many patients on a waiting list for psychotherapy may improve without ever receiving specific treatment (Endicott, 1963; Gottschalk et al., 1963).

AIMS
(1) To study the incidence of dropouts from a psychiatric clinic of a general hospital. (2) To study the socio-demographic variables and clinical diagnosis of the patients, who dropout from treatment and compare them with treatment acceptors. (3) To study the clinical outcome of the dropouts on follow up. (4) To study the attitudes towards mental illness of the treatment acceptors and dropouts.

MATERIAL AND METHODS
All the new patients attending the OPD of Psychiatry Department of Government Medical College, Patiala for the first time over a 3-month period from a defined catchment area were recorded. Detailed history was taken, wherever possible. The patients who started treatment, but failed to report back before full recovery were considered as dropouts. In the present study, a minimum number of eight visits (once weekly visit for a two-month period) was taken arbitrarily as the cut-off point for a treatment acceptor except in cases, where recovery had occurred earlier. Those patients coming for less than 8 visits and not recorded as clinically recovered were defined as dropouts. All the patients, considered dropouts by the above criterion, were posted letters requesting them to come. Those patients who did not turn up in spite of letters were visited at their place of residence. All the patients as well as their close relatives were interviewed personally to elicit their reasons for not continuing the treatment at the hospital, and the subsequent treatment received from any other source, their expectation from the clinic and their opinion about their experience at the clinic. In addition, an attitude scale was administered to all 425 patients in order to assess their knowledge and attitude regarding the nature of mental illness and its treatment.

RESULTS
Table I shows the socio-demographic variables of the treatment acceptors and dropouts. Out of the total 425 patients who contacted the clinic for the first time during the three-month intake period, 165 (38.8%) failed to come for follow up were labelled as "dropouts". In the two groups, there was no difference regarding age, sex and marital status. Regarding the domicile, among the acceptors 68.8% were from urban area, while 31.2% were from rural area, but there were significantly more (44.8%) dropouts from rural area (p<0.01). As regards income among the dropouts, significantly more patients were from lower and high income than middle income group (p<0.01). There were more illiterate in the dropout group (59.4%) as compared to those among acceptors, though the difference was
**TABLE 1. Socio demographic variables of patients**

|                | Non-dropouts |   | Dropout |   | p value |
|----------------|--------------|---|---------|---|---------|
|                | No. | %   | No.  | %   |         |
| A. Total new patients (125) | 260 | 61.1 | 165 | 38.8 |         |
| B. Sex distribution: |       |     |       |     |         |
| Males           | 136  | 52.3 | 88   | 53.3 | $X^2=0.42$ d.f. = 1 N.S. |
| Females         | 124  | 47.7 | 77   | 46.7 |         |
| C. Age in years: |       |     |       |     |         |
| Below 20        | 70   | 26.9 | 44   | 26.7 | $X^2=1.62$ d.f. = 4 |
| 21-29           | 59   | 22.7 | 40   | 24.2 |         |
| 30-39           | 54   | 20.8 | 34   | 20.6 |         |
| 40-49           | 33   | 12.7 | 20   | 12.1 |         |
| 50 and above    | 44   | 16.9 | 27   | 16.4 |         |
| D. Domicile:    |       |     |       |     |         |
| Rural           | 86   | 31.2 | 74   | 44.8 | $X^2=8.14$ d.f. = 1 p < .01 |
| Urban           | 174  | 68.8 | 91   | 55.2 |         |
| E. Income:      |       |     |       |     |         |
| Lower           | 60   | 23.1 | 59   | 35.8 | $X^2=15.44$ d.f. = 2 p < .01 |
| Middle          | 167  | 64.2 | 74   | 44.8 |         |
| High            | 33   | 12.7 | 32   | 19.4 |         |
| F. Education:   |       |     |       |     |         |
| Illiterate      | 136  | 52.3 | 98   | 59.4 | d.f. = 1 |
| Literate        | 124  | 47.7 | 67   | 40.6 |         |
| G. Marital Status: |     |     |       |     |         |
| Single          | 87   | 33.5 | 52   | 31.6 | $X^2=0.17$ d.f. = 1 N.S. |
| Married         | 170  | 65.4 | 111  | 68.2 |         |
| Widow/Others    | 3    | 1.1  | 2    | 1.2  |         |
| H. Occupation:  |       |     |       |     |         |
| Farmer          | 40   | 15.4 | 29   | 17.6 |         |
| Labourer        | 24   | 9.2  | 18   | 10.9 |         |
| Service         | 53   | 20.4 | 15   | 9.1  | $X^2=13.61$ d.f. = 6 p < .01 |
| Household       | 79   | 30.4 | 60   | 36.4 |         |
| Business        | 19   | 7.3  | 15   | 12.7 |         |
| Student         | 31   | 11.9 | 18   | 10.9 |         |
| Others          | 14   | 5.4  | 4    | 2.4  |         |

Not significant. Both the groups included patients from all occupations, the only positive finding was there were significantly less patients in service and more in business who dropped out of treatment. The maximum patients (59.32%) dropped out after the first visit. The number of the dropouts decreased as the treatment progressed. Another 23.63% dropped out after the 2 to 4 visits, while only 6% dropped out between 5 to 8 visits. The number of dropouts was minimum (24.2%) among the mentally retarded.
patients and was maximum (53.9%) in diagnostic category of epilepsy. Further, among the psychotics the dropout rate was less (34.8%) as compared to the neurotics (39.8%). Table 2 shows the attitudes towards mental illness of treatment acceptors and dropouts and their experience at the psychiatric clinic. Almost all the treatment acceptors felt satisfied with the behaviour and attitude of the attending doctors and staff towards them and their relatives. But among the dropouts, a vast majority (80.6%) were not satisfied with the experience at the clinic. Further, it can be observed that almost all the non-droppers (97.5%) accepted the treatment prescribed, but among the dropouts, a significantly large number of patients (81%) did not accept the treatment (p<.001). Similarly questioned about choice of therapy, all the regular treatment seekers stated that they wanted drugs or E. C. T. or both. On the other hand among dropouts, significantly low number of 56.9% considered drugs alone or with E. C. T. as the choice treatment (p<.005). 10.2% expressed more faith in homeopathic or ayurvedic treatment, and nearly one-third (32.7%) reported faith in faith healers. Thus, we find a high level of ambiguity in the dropout group about coming to an allopathic hospital, and medical treatment given therein. Further, a significantly large number among the dropouts (47.27%) expressed apprehension from the bad effects of somatic treatments as compared to the treatment acceptors (p<.001). Similarly a significant large

| Experience at clinic: | Non-droppers | Dropout | p value |
|-----------------------|--------------|---------|---------|
| Fully satisfied       | 20 (12.5%)   | 140 (9.9%) | X^2 = 267.1 |
| Just satisfied        | 140 (87.5%)  | 133 (86.6%) | d.f. = 2 |
| Not satisfied         | —            | —        | p<.001(S) |

| Acceptability: | Non-droppers | Dropout | p value |
|----------------|--------------|---------|---------|
| Treatment acceptable | 156 (97.5%) | 31 (18.79%) | X^2 = 20.59 |
| Treatment unacceptable | 4 (2.5%) | 134 (81.2%) | p<.001(S) |

| Preferred treatment of choice: | Non-droppers | Dropout | p value |
|-------------------------------|--------------|---------|---------|
| Drugs and E.C.T.               | 160 (100.0%) | 94 (56.97%) | X^2 = 63.2 |
| Ayurvedic/ Homeopathic drugs  | —            | 17 (10.31%) | p<.005(S) |
| Faith healers                 | —            | 54 (32.72%) |         |

| Assumed effect of somatic treatments: | Non-droppers | Dropout | p value |
|-------------------------------------|--------------|---------|---------|
| A. Bad effect on body               | 28 (17.5%)   | 78 (47.27%) | X^2 = 32.76 |
| No effect                           | 132 (82.5%)  | 87 (52.73%) | d.f. = 1 |
| B. Fear of drug dependence          | 12 (7.5%)    | 56 (33.94%) | X^2 = 112.4 |
| No fear                            | 148 (92.5%)  | 61 (33.97%) | d.f. = 2 |
| Not known                           | —            | 48 (29.09%) | p<.001(S) |

Table 2. Attitude of patients towards treatment
number of dropouts feared that they would get dependent upon drugs as compared to treatment acceptors (p < .001). The reasons for dropping out of treatment, were (a) difficulty in getting to the hospital on time due to long distance and non-availability of transport facilities (74%) (b) social stigma by 54% and (c) Economic factors i.e. cost of travel and medicines etc. by 23%. As opposed to this in the regular attenders only 42.5% expressed having transport or travelling difficulties and none admitted to any social or economic problems in continuing treatment.

The outcome of the dropouts, when contacted at home after an interval of 3-6 months was as follows: 49% were continuing the prescribed medicines at home, while the rest 51% had stopped medicines. Of these, only 17.6% consulted another psychiatrist, while 43.6% went to G. Ps. and 31.6% went to faith healers. At 6 months follow up, 6.7% had recovered from their illness, another 50.3% had improved, 23% were the same, while 20% had become worse i.e. roughly half had improved or recovered, while other half had remained ill or deteriorated.

DISCUSSION

In the present study the dropout rate is 38.8% from the psychiatry outpatient department of a general hospital which functions like a walk in clinic with no appointments necessary, although some relatives or patients do make an appointment before their visit. This figure compares with the earlier reports, 31% by Khanna et al. (1971), 30% by Srinivasanmurthy (1974), and 45% reported by Wig et al. (1974), from a psychiatric clinic in a general hospital and 50% dropout rate from the rural psychiatric clinic after the initial contact as reported by Kulhara (1987). In the present study 10.9% did not turn up after the initial appointment, 59.3% dropped after one visit, 23.6% dropped after 4 visits and 6% dropped after 8 visits indicating that dropout rate was highest after the first visit and came down as the number of visits made by the patient increased. Age and sex did not influence the dropout rate. In our study, 50.9% of dropouts were below 30 years, which is in keeping with observation of Turner et al. (1970), who observed that younger patients are lost to follow up in epidemiological studies. The various demographic variables as sex, marital status, education, occupation, religion, family structure did not differentiate between dropout and treatment acceptors. However the dropout and non-dropout differed as regards their income and domicile. The lower income group as well as higher income group were significantly more likely to dropout than middle range income group (p < .01), 24 of 58 studies on dropouts (41.9%) that showed that socio-economic status into account, income was an important guide for dropout from treatment (Hollingshed and Redlich, 1958; Kissin, 1968). Similarly, as regards the domicile, 44.8% of dropouts were from rural area, as compared to 36.5% among the non-dropout, which was significantly different (p < .01) indicating that rural patients were more likely to dropout of the treatment. Further, occupation wise, more dropouts were doing their own business and fewer were in service.

Analysing the dropouts according to nature of illness, it can be observed that in the present study the dropout rate was 34.8% in psychotics, 39.80% in neurotics, 53.9% in epileptics, and 24.2% in mentally retarded patients. The higher dropout rate among the neurotics indicates that neurotics tend to dropout once they get symptomatic relief. Such short term dropouts may have a different therapeutic goal than the therapist (Rosenthal and Frank, 1958; Cappon et al., 1964 and Johnson, 1969). Further the epileptics have much higher dropout rate (53.9%), indicating that they came for consultation
and after knowing the diagnosis, they continued to take prescribed medicine at home, as was indicated during home visits to dropouts. However, in cases of mental retardation the dropout rate was 24.2% indicating that they stuck to clinics and felt helped by guidance, suggestion and treatment offered to mentally retarded at the clinic.

Among the dropouts, 81.2% found the treatment advised by doctors as unacceptable, which was significantly different from the non-dropouts, who considered the treatment advised acceptable. The reason for not accepting the treatment by the patients offered by the psychiatrists is due to the difference in treatment offered and expected by the patient. 56.9% of dropouts considered that somatic treatments as medicines and P.C.T. was the treatment of choice, 32.7% considered only faith healers could help, 10.3% considered indigenous treatment was the choice treatment. Significantly 47.3% of the dropouts considered that somatic treatments have a bad effect on the patient, \((p<0.01)\) as compared to 17.5% among non-dropouts. Further significantly a higher number of dropouts (33.9%) considered that psychiatric drugs have a tendency to produce drug dependence as compared to 7.5% in non-dropouts \((p<.001)\).

One of variables affecting dropout rate is the clinic setting and treatment offered. In the present study 80% among the dropouts reported that experience at psychiatric clinic was not satisfying as compared to 87.5% among the non-dropouts who felt satisfied with experience at the clinic. Disatisfied with the clinic experience, the dropouts took treatment elsewhere. Surprisingly only 17.6% of dropouts took treatment from another psychiatrist, about one-third took treatment from faith healers, while the majority (44%) of dropouts went back to general practitioners. Analysing the various reasons for dropping out a large number of dropouts (73.9%) reported difficulty in coming in time to the clinic due to long distance from hospital as a reason for dropout. In 54.5% of dropouts, social reasons as a "feeling of stigma" on being detected taking psychiatric treatment, especially among the unmarried females was common. 23.2% dropped due to economic reasons as they felt that the drugs were costly.

Interestingly only 20% of dropouts reported worsening at home, when contacted at home 3 to 6 months after the initial contact. Surprisingly 50% reported improvement, 6.3% recovered, the reason being they continued prescribed drugs at home. Several other studies of untreated general psychiatric patients have too reported long term improvement rate of 37% (Salzow and Peter, 1956) and 61.3% (Wallace and Whyte, 1959).

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