Impact of Quality Rights Gujarat program on dropout rate of patients visiting outpatient psychiatry department of tertiary care hospital

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ABSTRACT

Background: Dropout from an outpatient clinic is the loss of patient to the scheduled follow-up. Noncompliance in the form of treatment dropouts is a major problem across outpatient mental health settings and can range from 15% to 60%. Follow-up studies provide valuable insights into improving the quality of existing mental health facilities. Quality Rights Gujarat (QRG) is a step toward improving mental health facilities across various centers.
Methods: This retrospective observational study aims to explore follow-up pattern, predictors and any change after QRG implementation. Pre intervention Group (A) attended psychiatry OPD for 6 months before implementation of QRG project and Post intervention Group (B) attended psychiatry OPD for 3 months after implementation of QRG project.
Results: Total 1632 Patients consulted in group A and 926 patients consulted Psychiatry OPD in group B. The most common Psychiatric disorder were Depression (A-19.55%, B-28.62%), Schizophrenia and related disorders (A-14.15%, B-15.01%), Neuropsychiatric disorders like headache and epilepsy (A-14.52%, B-18.68%), substance use disorder (A-15.26%, B-13.71%) and Bipolar disorder (A-11.76%, B-13.17%). 59.56% patients dropped out after the first visit in pre intervention group as compared to 51.94% patients in post intervention group. Significant reduction of about 8% in loss to follow up and 16% increase in follow-ups of initial visits after implementation of Quality Rights Gujarat project.
Conclusions: Much can be done to improve attendance in most services. The initiative like QRG significantly has positive results on patient's follow-up.

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1. Introduction

Many mental illnesses require prolonged treatment and the success of any mental health program can be measured by the number of new cases detected and number of such patients continuing treatment. A study of follow-up patterns will provide information about community or family's perception of mental illnesses. It also provides information on other problems faced by patients and their relatives in maintaining follow-up (Parthasarathy and Chandrashekar, 1981).

Follow up studies in mental health facilities will also provide valuable insights into improving the quality of existing mental health facilities and efficient use of scarce mental health resources (Gill et al., 1990).

The current paper focuses on dropout and the change in dropout rates after implementation of the discussed mental health program. Drop out is defined here as not coming for follow-up treatment for mental health problems before a therapeutic trail is completed. Dropout is known to be a common and important contributing factor to poor outcomes and results in inefficient use of limited resources.

World Health Organization's (WHO) World Mental Health Survey found overall percentage of patients dropped out of treatment for mental health problems over a period of one year as 31.7% in 24 countries. The drop out from the psychiatric sector was similar across high income, upper middle income and lower-middle income countries. The specific disorders had little relationship to dropout and what associations were seen were

inconsistent across high, middle and low income groups (Wells et al., 2013). The rate of dropping out of treatment in psychiatric outpatients is highly variable and estimated prevalence varies from 15 to 60% (Reneses et al., 2009; Edlung et al., 2002; Centorrino et al., 2001; Pang et al., 1996). Studies in general hospital psychiatry clinics, show that 20–60% of the patients failed to return after the first visit and 31–56% attended no more than four times (Dodd, 1970).

Other studies showed 18–22% of recently discharged psychiatric patients did not attend their scheduled first follow up (Nelson et al., 2000; Kruse and Rohland, 2002). Studies of psychiatry outpatients also showed 50% of the patients dropped out after the first visit, 23% did so in the next two visits and only 27% attended more than three visits (Agarwal, 2012). While another study showed 53.1% of the patients dropped out after first visit, 29.4% patients had 1–3 follow up, 14.9% had 4–10 follow up and only 2.6% had more than 10 follow ups (Singla et al., 2015). A Prospective Study in North Indian Psychiatric Outpatient Clinic of newly diagnosed psychiatry patients shows Maximum drop outs of patients were on first follow up visit. There was gradual decrease in dropout rate after every subsequent visit. Trust, rapport, first dose effect, immediate response to patient query were most important factors to hold the patient in initial few visits. Later on, the patients already having 3–4 visits, dropped out due to side effects, treatment response, economical factors, distance and timing of outpatient clinic (Singh, 2015). Clinic characteristics whether it is a walk-in-clinic, has simple admission procedure, staff training of handling patients, adequate staff, etc., also influence drop outs (Gill et al., 1990).

Common causes of dropouts

Socio-demographic – younger age, male gender, ethnic minority, low socio-economic status, low education, unemployment, Low social functioning, social isolation
Clinical – serious mental illness, substance use disorders, lack of insight, poor alliance with therapist, lack of active participation in treatment, initial period of illness, unsympathetic attitude, poor quality referral letter, longer delay between referral and appointment
Patient related – Dissatisfaction with treatment, feeling that they had improved, treatment would not helpful, they were too unwell, medication effects, previous experience of mistreatment, overtreatment or coercive treatment, not being listen to, not being actively participating in decision making, memory problem like dementia
Practical constraints – forgotten appointments, having moved, cost, transportation, lack of time, bureaucratic issues, not having health insurance

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Patient dropping out of treatment is a common problem in psychiatric settings across all ages, diagnoses and socio-cultural set-ups. Various clinical strategies like appointment reminders, treatment contracts, case management, patient education and activation, primary care physician communications about medication treatment plans and education about side effects may reduce early dropouts (Olfson et al., 2009). Dropout of treatment may reflect the patients perspective that treatment is not necessary, is not meeting their needs or is not being provided in collaborative manner. An emerging literature on patient-centered care and shared decision making in psychiatry provides suggestive evidence that efforts to increase patient centered communication and promote individuals active involvement in mental health treatment can also reduce dropouts.

Various interventions to reduce dropouts along a spectrum of intensity have been applied viz. low intensity interventions during periods of increased risk of dropouts like 'system responsiveness', and medium to high intensity interventions such as Critical time intervention (CTI) and assertive community training (ACT).

System responsiveness include minimizing wait time to first appointments, having inpatient staff clarify expectations about the role of aftercare, making an appointment, using 'reaching out 'strategies (telephone prompts, reminder letters use of referral coordinators, etc.) and discussing or providing medications at outpatient visits.

Linkage strategies aimed at increasing attendance at outpatient appointments after discharge targets at patient meeting outpatient staff and visit outpatient program prior to discharge. Development of community reintegration curriculum aimed at helping hospitalized patient develop skills in symptom identification, medication management, relapse prevention and making and keeping of appointments also increase treatment adherence.

The medium to high intensity interventions such as Critical time intervention (CTI) to assertive community treatment (ACT) were developed to address the issue of dropouts. CTI is a time limited psychosocial model that aims to strengthen individual ties to service providers and social networks and to provide emotional support and practical assistance during a time of transition. ACT is a highly intensive outpatient intervention in which community based clinical treatment is provided by multidisciplinary team to individuals who have difficulty engaging in traditional treatment services (Kreyenbuhl et al., 2009).

The Substance Abuse and Mental Health Services Administration's (SAMHSA's) Strengthening Treatment Access and Retention State Initiative (**STAR-SI**) supported NIATx (Network for the improvement of addiction treatment) and others (Molfenter et al., 2015) in conducting case studies of the use of telemedicine in addiction treatment. In each case study, treatment providers identified factors impeding or facilitating the sustainability and use of Treatment Assisted Care, which they were most interested in conducting via videoconferencing and mobile devices.

SAMHSA's Treatment Improvement Protocols uses electronic media and information technologies in behavioral health treatment, recovery support, and prevention programs. Technology based assessments and interventions are important therapeutic tools that clinicians can integrate into their work with clients.

Technology-assisted care (TAC) can transcend geographic boundaries to reach many people otherwise unable to access services and is useful in a wide variety of settings, including Web-based interventions offered in the home, community organizations, schools, emergency rooms, and health care providers' offices, as well as via mobile devices and online social networks. Furthermore, TAC is often accessible on demand at the user's convenience, thus reducing barriers to accessing care (Rockville, 2015).

Psychosocial interventions can play a critical role in a comprehensive treatment plan, and are probably necessary components if treatment is viewed in the context of the patient's overall level of functioning, quality of life, and compliance with prescribed treatments (Bellack, 2001).

We have used a novel Quality Rights Gujarat program intervention to strengthen the mental health care services across various domains and this can be briefly described as under:

1.1. Quality Rights Gujarat (QRG)

Quality Rights Gujarat (QRG), a project aimed at improving quality of mental health services and respect for the rights of persons with mental health conditions is being implemented in 6 mental health facilities in Gujarat. The project uses WHO's