

Improving Session Attendance in Mental Health and Substance Abuse Settings: A Review of Controlled Studies

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Patient nonattendance to scheduled sessions results in excessive costs to mental health and substance abuse providers and compromises the care of clients. This paper presents a comprehensive review of interventions that have been shown to increase session attendance rates in these settings. Unique to other review papers, reliability estimates were performed in the selection and evaluation of obtained studies. Reliability of article selection and evaluation strategies was excellent (.80 to .88). Study results indicate several attendance improvement methods appear to be particularly promising, such as scheduling appointments promptly, reminder letters and telephone calls, soliciting patient commitment, and helping to resolve obstacles to attending the session. The specific manner in which these interventions are implemented appears to influence session attendance rates. Moreover, some attendance improvement interventions are clearly effective in some settings, but not others. Specific recommendations are provided in light of the study findings.

THE PERCENTAGE OF SCHEDULED SESSIONS in mental health settings that are *not* attended by clients varies between 10% and 60% (Grunebaum et al., 1996; Lester, 1970; Nicholson, 1994; Palmer & Hampton, 1987; Sparr, Moffitt, & Ward, 1993). In general, about a third of appointments in clinical

settings are missed (Neeleman & Mikhail, 1997; Palmer & Hampton, 1987), and initial appointment attendance is particularly poor (Grunebaum et al., 1996; Sparr et al., 1993). Follow-up appointment nonattendance rates are comparably high and have been reported to be between 20% and 50% (Garvey, 1991). Importantly, most missed appointments are not rescheduled (Gottesfield & Martinez, 1972).

Missed appointments in clinical settings are costly, as they often lead to exacerbation of clients' symptoms (Sparr et al., 1993) and misuse of clinical resources (Miyake, Chemtob, & Torigoe, 1985; Webster, 1992), a tremendous problem given limited resources available at many mental health care facilities (Dubinsky, 1986). Indeed, the health care of patients is compromised by long waiting lists, which are often associated with lost time due to missed appointments (Freund, Russell, & Schweitzer, 1991). Although interventions have been developed to improve attendance rates in mental health care settings, the studies supporting these interventions have yet to be collectively examined in a systematic process. Therefore, the purpose of this paper is to review the various interventions evaluated in controlled studies that have targeted the improvement of attendance among clients in mental health settings, including those evaluated in substance abuse facilities.

Method of Searching the Literature

In conducting this review, attempts were made to obtain all controlled intervention studies that examined methods of improving attendance in mental health care settings, including substance abuse treatment programs. The title, abstract, and source of matches to the keyword *attendance* were

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used to identify such studies utilizing the PsycInfo search engine. The initial selection criteria for obtaining study articles are specified below:

1. The appointment must be scheduled to occur in a clinical setting (i.e., medical appointments, psychiatric appointments, psychological appointments, medical screenings, exercise meetings).
2. A measure of the independent variable's effect on attendance must be included in the study.
3. The study must be controlled (i.e., between-groups designs with random assignment, withdrawal designs with at least one return to baseline following intervention, multiple-baseline designs across subjects, behaviors, or settings).
4. Controlled studies involving nonattendance outcome measures must not be included in this review if the primary focus of the controlled study is *not* an attempt to increase attendance rate.
5. The focus of the study was on the improvement of initial session attendance (i.e., intervention was implemented prior to first session, and/or prior to beginning treatment). Studies implementing ongoing interventions throughout treatment were excluded.
6. The study must be published in a scientific journal or book chapter.

After each study was evaluated according to the aforementioned criteria, it was further examined to determine if it contained citations to other similar controlled outcome studies in clinical settings. The guidelines utilized in this process are specified below:

1. Identify citations within the Introduction section of each article that appear relevant to studies that evaluate attendance improvement interventions. Although this search should be overly inclusive, if the cited article seems relevant when selected from the Introduction section but does not appear relevant after reviewing its title in the Reference section, this reference may be eliminated from the selection.
2. Browse the Reference section of the article for any studies that may be relevant to interventions that improve attendance rates based on the titles presented in the Reference section. Be liberal in selecting referenced articles to be examined based on the title alone.
3. Collect all articles that appear to be relevant and determine if the article is a controlled treatment outcome study, as indicated above.

Results

RELIABILITY OF SEARCH METHOD

To assure reliability of the utilized search strategy, an interrater reliability estimate was obtained. Briefly, a rater blind to decisions made by the first author, who conducted the initial search, reviewed a sample of the articles that were selected to evaluate whether these articles met the specified criteria. A sample of 16 of the 169 collected articles (approximately 10%) was randomly selected for review by the blind rater. An agreement or disagreement between raters was considered for each article. Agreement was judged to occur if both raters believed the article did, or did not, meet the aforementioned selection criteria. Interrater reliability was calculated by dividing the total number of agreements by the total number of disagreements plus agreements. Interrater reliability of the 16 studies was good (i.e., reliability=0.88). Thus, the controlled intervention outcome studies were reliably selected from those obtained initially.

Reliability was also estimated in regards to the review of articles selected from the Reference sections of obtained articles. Specifically, an independent rater, who was blind to decisions made by the research assistant who conducted the initial search, reviewed the Reference sections of the 16 randomly selected studies mentioned above. There were a total of 358 references included in these 16 studies. Agreements or disagreements between raters were considered for each reference. An agreement indicated that both raters selected and/or rejected a particular reference for retrieval. On the other hand, a disagreement occurred if one of the raters selected a particular reference for retrieval and the other rater did not. There were a total of 291 agreements and 67 disagreements. A reliability coefficient of 0.81, calculated as described earlier, indicated good reliability.

The results of the aforementioned search method yielded 43 controlled attendance improvement outcome studies. To facilitate the review of these studies, three tables were created for each setting in which the studies took place (i.e., mental health care settings, substance abuse treatment programs for adults, interventions with children and adolescents). The tables include extensive details regarding the studies' sample characteristics, methodological design, intervention descriptions, method of measurement, and significant outcomes. In addition, the studies were rated by the first author on their degree of specificity in describing the intervention protocol (see Treatment Specified column). To ensure reliability of this procedure, approximately 10% of the original 43 studies were randomly selected for

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